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GOOD MEDICAL PRACTICE

PROFESSIONALISM, ETHICS AND LAW

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1 ETHICAL PRINCIPLES FOR THE MEDICAL PROFESSION

This chapter sets out to define what is meant by the term 'ethics', briefly introduces the reader to current frameworks for ethical thinking, summarises the key ethical principles for good medical practice, and presents the codes of ethics that guide the medical profession. The chapter is intended to provide a foundation for the ethical dimensions of issues addressed in later chapters. Modern doctors are required to be cognisant of the needs and rights of the individual patient, aware of the rights of patients' relatives, carers and guardians, alert to issues such as cultural and language barriers, prudent in the use of health resources, familiar with complaints processes, and involved in maintenance of professional competence and their own health. As subsequent chapters will demonstrate, doctors who possess good communication skills, respect their patients, have a broad knowledge of ethics and the law relating to medical practice, and are willing to consult more experienced colleagues when needed will be well equipped to resolve most of the ethical dilemmas that they will encounter in the daily practice of their profession.

More detailed historical or theoretical studies of medical ethics or in-depth discussion of the application of medical ethics in specific subjects areas such as in-vitro fertilisation, human cloning, euthanasia and organ transplantation are beyond the scope of this book. A suggested reading list is provided at the end of this chapter for those seeking to commence a more detailed study of medical ethics.

1.1 SOME HISTORICAL CONTEXT

Codes or statements of ethical principles have existed to guide medical practitioners for almost 2500 years. The basis for the principles contained in the modern codes originated in Greece through what is usually termed the Hippocratic Oath. Hippocrates was born on the island of Kos in 460 BC and was responsible for the beginnings of a scientific approach to medicine through his teaching and practice of medicine in Greece. His teachings covered all branches of medicine and included the moral and ethical requirements of an

ideal physician, which were subsequently epitomised in the Hippocratic Oath. His writings are collected into the Corpus Hippocraticum, which comprises 70 books. It is probable that many of the 70 books were written by his disciples after his death [1].

While the Hippocratic Oath is frequently used as a starting point to introduce the topic of medical ethics, in its original form it would not serve modern society well nor would it effectively guide modern medicine or the medical profession [2]. Its continued mention relates more to the medical profession's pride in its origins, traditions and right of self-regulation than to its immediate relevance. It does identify some key issues that still underpin more modern ethical codes, including the concepts of 'first, do no harm', abuse of privilege, confidentiality, respect for life and awareness of one's limitations. As discussed below, many medical professional bodies, international and national, now publish ethical codes and more detailed guides to professional conduct [3–6]. Many medical schools in Australia [7] and abroad [8–9] have maintained or reintroduced the swearing of modernised 'Hippocratic' oaths for medical students at graduation ceremonies. However, medical education in Australia does not rely on this symbolic practice and instead concentrates on providing education in ethical, legal and professional development issues in an integrated manner through the entire medical student curricula and (to a lesser extent to date) through postgraduate curricula [10].

1.2 WHAT ARE ETHICS?

When we speak of ethics in a modern sense, we refer to a systematic approach to how we as individuals or as a society wish to live our lives, expressed as an 'ethos', meaning a way of life. Ethics and ethical codes can then be seen as 'an accumulation of values and principles that address questions of what are good or bad in human affairs. Ethics searches for reasons for acting or refraining from acting; for approving or not approving conduct; for believing or denying something about virtuous or vicious conduct or good or evil rules' [11].

As this book addresses both ethical and legal issues in the practice of medicine, it is important for doctors to appreciate that ethics and the law are quite different concepts, although in most areas of medical practice they may often seem to be closely aligned. When faced with clinical decisions involving ethical considerations, recourse to what the law says will generally be unhelpful. The law is in essence a system of rules developed by government on behalf of a community to regulate the interaction between individuals and the state, to which system the community agrees to be bound.

1.3 AN INTRODUCTION TO ETHICAL THINKING

Ethics is not only a set of principles or values; ethics also has characteristic modes of reasoning and justification. Traditionally, the two major schools of ethical

reasoning are the consequentialist and the deontological. When applied to medical ethical problems, these systems of reasoning can be regarded as procedures for making and justifying value judgments. Their usefulness in the study of medical ethics is to reveal who is making these judgments and how they are being justified – in starkest relief, are doctors applying only their own value judgments and ignoring those of patients or the community? More recently, as discussed below, there has been revived interest in applying what is termed 'virtue ethics' when considering the ethical qualities required of medical practitioners.

The best known consequentialist school of moral thinking is utilitarianism, measuring the good or bad of any action according to whether its results are good or bad. Utilitarianism was described by the English philosopher Jeremy Bentham towards the end of the eighteenth century. Bentham proposed that actions be evaluated by their ability to produce pleasure (moral good) or pain (moral evil). In its present form, utilitarianism finds expression in terms of an action's ability to best satisfy the needs of all those affected by the proposed action; it involves examining the results and effects of actions, and not the motives or thoughts of the actor.

Conversely the deontological approach centres on the standards or values to which the action conforms or to the motivation behind the action, according fixed moral values to actions. The ten commandments are a well-known deontological set of rules, albeit religiously founded, but other deontological codes that do not have a religious basis have been developed, for example that developed by the German philosopher Immanuel Kant in the eighteenth century. The deontological approach, based on fixed moral values, is almost certainly a common method of justifying many professional judgments. For example, seeking consent of a patient is more likely to be justified because of the ethical principle of respect for autonomy that it expresses than whether doing so will lead to a better outcome for the patient. A deontological approach is also a common basis for the personal moral judgments made by most doctors. When these personal values conflict with requests for treatments that are lawful, difficulties may arise, for example requests for sterilisation or abortion to a doctor who views such procedures as morally unacceptable.

While the consequentialist and deontological approaches to ethical justification are the best-known procedures for analysing medical ethical problems, modern thinking has produced or revived a number of other frameworks, including virtue-based theory, values-based medicine, narrative ethics, discussion or discourse ethics, professional ethics and critical ethics [12]. Despite this proliferation, doctors should not be deterred from engaging in debate and discussion of ethical issues in medicine simply through lack of familiarity with the language and frameworks used by moral philosophers and ethicists.

In practice, it seems most doctors pragmatically combine elements of both the deontological and utilitarian approaches to ethical decisions, often without articulating the processes involved or identifying and explicating the ethical component of a decision. Often, when they use a deontological approach only to

find that it is likely to produce undesirable outcomes, they will switch to utilitarian approach – providing an ethical justification for the value judgments that resolve difficult issues. There is nothing inherently wrong with this approach. However, if difficult ethical problems are to be debated frankly within the community, or even discussed between patient and doctor, it is enlightening for the doctor to understand how he or she has reached a position. Doing so also increases the likelihood that the values of the other party or parties will be appreciated.

1.4 A MODERN FRAMEWORK FOR DISCUSSING MEDICAL ETHICS

In recent times, many of those responsible for teaching ethics to medical students have adopted four generally agreed basic moral principles relevant to medical practice [13]. Three of these four principles, drawn largely but not exclusively from a deontological ethical philosophy, were first identified systematically in the US Belmont report [14] and were later extended to four and popularised by James Childress and Thomas Beauchamp, teachers from Georgetown University in that country (hence the colloquial reference to the 'Georgetown mantra') in their *Principles of Medical Ethics* first published in 1979 [13]. These four ethical principles are described as autonomy, beneficence, non-maleficence and justice:

1 *Autonomy*, or more accurately, respect for autonomy, in this context may be defined as the obligation of doctors to respect the right of individuals to make decisions on their own behalf. While most societies have long recognised a basic moral obligation to respect each person's autonomy, it is only relatively recently that this ethical principle has evolved to be of such central importance in the doctor–patient relationship. Respect for autonomy is a component of respect for human dignity, a principle embedded in international covenants.
2 *Beneficence* is defined as the duty to do the best for the individual patient or to act in the best interests of the patient. Although this is a relatively straightforward obligation, its application is often challenged by such questions as who is to decide what is best, an issue of autonomy, and the availability of the required resources, an issue of justice.
3 *Non-maleficence* is defined as the duty to do no harm. This also appears to be a relatively straightforward moral obligation and probably is the best understood and most widely adhered to ethical principle in clinical practice. However, as medical inventiveness yields new techniques and new diagnostic tests, subtle potential breaches of this obligation are not readily identified by enthusiastic innovators, as may be seen with the premature promotion of new tests for 'earlier' diagnosis or for population screening.
4 *Justice* is more difficult to define but incorporates notions of equity and fair distribution. While it may be tempting for doctors to shun this obligation,

leaving it to managers, administrators and government, this is neither realistic nor desirable. Increasingly, individual doctors are being made aware of the resource consequences of their decisions and prompted to reflect on how those decisions can effect equitable access to health care. This ethical principle emphasises that the doctors have a responsibility to the community at large as well as to individual patients (see Chapter 13).

These four ethical 'pillars' do not stand on their own, but are interpreted and applied as justifications for clinical decisions using systems of reasoning or thinking developed by moral philosophers as outlined above. Doctors trained in the scientific method, where hypothesis is refuted by factual observation, are often uncomfortable with the approaches of moral philosophers, although subconsciously or unknowingly they themselves use these approaches to problems.

An important consideration and shortcoming of an exclusive reliance on these four principles is that they can be deployed to justify opposite resolutions of the same ethical choice. Thus, a decision in favour of a treatment can be justified because it respects the patient autonomy principle but can be opposed on the ground that it will infringe the non-maleficence principle. This characteristic underlines the limits of adopting a narrow approach to the sources of ethical justification. In response to this shortcoming and in recognition that the above four principles tend to limit rather than enhance ethical debate, some observers have turned, or returned, to the alternative framework of virtue ethics, an approach that assesses the nature of professional behaviour by the way that it expresses desirable qualities or virtues [12].

1.5 QUALITIES OF AN 'ETHICAL' DOCTOR; VIRTUE ETHICS

1.5.1 Capacity for self-reflection

One of the long-standing distinguishing features of a learned profession has been said to be a capacity for self-regulation. In earlier times, this was taken to mean personal self-regulation (self-reflection). Society accepted this approach by the medical profession until the mid-nineteenth century when the registration and disciplinary processes of medical boards were first established (see Chapter 8). Gradually the concept of self-regulation came to be understood as the regulation of the profession by medical boards consisting solely of medical practitioners. The earlier notion of a key feature of being a professional meaning taking personal responsibility for maintaining professional standards and competence faded from view. This is unfortunate as the capacity for self-reflection remains a central element of professionalism. It encompasses such things as keeping one's knowledge and skills up to date, being aware of the nature of one's interactions with patients and colleagues, being capable of self-criticism, and taking responsibility for one's own health. Being a doctor is first a vocation, and secondly a profession. For those

who espouse this perspective, externally imposed regulation and codes of conduct should represent an affirmation of this professionalism rather than a burden.

In addition to this primary quality of the capacity for self-reflection, there are additional qualities that have been proposed as making the good or 'ethical' doctor. The qualities, or virtues, that have been proposed include [15]:

- fidelity to trust
- compassion
- phronesis – practical wisdom or prudence
- justice
- fortitude – courage
- temperance
- integrity
- self-effacement.

From our perspective, there are a more limited number of qualities that, if possessed and/or practised, would ensure that patients were secure in their trust and confidence in their doctor. These include veracity (truthfulness), maintenance of privacy and confidentiality, and fidelity.

1.5.2 Veracity (truthfulness)

The profession's recognition of the move away from paternalism and towards respect for autonomy should make it clear to doctors that they have an obligation to be truthful and that patients expect doctors to tell them the truth. It would be unusual for an 'ethical' doctor to deliberately lie to patients, but some doctors experience difficulty in discerning the difference between obfuscation and compassionate provision of information. This difficulty may be compounded in many parts of Australia, where doctors are dealing with patients and patients' families from many other cultures. Arguments against the virtue of veracity include the suggestions that 'benevolent deception' is warranted at times to reduce patient anxiety, that neither patients nor doctors can ever know 'the whole truth' and that some patients do not want the truth. While sincerely considered clinical examples can be gathered to support these arguments, they are not acceptable to the community and would be unlikely to be accepted by the doctor if the doctor became a patient. The existence of these arguments simply emphasises that effective medical practice has to combine veracity with compassion, patience, discernment and good communication skills.

Truthfulness, veracity and frankness can present challenges for doctors, including how to explain to patients that something has 'gone wrong' with an operation or procedure conducted by that doctor or another, or whether the doctor should notify the medical board regarding a colleague whose ability to practise may be impaired (see Chapter 8). In many such situations, these challenges are ethical dilemmas that arise because there may be no one best or correct answer to a problem. Such challenges are intrinsic to the nature of ethics and especially

professional ethics. Their resolution requires a sound knowledge of the competing ethical justifications and the wisdom to decide between them. Ethics has been criticised because it does not provide *the* resolution in such situations, but this misunderstands its role. Ethics clarifies the choices and the alternative justifications: it cannot, and should not, displace the individual professional judgment that is required.

1.5.3 Privacy and confidentiality

These concepts, which have both ethical and legal origins and applications, are discussed more fully in Chapter 5. The ethical concept of maintenance of confidentiality of information about patients was probably based in the need to earn the confidence of patients so that they would be willing to disclose all relevant personal information so that, in turn, accurate and beneficial judgments could be made about diagnosis and treatment. In ethical terms, this could have been described as fulfilling the principle of beneficence – ensuring that decisions are in the patient's best interests. It is now also based on the principle of respect for autonomy (so that a patient does not surrender the right to privacy and confidentiality by consulting a doctor and retains the right to control the disclosure of personal information). Even if a basis in ethical principle is not sought, confidentiality would remain pivotal, for the practical reason of the need for trust to underpin a satisfactory doctor–patient relationship.

There are legal and ethical conflicts with the maintenance of patient confidentiality, for example when a doctor possesses confidential information that, if released, might prevent harm or injury to others (see Chapter 5). In routine medical practice breaches of this duty do occur; their avoidance is important to the maintenance of trust which the duty serves. In daily practice, it is essential to be aware that sharing of information in hospitals with other staff or students breaches confidentiality if it is not necessary for the patient's treatment or care. Normally implied consent can be safely assured where it is necessary for that care. Confidentiality can also be breached thoughtlessly, systematically or deliberately. Thoughtlessly, many doctors breach confidentiality in public discussions with colleagues or at clinical conferences. Systematically, institutional procedures can breach confidentiality by, for example, not keeping records secure or by the ready visibility of operating and admission lists. Finally, some doctors breach confidentiality deliberately in seeking to learn more of the illness of colleagues or public figures not under their care.

1.5.4 Fidelity/trustworthiness/integrity

It is not possible to adhere to the basic ethical principles of autonomy, beneficence and non-maleficence without demonstrating fidelity (dependability), trustworthiness or integrity, and reliability. These qualities explain why doctors cannot

abandon their patients without making or allowing time for other arrangements; why doctors must never use the doctor–patient relationship for sexual or improper purposes; why they must leave their family or friends when on call or called to an emergency; and why the profession has long claimed that 'the patient's interests must always come first'.

Conflicts of interest that greatly try the virtue of fidelity do arise. In the grey zone of conflict between self-interest and patient interest, these conflicts are frequently not recognised, or certainly not openly admitted, for example where additional medical services will increase the doctor's income, where the completion of a clinical trial competes with a patient's desire to withdraw or where attendance upon a patient is deferred until the next morning. Conflicts of interest in relation to selected aspects of medical practice, including the conduct of clinical research and interactions with the pharmaceutical and medical devices industries, are considered in more detail in Chapters 17 and 18.

1.6 OTHER DESIRABLE QUALITIES

While less pivotal for the satisfactory completion of any doctor–patient interaction, there are two other characteristics that we believe assist most doctors in developing and maintaining effective relationships with their patients and also assist in finding means acceptable to all parties to avoid potential breaches of ethical responsibilities. These are compassion and discernment.

Compassion in the context of medical practice encompasses empathy, perceptivity and sensitivity to the needs of the patient, kindness and humaneness [16]. It is a quality that helps separate the giving of medical care from mere application of technology. The converse of compassion includes thoughtlessness, rudeness, abruptness and insensitivity. Although these negative characteristics are sometimes excused on the grounds of efficiency and effectiveness, this does not lessen their likely negative impact on the patient–doctor relationship.

Discernment or *judgment* can be defined in two ways. Most medical students learn of the term 'clinical judgment' in the setting of making a diagnosis from a list of possibilities, weighing the clinical evidence or choosing between treatment options. However, discernment in good medical practice takes this considerably further and implies (whether by intuition, insight, good communication, experience or other reasons) that the doctor is able to discern the real need of the patient, the hidden concerns of the family, even the true reason for the patient presenting on a particular day. Another way of expressing discernment is to separate knowledge from wisdom; knowledge derived from information tells the doctor what can be done while wisdom derived from experience informs what should be done. Discernment is a quality more readily developed by some doctors than others and will never be developed if no effort is applied. Of course, judgment and discernment can never be perfected. Even the most experienced and caring of

doctors will occasionally get it wrong – misunderstandings, particularly based on cultural differences or personality, can always arise [17–19].

Finally, an important additional quality expected of doctors is a *commitment to teaching*, expressed in the code of ethics of the Australian Medical Association (AMA) as 'Honour your obligation to pass on your professional knowledge and skills to colleagues and students'. Teaching brings its own professional responsibilities; these are discussed in Chapter 2.

1.7 MODERN CODES OF MEDICAL ETHICS

Most professions have developed their own ethical codes of behaviour. These are guides to proper conduct for their members whose particular obligations to society are, because of the nature of their training and responsibilities, different from those of the community as a whole. The codes are derived from and reflect moral principles already generally agreed upon by the community, but are often more restrictive than the norm because their function is to define the conduct that is required of a member of the profession. While the standards they set can be quite demanding, they are not absolute and vary between different communities and professions, and change with time as the attitudes and values of a society change. They act as standards by which people, within and without a particular profession, may judge or measure what is considered proper behaviour for people in that profession at that particular time and in that particular society. Most professional codes set standards of integrity and competency, with the primary aim of ensuring the trust and respect of the community. Most also contain reference to standards of intra-professional behaviour (professional etiquette).

For the medical profession, the best known and most influential code is the *Declaration of Geneva*, adopted by the World Medical Association (WMA) at its First Assembly in Geneva in 1948 and amended from time to time, most recently in 2006 [3]. It is regarded as the modern version of the Hippocratic Oath and reads as follows:

> *AT THE TIME OF BEING ADMITTED AS A MEMBER OF THE MEDICAL PROFESSION:*
>
> *I SOLEMNLY PLEDGE* to consecrate my life to the service of humanity;
>
> *I WILL GIVE* to my teachers the respect and gratitude that is their due;
>
> *I WILL PRACTISE* my profession with conscience and dignity;
>
> *THE HEALTH OF MY PATIENT* will be my first consideration;
>
> *I WILL RESPECT* the secrets that are confided in me, even after the patient has died;

I WILL MAINTAIN by all the means in my power, the honour and the noble traditions of the medical profession;

MY COLLEAGUES will be my sisters and brothers;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely and upon my honour.

The most recent revision of the code of ethics of the Australian Medical Association [4] was published in 2004 and revised in a minor way in 2006. It is reproduced in full as Appendix 1. Medical colleges have also issued codes of ethics that include principles specific to the relevant field of practice. National bodies such as the National Health and Medical Research Council, the medical colleges and professional associations from time to time issue ethical statements specific to topical issues; examples of these are referred to in other chapters.

1.8 THE RIGHTS OF PATIENTS

Fundamental to any meaningful 'doctor–patient relationship', and essential for good patient care, is that the relationship is based on mutual respect, trust and confidence between doctor and patient. The reciprocal nature of this relationship is emphasised by increasing reference to it being a partnership. The relationship includes respect for the competent adult patient's right to decide what will happen. This emphasis on patient autonomy and partnership does not diminish the fundamental ethical responsibilities of the doctor doing good and not doing harm to the patient. This change in emphasis of ethical principles (towards patients' rights and away from earlier codes that now appear too paternalistic in approach) is not a particularly new trend. In September 1981, the 34th Assembly of the WMA met in Lisbon and approved the following statement on the rights of the patient. It was referred to as the *Declaration of Lisbon* and stated:

> Recognising that there may be practical, ethical or legal difficulties, a physician should always act according to his/her conscience and always in the best interest of the patient. The following Declaration represents some of the principal rights which the medical profession seeks to provide to patients. Whenever legislation

> or government action denies these rights of the patient, physicians should seek by appropriate means to assure or to restore them.
> (a) The patient has the right to choose his physician freely.
> (b) The patient has the right to be cared for by a physician who is free to make clinical and ethical judgments without any outside interference.
> (c) The patient has the right to accept or to refuse treatment after receiving adequate information.
> (d) The patient has the right to expect that his physician will respect the confidential nature of his medical and personal details.
> (e) The patient has the right to die in dignity.
> (f) The patient has the right to receive or to decline spiritual and moral comfort, including the help of a minister of an appropriate religion. [20]

The declaration was revised, updated and extended in 2005. Now entitled *World Medical Association Declaration on the Rights of the Patient*, it continues to emphasise patient autonomy with the following introduction:

> The relationship between physicians, their patients and broader society has undergone significant changes in recent times. While a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to guarantee patient autonomy and justice. The following Declaration represents some of the principal rights of the patient that the medical profession endorses and promotes. Physicians and other persons or bodies involved in the provision of health care have a joint responsibility to recognize and uphold these rights. Whenever legislation, government action or any other administration or institution denies patients these rights, physicians should pursue appropriate means to assure or to restore them. [20]

In 2008, the Australian Commission on Safety and Quality in Health Care issued the *Australian Charter on Healthcare Rights*, a document that covers access, safety, respect, communication, participation, privacy and comment (complaints) [21]. The charter is complemented by more detailed advice on its application and use. In most spheres of life, those who have rights are usually deemed to carry matching responsibilities. It is becoming more frequent that statements of patients' rights also include patients' responsibilities, as is seen from one Australian hospital [22]. The Australian Charter obliquely identifies similar responsibilities for patients. Doctors should also be aware of the advice given to patients by consumer advocate groups [23]. Most of this advice can only enhance the doctor–patient relationship, as it strives to make patients more aware of their role in the relationship.

1.9 UPHOLDING ETHICAL CODES OF CONDUCT

Doctors who breach ethical codes are open to possible action on several levels according to the seriousness of the breach. Disciplinary actions may be taken by colleagues, employers or professional associations, but generally do not carry legal or statutory sanctions. Medical registration boards' sanctions range from reprimand to deregistration; the allegations faced by the doctor at a medical board or tribunal will be specific instances of unprofessional conduct as provided for under the relevant legislation (see Chapter 8) rather than breaches of ethical codes. Some conduct that constitutes a breach may also lead to criminal charges (for example, sexual assault, if the alleged assault occurred in the setting of clinical practice). Other breaches may be the basis of civil claims for damages.

Speaking generally, criminal law sets the minimum standards for conduct in a society by prohibiting behaviour that is offensive to the community and unacceptable in any circumstances, using state agencies to enforce those prohibitions. Civil law, by contrast, enables citizens to enforce rights that the society grants by, most commonly, seeking compensation for harm caused when those rights are ignored by others. Administrative law sets standards for the agencies of the state and governs the relationship between them and citizens. Legislation that establishes medical boards and tribunals reflects a blend of elements of all of these types of law by fixing and empowering the enforcement of standards for professional conduct and enabling citizens to enforce their rights to that level of performance. The medical profession itself, relying on the processes of undergraduate, postgraduate and continuing education, and quality assurance programs, promotes standards of professional excellence that are designed to exceed, and thus ensure conformity with, the levels of performance that the community is entitled to expect. Medical codes of ethics play a central role in articulating and promoting those standards of excellence throughout the course of that education.

1.10 THE MUTABILITY OF MEDICAL ETHICS

The similarity of some of the key tenets of the Hippocratic Oath to modern codes of medical ethics has already been remarked upon. However, codes of ethics are designed to guide and inform professional conduct and each ethical principle is intended to be interpreted in the light of prevailing circumstances and should not be followed rigidly, without thought about the real issues involved. Further, the codes are responsive to broader social shifts on ethical and moral issues. For example, two principles stand out as differences between the Hippocratic Oath and modern ethical concepts – namely the modern emphasis on patient autonomy and the concept of distributive justice.

A more mundane example of changing ethical views has been the evolution of the controls on advertising by doctors that occurred during the last 25 years. Previously, ethical codes had strictly limited advertising by doctors on the somewhat

paternalistic basis that people who were ill and seeking medical attention were vulnerable to misleading advertisements that promised more than medicine could offer. This limitation was gradually replaced by the principle of a community's right to information (advertising), and to the exercise of their free, autonomous and informed choice. Experience of potential and even real harm, especially in the area of advertising of non-essential cosmetic surgery [24], has since provoked some communities, via their parliament, to revisit the controls placed on advertising by doctors (see Chapter 8).

1.11 THE LAW AND MEDICAL ETHICS IN CONFLICT

Conflicts between specific ethical principles, or conflict between the conscience of the individual doctor and a lawful request for medical services that are morally unacceptable to that doctor, are dilemmas with which the medical profession is familiar. In the latter type of situation, the doctor should recognise and disclose the personal ethical conflict and advise the patient to consult another doctor. Doctors must refrain from imposing their personal moral judgments onto patients, who are fully entitled to make choices according with their own moral values.

As society through its parliament and its courts increasingly wishes to use the law to regulate aspects of medical practice, situations will arise where the law appears to be in direct conflict with the generally agreed approach of the profession. This was seen in the *Rights of the Terminally Ill Act 1995* of the Northern Territory, which legalised euthanasia, an initiative subsequently overruled by federal parliament.

Parliament, as the democratic expression of the society, can create new laws limiting the scope of professional conduct when it perceives that patients could suffer harm should doctors not voluntarily recognise or accept the ethical obligations and the privileged position they occupy. Such laws generally set the outermost limits within which doctors must function in any given circumstance. Past examples include laws about the use of certain surgical treatments of the mentally ill.

1.12 CONFLICTS BETWEEN ETHICAL PRINCIPLES

1.12.1 Autonomy versus beneficence

The Hippocratic tradition emphasised beneficence in a way that the community would now regard as unacceptably paternalistic. In the space of a generation, respect for autonomy has supplanted beneficence as the overriding principle guiding medical practice. (Incidentally, the term 'generation' conceals the fact that learning to be a doctor and practising as a doctor is a continuum. The doctor nearing retirement and the young doctor entering practice are a generation or more apart, but are still practising medicine in the same community. The community probably expects similar ethical values from both, but human nature

assures us that this is unlikely, a fact which itself can create ethical conflict.) The pre-eminence which society now places on autonomy has been the basis for widespread discussion of the issue of informed consent or informed decision making (see Chapter 4). Autonomy may also conflict with the principle of justice, in relation to the allocation of medical resources (see Chapter 13).

The principle of respect for autonomy is increasingly being supported by or incorporated into legislation. Most Australian states have legislated for the right of patients to refuse medical treatment. For example, in Victoria, the *Medical Treatment Act 1988* prescribes that patients can refuse medical treatment that may preserve or sustain their lives.

1.12.2 Autonomy versus non-maleficence

An example of this conflict is whether a patient should be informed of a diagnosis of terminal malignancy when the opinion of an attending doctor and that of his or her relatives is that such knowledge would be psychologically harmful to the patient. The principle of respect for autonomy would say that patients should be told everything they wish to know about their condition so that they may make properly informed decisions about their future. However, in certain situations the principles of non-maleficence and beneficence might be given more weight. Such an outcome should only follow a discussion with the patient to establish the patient's capacity to manage bad news and to ascertain the patient's attitude to the involvement of relatives in decision making. It may also require cautious discussion with those closest to the patient, normally the relatives. This latter discussion faces the criticism that it is a breach of autonomy and of confidentiality if the patient has not given informed consent to discuss the diagnosis with others. The response to such criticism is that, in the circumstances, the principle of beneficence is a preferred justification or, drawing on a utilitarian approach, that such discussion is most likely to have the best outcomes. Again, ethics helps to clarify the choices and justification available, but does not replace the judgment that must be made. As the values of patients are greatly influenced by their cultural heritage, this example remains very real in multicultural Australia, despite all that has been written and said in the Western world about the pre-eminence of autonomy.

1.13 ETHICS BEYOND THE DOCTOR–PATIENT RELATIONSHIP

The traditional one-to-one doctor–patient relationship is increasingly altered or strained by various changes in the practice of medicine and in its financing. An increasing number of doctors, including specialists, practise in groups or in hospital teams. Modern patterns of medical practice as well as specialisation have

meant that for many encounters, more than one doctor is involved in the care of the patient. The term 'health-care team' is an abbreviation for the various professional groups who may need to assist in patient care; this team includes specialist nurses, physiotherapists, social workers, psychologists and others.

Various strategies to monitor or control the cost of health care introduced by government and applied by third parties (such as financial agreements between private hospitals and medical insurers) may also affect the doctor–patient relationship to such an extent that patients' rights or the doctor's ethical duties are seriously challenged (see Chapter 13).

Where the other health-care professional is present at the request of the doctor and is instituting care at the direction of the doctor, the prime responsibility for the overall care of the patient remains with the attending doctor. Other health-care professionals have their own codes of ethics and are usually subject to disciplinary oversight by a registration body. The experience, expertise and ethical codes of the other members of the health-care team should be respected by the doctor. Ethical conflicts do arise from time to time, with many being explained by misunderstanding or poor communication (see Chapter 3).

1.14 ETHICS AND LIMITED RESOURCES

While respect for autonomy has dominated the ethical debates and been the focus of community attention in the past 25 years, the ethical principle of justice is likely to become the dominant influence over the next twenty-five. There is an obligation on doctors to provide the best possible care to their patients. When resources are limited, a decision may have to be made about the benefit of a treatment to one patient versus another (for example, the young versus the old, the curable versus the incurable) or made about one form of treatment versus another (for example, does the patient 'need' liver transplantation or should supportive 'treatment' be advised?). An obligation to practise cost-effective medicine will clash with the other obligations of the doctor. This increasingly important subject is discussed more fully in Chapter 13.

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