Some Common Ethical Problems in Medical Practice

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Introduction

The practice of medicine is guided and regulated by ethical code as well as by the laws of the land. A doctor, therefore, not only spends most of his practicing life making scientific decisions in the process of patient care but also must ensure that those decisions are in keeping with ethical and legal requirements. Upholding ethical and legal requirements may sound like an easy and a straightforward thing for a good, decent doctor to always adhere to, but in practice it is not the case. Conflicts and dilemmas do arise. These conflicts may be ethical, legal, or both. This presentation, however, will be confined almost entirely to ethical dilemmas. Such dilemmas are divided into those with *consensus views* and those where there is *no consensus* but there is a continuing discussion. I would like to suggest, in passing, that if a doctor encounters a legal dilemma, then he should seek a legal advice from a reputable legal practitioner or try to secure a court decision. There are a number of occasions when the demands of ethical code are in direct conflict with the legal interest, and the consensus is that the law takes a priority. In this presentation I am going to cite a few commonly encountered situations in which doctors may find themselves in a dilemma and try to point out the current consensus views.

1. Consent

The issue of patient's consent is something that arises almost continuously when the doctor is practicing. Sometimes this is taken for granted: A patient walks to the doctor's clinic for consultation and the doctor goes ahead and examines him or her without seeking consent. Because the patient came to the doctor by his/her own free will and the examination is part of the procedure that the patient expects to take place, consent is taken as already given. This is not the case when it comes to treatment, and in particular, when a surgical procedure is necessary. Here the patient's consent must specifically be asked for and obtained. Now consent is meaningless if it is not an *informed consent*. This means the patient must be given all the necessary information, without any bias, in order to enable him to arrive at a decision. That decision then becomes his.

Dilemma. How much information do you give such a patient? Suppose the patient is not bright enough to ask the relevant questions: Can he still arrive at a correct decision if you present unbiased facts to him? Shouldn't you show some bias and let your own view be known in order to lead him into

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making a correct decision? Again there are times when informing the patient too much may produce a negative impact, for example, a patient with an incurable cancer. Whatever information you give must be given with a lot of caution. Again, what do you do to a patient who cannot give consent either because he is unconscious or he is insane?

Furthermore we have *special situations* like the following:

a. *Jehovah's Witnesses.* Their faith forbids them from accepting blood transfusions. What do you do?
b. *Protesters.* We come across people who are on hunger strike because they are pressing for certain demands. Do you take part in force-feeding such people, and if so, when? The consensus is that you don't. If, however, their demands have been met, but at a time when they are too weak, or are unconscious and unable, to consent to feeding, it is ethically correct for the doctor to feed them.

2. Confidentiality

The code of ethics states that a doctor must observe absolute confidentiality of all the information that he obtained from a patient even after the patient dies. There are, however, a number of exceptions:

a. When a patient gives consent.
b. When it is desirable on medical grounds to seek a patient's consent, but it is in the interest of the patient that confidentiality be broken (e.g., breaking news to a spouse or a close relative about the serious nature of the patient's illness).
c. The doctor's overriding duty to society. A common example nowadays is an AIDS patient who persistently refuses to give permission to the doctor to inform a partner. Similarly, if a patient has a notifiable disease, the doctor is duty-bound to notify the authorities.
d. For the purpose of research when approved by local ethical clearance committee.
e. When information is required by due legal process (e.g., by court of law or by police following a serious crime).

Dilemma. What is the value of the principle if there are so many exceptions? The principle is indispensable no matter how diluted it may be; otherwise the information obtained from a patient would itself be so dilute as to compromise the proper care for the patient. There must be trust between doctor and patient based on the understanding that it is only in special and rare circumstances that a doctor will be forced to reveal the information the patient has entrusted to the doctor. Whose confidences are they? They belong to where they came from, that is, the patient. They belong to the patient even after he dies. That indeed is the consensus. So confidential information belongs to the patient, who may share it with the doctor and anyone else he consents to have the information shared with in order to make proper decisions about how to treat his condition.

Another dilemma. Is it true that this information really belongs to the patient and the doctor? Take a doctor employed by the Government Health Service or another institution (e.g., Muhimbili Medical Centre). The law of master and servant is clear in that anything a servant is paid to bring into existence on the employer's time or with the use of employer's property (e.g., case notes and other stationery) belongs to the employer. So it would seem that information obtained under these circumstances, after all, belongs neither to the patient nor to the doctor but rather to the administration in those institutions. Administrators are mostly laypeople. Medical ethics don't apply to them, and in fact, they may not even know them. There have been cases in which hospital administrators have released sensitive information about patients to the press without getting the consent of the patient or even attempting to protect the patient's identity. This is very unfortunate, for it robs the patient of that confidentiality he had believed belonged to him and his doctor. Fortunately, there is a consensus now that the information does not belong to the hospital administration (the master) either: They are only custodians of the information. To whom does it belong then? It belongs to no one. According to Britain's Home Office Legal Advisor's branch, in an answer to a request from the Lindop Committee on Data Protection: Information is the knowledge convened to the mind by a statement of fact, and it is not therefore susceptible of ownership. Where the information is contained in a document or other object having physical existence, that object is capable of being owned like any other chattel; but there is no ownership in the knowledge that the document can be used to convey.

3. Abortion

In Tanzania, performing an abortion, unless on medical grounds, is a crime punishable by law. There is a fair amount of consensus among doctors regarding medical indications for an abortion. Individual problems dictated by conscience or religious beliefs are sometimes encountered, however, and need to be addressed. In general principle, therapeutic abortion is carried out to preserve the mother's life. Traditionally it is accepted that delivery before the twenty-eighth week is an abortion, since the child is "incapable of independent existence," and that delivery after the twenty-eighth week is classified as premature delivery. The law holds that life begins after the twenty-eighth week. So after the twenty-eighth week, any interference with the pregnancy leading to the death of the unborn baby constitutes murder, but before that it is not murder, it is an abortion. The concept "incapable of independent existence" is now known to be wrong. Not only have babies born as early as twenty-two weeks survived with the aid of incubators, but we are now talking of test tube babies.

Dilemma. When, then, does life begin? Surely not at the twenty-eighth week and not at the twenty-second week of pregnancy either. The Catholic religion holds the view that life begins at the time of conception, that is, when the ovum is fertilized. Up to two years ago, I could not see a very serious challenge to that view. What happened two years ago? You probably

remember the birth of Dolly the cloned sheep. Here there was no conception, no fertilization. It was just a matter of taking of a few living cells and cloning them to produce a new living individual. So when did the life of this individual, Dolly, begin? I see highly complex legal and ethical dilemmas ahead.

Other dilemmas. A few more problems are worth mentioning before we leave the subject of abortion. I have in mind the case of a rape victim who becomes pregnant. If she requests an abortion, what will you do as a doctor? In some countries where abortion is legalized the problem doesn't arise. In this country, however, it represents a dilemma, and I don't think there is a consensus. There is also the question of fetal malformation diagnosed during pregnancy. Do you get the fetus aborted and if it is after the twenty-eighth week—do you go ahead and murder the unborn baby? What if an insane or mentally deficient woman becomes pregnant and has no known relatives? Who can look after the baby? Should she be helped to abort?

4. Medical Examination and Medical Reports

A doctor is often required to carry out a medical examination for the purpose of employment or life insurance. It is an ethical requirement that the patient's interest be safeguarded. If, as is usually the case, the doctor is being paid by the authorities to carry out the examination, then he may be under pressure to give details of the examination to the authorities. Such information must not be given out without the consent of the patient, and as we said earlier, it must be an informed consent. The patient must be made fully aware of the consequences that may follow such revelation. It may be sufficient to simply state that the patient is fit or unfit, without giving details. That is certainly the best and the easiest way of handling the situation.

Dilemma. What if the authorities want to know specifically whether the candidate is HIV positive or not? My view, and I think it is a majority view, is that no examination or test, particularly sensitive tests as HIV, should be carried out without the consent of the patient. If the patient consents to the test, after being duly counseled, then the test can be carried out—but the results should not be passed on to the authorities. In regard to medical reports, although the doctor will, as usual, take a detailed history, sometimes going into very sensitive and intimate details, the report that he sends to the authorities must not contain such details. The patient must know all that is on the report and the implications of including that information.

5. Judicial Punishment

In countries where judicial amputations and flogging are carried out, doctors are required to take part. They may be called upon to carry out the amputation or to certify whether a victim is fit to be flogged.

Dilemma. Should doctors agree or refuse to perform these amputations or certifications? Refusal may be to the disadvantage of the victim. In America,

the death penalty is often carried out by administering a lethal injection. Should that be administered by a doctor?

6. Terminal Illness and Death

The word "euthanasia" literally means "gentle and easy death." The duty of the doctor is to preserve life and not to end it. When it is inevitable that death is coming, it is also the doctor's duty to ensure that the patient dies with dignity and with as little suffering as possible. So far there are no ethical dilemmas in this context. The dilemma arises when it comes to the question of maintaining a "physiological life"—that is, the continuation of the body functions by artificial means while the patient is unconscious for a long time. This has introduced a new dimension into the debate: "quality of life."

Dilemma. When should a doctor switch off the machines? What about the quality of life—is there a rigid code by which such considerations as quality of life can be considered when a doctor is deciding on a form of treatment? No, because the doctor's basic duty is to preserve life. Euthanasia has been misinterpreted as "mercy killing," which is illegal in most countries. Euthanasia may be *compulsory* (totally abhorrent) or *voluntary* (has its followers), *active* (drugs are given or certain procedures are carried out to cause death) or *passive* (drugs or procedures that might prolong life are withheld). Doctors vary in their approach to passive euthanasia, but the profession condemns legalized active voluntary euthanasia.

Conclusion

What I have presented are only some of the common dilemmas that I have come across, or know that my fellow colleagues have encountered or are likely to encounter, in the course of medical practice. It has not been the intention of this paper to cover all the possible dilemmas, for indeed that is not possible. There are areas of consensus and areas where there is no consensus but the debate continues. Where there is no consensus the doctor must be careful in deciding one way or another. He should try as far as possible to consult colleagues, the medical association, or the medical council, or even to seek legal advice depending on the gravity and the complexity of the problem.