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3rd edition 2015

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FOREWORD

Dr. Delon Human
Secretary General
World Medical Association

It is incredible to think that although the founders of medical ethics, such as Hippocrates, published their works more than 2000 years ago, the medical profession, up until now, has not had a basic, universally used, curriculum for the teaching of medical ethics. This first WMA Ethics Manual aims to fill that void. What a privilege it is to introduce it to you!

The Manual's origin dates back to the 51st World Medical Assembly in 1999. Physicians gathered there, representing medical associations from around the world, decided "to strongly recommend to Medical Schools worldwide that the teaching of Medical Ethics and Human Rights be included as an obligatory course in their curricula." In line with that decision, a process was started to develop a basic teaching aid on medical ethics for all medical students and physicians that would be based on WMA policies, but not be a policy document itself. This Manual, therefore, is the result of a comprehensive global developmental and consultative process, guided and coordinated by the WMA Ethics Unit.

Modern healthcare has given rise to extremely complex and multifaceted ethical dilemmas. All too often physicians are unprepared to manage these competently. This publication is specifically structured to reinforce and strengthen the ethical mindset and practice of physicians and provide tools to find ethical solutions to these dilemmas. It is not a list of "rights and wrongs" but an attempt to sensitise the conscience of the physician, which is the basis for all sound and ethical decision-making. To this end, you will find several case studies in the book, which are intended to

foster individual ethical reflection as well as discussion within team settings.

As physicians, we know what a privilege it is to be involved in the patient-physician relationship, a unique relationship which facilitates an exchange of scientific knowledge and care within a framework of ethics and trust. The Manual is structured to address issues related to the different relationships in which physicians are involved, but at the core will always be the patient-physician relationship. In recent times, this relationship has come under pressure due to resource constraints and other factors, and this Manual shows the necessity of strengthening this bond through ethical practice.

Finally, a word on the centrality of the patient in any discussion on medical ethics. Most medical associations acknowledge in their foundational policies that ethically, the best interests of the individual patient should be the first consideration in any decision on care. This WMA Ethics Manual will only serve its purpose well if it helps prepare medical students and physicians to better navigate through the many

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more generally. Bioethics also differs from medical ethics insofar as it does not require the acceptance of certain traditional values that, as we will see in Chapter Two, are fundamental to medical ethics.

As an academic discipline, medical ethics has developed its own

CHAPTER ONE –





how to treat their patients. Physicians collectively (the medical profession) have been free to determine the standards of medical education and medical practice. As will be evident throughout this Manual, both of these ways of exercising physician autonomy have been moderated in many countries by governments and

THE WORLD MEDICAL ASSOCIATION DECLARATION OF GENEVA

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

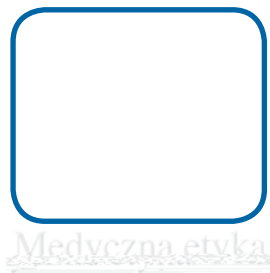
other authorities imposing controls on physicians. Despite these challenges, physicians still value their clinical and professional autonomy and try to preserve it as much as possible. At the same time, there has been a widespread acceptance by physicians worldwide of patient autonomy, which means that patients should be the ultimate decision-makers in matters that affect themselves. This Manual will deal with examples of potential conflicts between physician autonomy and respect for patient autonomy.

Besides its adherence to these three core values, medical ethics differs from the general ethics applicable to everyone by being publicly *professed* in an oath such as the World Medical Association **Declaration of Geneva** and/or a code. Oaths and codes vary from one country to another and even within countries, but they have many common features, including promises that physicians will consider the interests of their patients above their own, will not discriminate against patients on the basis of race, religion or other human rights grounds, will protect the confidentiality of patient information and will provide emergency care to anyone in need.

WHO DECIDES WHAT IS ETHICAL?

Ethics is *pluralistic*. Individuals disagree among themselves about what is right and what is wrong, and even when they agree, it can be for different reasons. In some societies, this disagreement is regarded as normal and there is a great deal of freedom to act however one wants, as long as it does not violate the rights of others. In more traditional societies, however, there is greater agreement on ethics and greater social pressure, sometimes backed by laws, to act in certain ways rather than others. In such societies culture and religion often play a dominant role in determining ethical behaviour.

The answer to the question, "who decides what is ethical for people in general?" therefore varies from one society to another and even



forced by their government to do anything unethical while in other countries it may be difficult for them to meet their ethical obligations, for example, to maintain the confidentiality of patients in the face of police or army requirements to report 'suspicious' injuries.

Although these differences may seem significant, the similarities are far greater. Physicians throughout the world have much in common, and when they come together in organizations such as the WMA, they usually achieve agreement on controversial ethical issues, though this often requires lengthy debate. The fundamental values of medical ethics, such as compassion, competence and autonomy, along with physicians' experience and skills in all aspects of medicine and healthcare, provide a sound basis for analysing ethical issues in medicine and arriving at solutions that are in the best interests of individual patients and citizens and public health in general.

THE ROLE OF THE WMA

As the only international organization that seeks to represent all physicians, regardless of nationality or specialty, the WMA has undertaken the role of establishing general standards in medical ethics that are applicable worldwide. From its beginning in 1947 it has worked to prevent any recurrence of the unethical conduct exhibited by physicians in Nazi Germany and elsewhere. The WMA's first task was to update the Hippocratic Oath for 20th century use; the result was the [Declaration of Geneva](#), adopted at the WMA's 2nd General Assembly in 1948. It has been revised several times since, most recently in 2006. The second task was the development of an [International Code of Medical Ethics](#), which was adopted at the 3rd General Assembly in 1949 and revised in 1968, 1983 and 2006. The next task was to develop ethical guidelines for research on human subjects. This took much longer than the first two documents; it was

not until 1964 that the guidelines were adopted as the [Declaration of Helsinki](#). This document has also undergone periodic revision, most recently in 2013.

In addition to these foundational ethical statements, the WMA has adopted policy statements on more than 100 specific issues, the majority of which are ethical in nature while others deal with socio-medical topics, including medical education and health systems. Each year the WMA General Assembly revises some existing policies and/or adopts new ones.

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HOW DOES THE WMA DECIDE WHAT IS ETHICAL?

Achieving international agreement on controversial ethical issues is not an easy task, even within a relatively cohesive group such as physicians. The WMA ensures that its ethical policy statements reflect a consensus by requiring a 75% vote in favour of any new or revised policy at its annual Assembly. A precondition for achieving this degree of agreement is widespread consultation on draft statements, careful consideration of the comments received by the WMA Medical Ethics Committee and sometimes by a specially appointed work

Declaration of Helsinki was begun early in 1997 and completed only in October 2000. Even then, outstanding issues remained and these continued to be studied by the Medical Ethics Committee and successive workgroups.

A good process is essential to, but does not guarantee, a good outcome. In deciding what is ethical, the WMA draws upon a long tradition of medical ethics as reflected in its previous ethical statements. It also takes note of other positions on the topic under consideration, both of national and international organizations and of individuals with skill in ethics.

On some issues, such as informed consent, the WMA finds itself in agreement with the majority view.

On others, such as the confidentiality of personal medical information, the position of physicians may have to be promoted forcefully against those of governments, health system administrators and/or commercial enterprises. A defining feature of the WMA's approach to ethics is the

priority that it assigns to the individual patient or research subject.

In reciting the **Declaration of Geneva**, the physician promises, "The health of my patient will be my first consideration." And the

Declaration of Helsinki states, "While the primary purpose of medical research is to generate new knowledge, this goal can never take precedence over the rights and interests of individual research subjects."

HOW DO INDIVIDUALS DECIDE WHAT IS ETHICAL?

For individual physicians and medical students, medical ethics does not consist simply in following the recommendations of the WMA

or other medical organizations. These recommendations are usually general in nature and individuals need to determine whether or not they apply to the situation at hand. Moreover, many ethical issues arise in medical practice for which there is no guidance from medical associations. Individuals are ultimately responsible for making their own ethical decisions and for implementing them.

There are different ways of approaching ethical issues such as the ones in the cases at the beginning of this Manual. These can be divided roughly into two categories: non-rational and *rational*. It is important to note that non-rational does not mean irrational but simply that it is to be distinguished from the systematic, reflective use of reason in decision-making.

Non-rational approaches:

- **Obedience** is a common way of making ethical decisions, especially by children and those who work within authoritarian structures (e.g., the military, police, some religious organizations, many businesses). Morality consists in following the rules or instructions of those in authority, whether or not you agree with them. [For *ia caspiras*](#)

values portrayed.

- **Feeling** or **desire** is a subjective approach to moral decision-making and behaviour. What is right is what feels right or satisfies one's desire; what is wrong is what feels wrong or frustrates one's desire. The measure of morality is to be found within each individual and, of course, can vary greatly from one individual to another, and even within the same individual over time.
- **Intuition** is an immediate perception of the right way to act in a situation. It is similar to desire in that it is entirely subjective; however, it differs because of its location in the mind rather than the will. To that extent it comes closer to the rational forms of ethical decision-making than do obedience, imitation, feeling and desire. However, it is neither systematic nor reflexive but directs moral decisions through a simple flash of insight. Like feeling and desire, it can vary greatly from one individual to another, and even within the same individual over time.
- **Habit** is a very efficient method of moral decision-making since there is no need to repeat a systematic decision-making process each time a moral issue arises similar to one that has been dealt with previously. However, there are bad habits (e.g., lying) as well as good ones (e.g., truth-telling); moreover, situations that appear similar may require significantly different decisions. As useful as habit is, therefore, one cannot place all one's confidence in it.

Rational approaches:

As the study of morality, ethics recognises the prevalence of these non-rational approaches to decision-making and behaviour. However, it is primarily concerned with rational approaches. Four such approaches are deontology, consequentialism, principlism and

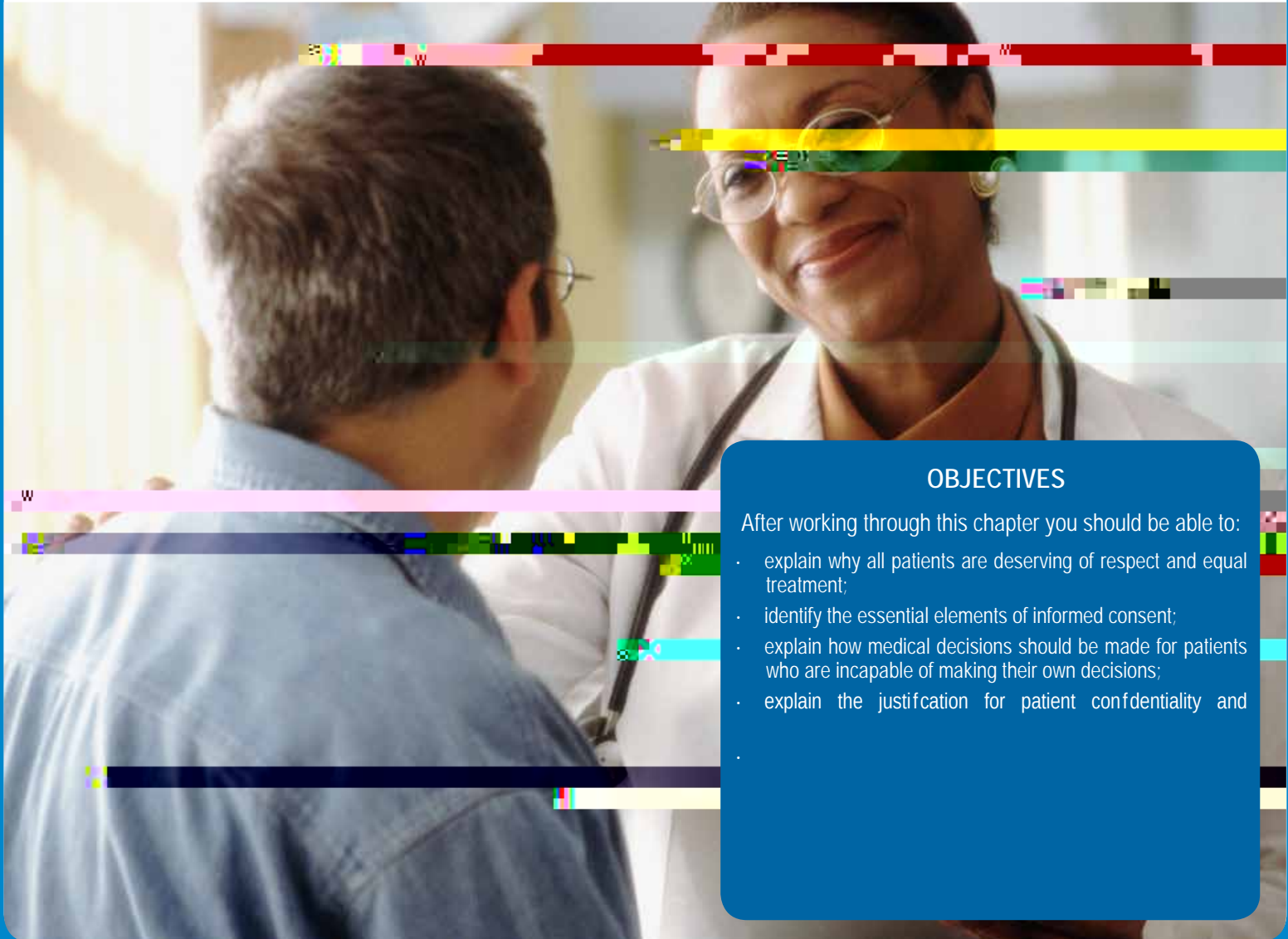
virtue ethics:

- **Deontology** involves a search for well-founded rules that can serve as the basis for making moral decisions. An example of such a rule is, "Treat all people as equals." Its foundation may be religious (for example, the belief that all God's human creatures are equal) or non-religious (for example, human beings share almost all of the same genes). Once the rules are established, they have to be applied in specific situations, and here there is often room for disagreement about what the rules require (for example, whether the rule against killing another human being would prohibit abortion or capital punishment).
- **Consequentialism** bases ethical decision-making on an analysis of the likely consequences or outcomes of different choices and actions. The right action is the one that produces the best outcomes. Of course there can be disagreement about what counts as a good outcome. One of the best-known forms of consequentialism, namely **utilitarianism**, uses 'utility' as its measure and defines this as 'the greatest good for the greatest number'. Other outcome measures used in healthcare decision-making include cost-effectiveness and quality of life as measured in QALYs (quality-adjusted life-years) or DALYs (disability-adjusted life-years). Supporters of consequentialism generally do not have much use for principles; they are too difficult to identify, prioritise and apply, and in any case they do not take into account what in their view really matters in moral decision-making, i.e., the outcomes. However, this setting aside of principles leaves consequentialism open to the charge that it accepts that 'the end justifies the means', for example, that individual human rights can be sacrificed to attain a social goal.
- **Principlism**, as its name implies, uses ethical principles as the basis for making moral decisions. It applies these principles

to particular cases or situations in order to determine what is the right thing to do, taking into account both rules and consequences. Principlism has been extremely influential in recent ethical debates, especially in the USA. Four principles in particular, respect for autonomy, , and *justice*, have been identified as the most important for ethical decision-making in medical practice. Principles do indeed play an important role in rational decision-making. However, the choice of these four principles, and especially the prioritisation of respect for autonomy over the others, is a reflection of Western liberal culture and is not necessarily universal. Moreover, these four principles often clash in particular situations and there is need for some criteria or process for resolving such conflicts.

- **Virtue ethics** focuses less on decision-making and more on the

CHAPTER TWO – PHYSICIANS AND PATIENTS



OBJECTIVES

After working through this chapter you should be able to:

- explain why all patients are deserving of respect and equal treatment;
- identify the essential elements of informed consent;
- explain how medical decisions should be made for patients who are incapable of making their own decisions;
- explain the justification for patient confidentiality and

is often very problematic. Equally problematic are other aspects of the relationship, such as the physician's obligation to maintain patient confidentiality in an era of computerized medical

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the latter, the French Revolution and related political developments. Under these two influences, democracy very gradually took hold and began to spread throughout the world. It was based on a belief in the political equality of all men (and, much later, women) and the consequent right to have a say in who should govern them.

In the 20th century there was considerable elaboration of the concept of human equality in terms of human rights. One of the first acts of the newly established United Nations was to develop the **Universal Declaration of Human Rights** (1948), which states in article 1, "All human beings are born free and equal in dignity and rights." Many other international and national bodies have produced statements of rights, either for all human beings, for all citizens in a specific country, or for certain groups of individuals ('children's rights', 'patients' rights', 'consumers' rights', etc.). Numerous organizations have been formed to promote action on these statements. Unfortunately, though, human rights are still not respected in many countries.

The medical profession has had somewhat conflicting views on patient equality and rights over the years. On the one hand, physicians have been told not to "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" (**Declaration of Geneva**). At the same time physicians have claimed the right to refuse to accept a patient, except in an emergency. Although the legitimate grounds for such refusal include a full practice, (lack of) educational qualifications and specialization, if physicians do not have to give any reason for refusing a patient, they can easily practise discrimination without being held accountable. A physician's conscience, rather than the law or disciplinary authorities, may be the only means of preventing abuses of human rights in this regard.

Even if physicians do not offend against respect and human equality in their choice of patients, they can still do so in their attitudes

towards and treatment of patients. The case study described at the beginning of this chapter illustrates this problem. As noted in Chapter One, compassion is one of the core values of medicine and is an essential element of a good therapeutic relationship. Compassion is based on respect for the patient's dignity and values but goes further in acknowledging and responding to the patient's vulnerability in the face of illness and/or disability. If patients sense the physician's compassion, they will be more likely to trust the physician to act in their best interests, and this trust can contribute to the healing process.

Respect for patients requires that physicians do not put them at any avoidable risk of harm during treatment. In recent years patient safety has become a major concern for healthcare professionals and institutions. Studies have shown that many patients suffer harm and even death because of inadequate procedures for infection control (including hand hygiene), accurate record keeping, understandable medicine labels, and safe medicines, injections and surgical procedures. The WMA **Declaration on Patient Safety** calls on physicians to "go beyond the professional boundaries of health care and cooperate with all relevant parties, including patients, to adopt a proactive systems approach to patient safety."

The trust that is essential to the physician-patient relationship has generally been interpreted to mean that physicians should not desert patients whose care they have undertaken. The WMA's **International Code of Medical Ethics** specifies only one reason for ending a physician-patient relationship – if the patient requires another physician with different skills: "A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her. Whenever an examination or treatment is beyond the physician's capacity, he/she should consult with or refer to another physician who has the necessary ability." However, there are many

other reasons for a physician wanting

**“...in ending a
physician-patient
relationship...
physicians...
should be prepared to
justify their decision,
to themselves, to the
patient and to a third
party if appropriate.”**

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**“A person who
is afflicted with AIDS
needs competent,
compassionate
treatment.”**

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The intimate nature of the physician-patient relationship can give rise to sexual attraction. A fundamental rule of traditional medical ethics is that such attraction must be resisted. The Oath of Hippocrates includes the following promise: "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons...." In recent years many medical association have restated this prohibition of sexual relations between physicians and their patients. The reasons for this are as valid today as they were in Hippocrates' time, 2500 years ago. Patients are vulnerable and put their trust in physicians to treat them well. They may feel unable to resist sexual advances of physicians for fear that their treatment will be jeopardized. Moreover, the clinical judgment of a physician can be adversely affected by emotional involvement with a patient.

This latter reason applies as well to physicians treating their family members, which is strongly discouraged in many medical codes of ethics. However, as with some other statements in codes of ethics, its application can vary according to circumstances. For example, solo practitioners working in remote areas may have to provide medical care for their family members, especially in emergency situations.

COMMUNICATION AND CONSENT

Informed consent is one of the central concepts of present-day medical ethics. The right of patients to make decisions about their healthcare has been enshrined in legal and ethical statements throughout the world. The WMA [Declaration on the Rights of the Patient](#) states:

The patient has the right to self-determination, to make free decisions regarding himself/herself. The physician will inform

the patient of the consequences of his/her decisions. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions. The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.

A necessary condition for informed consent is good communication between physician and patient. When medical paternalism was normal, communication was relatively simple; it consisted of the physician's orders to the patient to comply with such and such a treatment. Nowadays communication requires much more of physicians. They must provide patients with all the information the patients need to make their decisions. This involves explaining complex medical diagnoses, prognoses and treatment regimes in simple language, ensuring that patients understand the treatment options, including the advantages and disadvantages of each, answering any questions they may have, and understanding whatever decision the patient has reached and, if possible, the reasons for it. Good communication skills do not come naturally to most people; they must be developed and maintained with conscious effort and periodic review.

Two major obstacles to good physician-patient communication are differences of language and culture. If the physician and the patient do not speak the same language, an interpreter will be required. Unfortunately, in many settings there are no qualified interpreters and the physician must seek out the best available person for the task. Culture, which includes but is much broader than language, raises additional communication issues. Because of different cultural understandings of the nature and causes of illness, patients may not understand the diagnosis and treatment options provided by their physician. In such circumstances physicians should make

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their families not infrequently demand access to medical services that, in the considered opinion of physicians, are not appropriate. Examples of such services range from antibiotics for viral conditions to intensive care for brain-dead patients to promising but unproven drugs or surgical procedures. Some patients claim a 'right' to any medical service that they feel can benefit them, and often physicians are only too willing to oblige, even when they are convinced that the service can offer no medical benefit for the patient's condition. This problem is especially serious in situations where resources are limited and providing 'futile' or 'nonbeneficial' treatments to some patients means that other patients are left untreated.

Futile and **nonbeneficial** can be understood as follows. In some situations a physician can determine that a treatment is 'medically' futile or nonbeneficial because it offers no reasonable hope of recovery or improvement or because the patient is permanently unable to experience any benefit. In other cases the utility and benefit of a treatment can only be determined with reference to the patient's subjective judgement about his or her overall well-being. As a general rule a patient should be involved in determining futility in his or her case. In exceptional circumstances such discussions may not be in the patient's best interests. The physician has no obligation to offer a patient futile or nonbeneficial treatment.

“The physician has no obligation to offer a patient futile or nonbeneficial treatment.”

medical ethics

The principle of informed consent incorporates the patient's right to choose from among the options presented by the physician. To what extent patients and their families have a right to services not recommended by physicians is becoming a major topic of controversy in ethics, law and public policy. Until this matter is

decided by governments, medical insurance providers and/or professional organisations, individual physicians will have to decide for themselves whether they should accede to requests for inappropriate treatments. They should refuse such requests if they are convinced that the treatment would produce

Do patients have a right to services not recommended by physicians?

Læknisfræðileg siðfræði

some states specify the appropriate substitute decision-makers in descending order (e.g., husband or wife, adult children, brothers and sisters, etc.). In such cases physicians make decisions for patients only when the designated substitute cannot be found, as often happens in emergency situations. The WMA **Declaration on the Rights of the Patient** states the physician's duty in this matter as follows:

If the patient is unconscious or otherwise unable to express his/her will, informed consent must be obtained, whenever possible, from a legally entitled representative. If a legally entitled representative is not available, but a medical intervention is urgently needed, consent of the patient may be presumed, unless it is obvious and beyond any doubt on the basis of the patient's previous firm expression or conviction that he/she would refuse consent to the intervention in that situation.

Problems arise when those claiming to be the appropriate substitute decision-makers, for example different family members, do not agree among themselves or when they do agree, their decision is, in the physician's opinion, not in the patient's best interests. In the first instance the physician can serve a mediating function, but if the disagreement persists, it can be resolved in other ways, for example, by letting the senior member of the family decide or by voting. In cases of serious disagreement between the substitute decision-maker and the physician, the **Declaration on the Rights of the Patient** offers the following advice: "If the patient's legally entitled representative, or a person authorized by the patient, forbids treatment which is, in the opinion of the physician, in the patient's best interest, the physician should challenge this decision in the relevant legal or other institution."

The principles and procedures for informed consent that were discussed in the previous section are just as applicable to substitute decision-making as to patients making their own decisions. Physicians have the same duty to provide all the information the substitute decision-makers need to make their decisions. This involves explaining complex medical diagnoses, prognoses and treatment regimes in simple language, ensuring that the decision-makers understand the treatment options, including the advantages and disadvantages of each, answering any questions they may have, and understanding whatever decision they reach and, if possible, the reasons for it.

The principal criteria to be used for treatment decisions for an incompetent patient are his or her preferences, if these are known. The preferences may be found in an *advance directive* or may have been communicated to the designated substitute decision-maker, the physician or other members of the healthcare team. When an incompetent patient's preferences are not known, treatment decisions should be based on the patient's best interests, taking into account: (a) the patient's diagnosis and prognosis; (b) the patient's known values; (c) information received from those who are significant in the patient's life and who could help in determining his or her best interests; and (d) aspects of the patient's culture and religion that would influence a treatment decision. This approach is less certain than if the patient has left specific instructions about treatment, but it does enable the substitute decision-maker to infer, in light of other choices the patient has made and his or her approach to life in general, what he or she would decide in the present situation.

Competence to make medical decisions can be difficult to assess, especially in young people and those whose capacity for reasoning has been impaired by acute or chronic illness. A person may be competent to make decisions regarding some aspects of life but

not others; as well, competence can be intermittent -- a person may be lucid and oriented at certain times of the day and not at others. Although such patients may not be legally competent, their preferences should be taken into account when decisions are being made for them. The [Declaration on the Rights of the](#)

[Patient](#) states the matter thus: "If a patient is a minor or otherwise legally incompetent, the consent of a legally

"...the patient must be involved in the decision-making to the fullest extent allowed by his/her capacity"

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"In certain limited circumstances it is not unethical to disclose confidential information."

met: the partner is at risk of infection with HIV and has no other reasonable means of knowing the risk; the patient has refused to inform his or her sexual partner; the patient has refused an offer of assistance by the physician to do so on the patient's behalf; and the physician has informed the patient of his or her intention to disclose the information to the partner.

The medical care of suspected and convicted criminals poses particular difficulties with regard to confidentiality. Although physicians providing care to those in custody have limited independence, they should do their best to treat these patients as they would any others. In particular, they should safeguard confidentiality by not revealing details of the patient's medical condition to prison authorities without first obtaining the patient's consent.

Many of the most prominent issues in medical ethics relate to the beginning of human life. The limited scope of this Manual means that these issues cannot be treated in detail here but it is worth listing them so that they can be recognized as ethical in nature and dealt with as such. Each of them has been the subject of extensive analysis by medical associations, ethicists and government advisory bodies, and in many countries there are laws, regulations and policies dealing with them.

- **CONTRACEPTION** – although there is increasing international recognition of a woman's right to control her fertility, including the prevention of unwanted pregnancies, physicians still have to deal with difficult issues such as requests for contraceptives from minors and explaining the risks of different methods of contraception.

- **ASSISTED REPRODUCTION** – for couples (and individuals) who cannot conceive naturally there are various techniques of assisted reproduction, such as artificial insemination and in-vitro fertilization and embryo transfer, widely available in major medical centres. *Surrogate or substitute gestation* is another alternative. None of these techniques is unproblematic, either in individual cases or for public policies. The 2006 WMA **Statement on Assisted Reproductive Technologies** notes that “whilst consensus can be reached on some issues, there remain fundamental differences of opinion that cannot be resolved.” The statement identifies areas of agreement and also highlights those matters on which agreement cannot be reached.”
- **PRENATAL GENETIC SCREENING** – genetic tests are now available for determining whether an embryo or foetus is affected by certain genetic abnormalities and whether it is male or female. Depending on the findings, a decision can be made whether or not to proceed with pregnancy. Physicians need to determine when to offer such tests and how to explain the results to patients.
- **ABORTION** – this has long been one of the most divisive issues in medical ethics, both for physicians and for public authorities. The WMA **Statement on Therapeutic Abortion** acknowledges this diversity of opinion and belief and concludes that “This is a matter of individual conviction and conscience that must be respected.”
- **SEVERELY COMPROMISED NEONATES** – because of extreme prematurity or congenital abnormalities, some neonates have a very poor prognosis for survival. Difficult decisions often have to be made whether to attempt to prolong their lives or allow them to die.

- **RESEARCH ISSUES** – these include the production of new embryos or the use of ‘spare’ embryos (those not wanted for reproductive purposes) to obtain stem cells for potential therapeutic applications, testing of new techniques for assisted reproduction, and experimentation on fetuses.

End-of-life issues range from attempts to prolong the lives of dying patients through highly experimental technologies, such as the implantation of animal organs, to efforts to terminate life prematurely through euthanasia and medically assisted suicide. In between these extremes lie numerous issues regarding the initiation or withdrawing of potentially life-extending treatments, the care of terminally ill patients and the advisability and use of advance directives.

Two issues deserve particular attention: euthanasia and assistance in suicide.

- **EUTHANASIA** means knowingly and intentionally performing an act that is clearly intended to end another person’s life and that includes the following elements: the subject is a competent, informed person with an incurable illness who has voluntarily asked for his or her life to be ended; the agent knows about the person’s condition and desire to die, and commits the act with the primary intention of ending the life of that person; and the act is undertaken with compassion and without personal gain.
- **ASSISTANCE IN SUICIDE** means knowingly and intentionally providing a person with the knowledge or means or both required to commit suicide, including counselling about lethal doses of drugs, prescribing such lethal doses or supplying the drugs.

Euthanasia and assisted suicide are often regarded as morally equivalent, although there is a clear practical distinction, and in some jurisdictions a legal distinction, between them.

Euthanasia and assisted suicide, according to these definitions, are to be distinguished from the withholding or withdrawal of inappropriate, futile or unwanted medical treatment or the provision of compassionate palliative care, even when these practices shorten life.

Requests for euthanasia or assistance in suicide arise as a result of pain or suffering that is considered by the patient to be intolerable. They would rather die than continue to live in such circumstances. Furthermore, many patients consider that they have a right to die if they so choose, and even a right to assistance in dying. Physicians are regarded as the most appropriate instruments of death since they have the medical knowledge and access to the appropriate drugs for ensuring a quick and painless death.

Physicians are understandably reluctant to implement requests for euthanasia or assistance in suicide because these acts are illegal in most countries and are prohibited in most medical codes of ethics. This prohibition was part of the Hippocratic Oath and has been emphatically restated by the WMA in its 2005 [Statement on Physician-Assisted Suicide](#) and its 2005 [Declaration on Euthanasia](#). The latter document states:

Euthanasia, that is the act of deliberately ending the life of a patient, even at the patient’s own request or at the request of close relatives, is unethical. This does not prevent the physician from respecting the desire of a patient to allow the natural process of death to follow its course in the terminal phase of sickness.

The rejection of euthanasia and assisted suicide does not mean that physicians can do nothing for the patient with a life-threatening

illness that is at an advanced stage and for which curative measures are not appropriate. The 2006 WMA [Declaration of Venice on Terminal Illness](#) and the 2011 WMA [Declaration on End-of-Life Medical Care](#) provide guidance for assisting such patients, especially by means of palliative care. In recent years there have been great advances in palliative care treatments for relieving pain and suffering and improving quality of life. Palliative care can be appropriate for patients of all ages, from a child with cancer to a senior nearing the end of life. One aspect of palliative care that needs greater attention for all patients is pain control. All physicians who care for dying patients should ensure that they have adequate skills in this domain, as well as, where available, access to skilled consultative help from palliative care specialists. Above all, physicians should not abandon dying patients but should continue to provide compassionate care even when cure is no longer possible.

The approach of death presents many other ethical challenges for patients, substitute decision-makers and physicians. The

CHAPTER THREE – PHYSICIANS AND SOCIETY



or institution denies patients [their] rights, physicians should pursue appropriate means to assure or to restore them.” Physicians are also called upon to play a major role in the allocation of society’s scarce healthcare resources, and sometimes they have a duty to prevent patients from accessing services to which they are not entitled. Implementing these responsibilities can raise ethical conflicts, especially when the interests of society seem to conflict with those of individual patients.

DUAL LOYALTY

When physicians have responsibilities and are accountable both to their patients and to a third party and when these responsibilities and accountabilities are incompatible, they find themselves in a situation of ‘dual loyalty’. Third parties that demand physician loyalty include governments, employers (e.g., hospitals and managed healthcare organizations), insurers, military officers, police, prison officials and family members. Although the WMA [International Code of Medical Ethics](#) states that “A physician shall owe his/her patients complete

“...physicians may in exceptional situations have to place the interests of others above those of the patient.”

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loyalty,” it is generally accepted that physicians may in exceptional situations have to place the interests of others above those of the patient. The ethical challenge is to decide when and how to protect the patient in the face of pressures from third parties.

Dual loyalty situations comprise a spectrum ranging from those where society’s interests should take precedence to those where the patient’s interests are clearly paramount. In between is a large grey area where the right course of action requires considerable discernment.

At one end of the spectrum are requirements for mandatory reporting of patients who suffer from designated diseases, those deemed not fit to drive or those suspected of child abuse. Physicians should fulfil these requirements without hesitation, although patients should be informed that such reporting will take place.

At the other end of the spectrum are requests or orders by the police or military to take part in practices that violate fundamental human rights, such as torture. In its 2007 [Resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment of which They are Aware](#), the WMA provides specific guidance to physicians who are in this situation. In particular, physicians should guard their professional independence to determine the best interests of the patient and should observe, as far as possible, the normal ethical requirements of informed consent and confidentiality. Any

breach of these requirements must be justified and must be disclosed to the patient. Physicians should report to the appropriate authorities any unjustified interference in the care of their patients, especially if fundamental human rights are being denied. If the authorities are unresponsive, help may be available from a national medical association, the WMA and human rights organizations.

“Physicians should report to the appropriate authorities any unjustified interference in

Closer to the middle of the spectrum are the practices of some managed healthcare programmes that limit the clinical autonomy of physicians to determine how their patients should be treated. Although such practices are not necessarily contrary to the best interests of patients, they can be, and physicians need to consider carefully whether they should participate in such programmes. If

decisions at all levels, they have the greatest involvement at the micro-level. Accordingly, this will be the focus of what follows.

As noted above, physicians were traditionally expected to act solely in the interests of their own patients, without regard to the needs of others. Their primary ethical values of compassion, competence and autonomy were directed towards serving the needs of their own patients. This individualistic approach to medical ethics survived the transition from physician paternalism to patient autonomy, where the will of the individual patient became the main criterion for deciding what resources he or she should receive. More recently, however, another value, justice, has become an important factor in medical decision-making. It entails a more social approach to the distribution of resources, one that considers the needs of other patients. According to this approach, physicians are responsible not just for their own patients but, to a certain extent, for others as well.

This new understanding of the physician's role in allocating resources is expressed in many national medical association codes of ethics and, as well, in the WMA [Declaration on the Rights of the Patient](#), which states: "In circumstances where a choice must be made between potential patients for a particular treatment that is in limited supply, all such patients are entitled to a fair selection procedure for that treatment. That choice must be based on medical criteria and made without discrimination."

One way that physicians can exercise their responsibility for the allocation of resources is by avoiding wasteful and inefficient practices, even when patients request them. The overuse of

antibiotics is just one example of a practice that is both wasteful and harmful. Many other common



In dealing with these allocation issues, physicians must not

**“...physicians
...have a responsibility
to advocate for
expansion of these
resources where they
are insufficient to
meet patient
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is required, the patient's confidentiality should be protected to the greatest extent possible while fulfilling the legal requirements.

A different type of conflict between the interests of individual

to pursue career opportunities in another country. It does, however, call on every country to do its utmost to educate an adequate number of physicians, taking into account its needs and resources, and not to rely on immigration from other countries to meet its need for physicians.

Physicians in the industrialized countries have a long tradition of providing their experience and skills to developing countries. This takes many forms: emergency medical aid coordinated by organizations such as the Red Cross and Red Crescent Societies and Médecins sans Frontières, short-term surgical campaigns to deal with conditions such as cataracts or cleft palates, visiting faculty appointments in medical schools, short- or long-term medical research projects, provision of medicines and medical equipment, etc. Such programmes exemplify the positive side of globalization and serve to redress, at least partially, the movement of physicians from poorer to wealthier countries.

PHYSICIANS AND THE ENVIRONMENT

A major threat to both public health and global health is the deterioration of the environment. The 2006 WMA [Statement on the Role of Physicians in Environmental Issues](#) states that “The effective practice of medicine increasingly requires that physicians and their professional associations turn their attention to environmental issues that have a bearing on the health of individuals and population.” These issues include air, water and soil pollution, unsustainable deforestation and fishing, and the proliferation of hazardous chemicals in consumer products. But perhaps the most serious environmental challenge to health is climate change. The 2009 WMA [Declaration of Delhi on Health and Climate Change](#) notes that “Climate change currently contributes to the global burden of disease and premature deaths..... At this early stage the effects are small but are projected to progressively increase in all countries

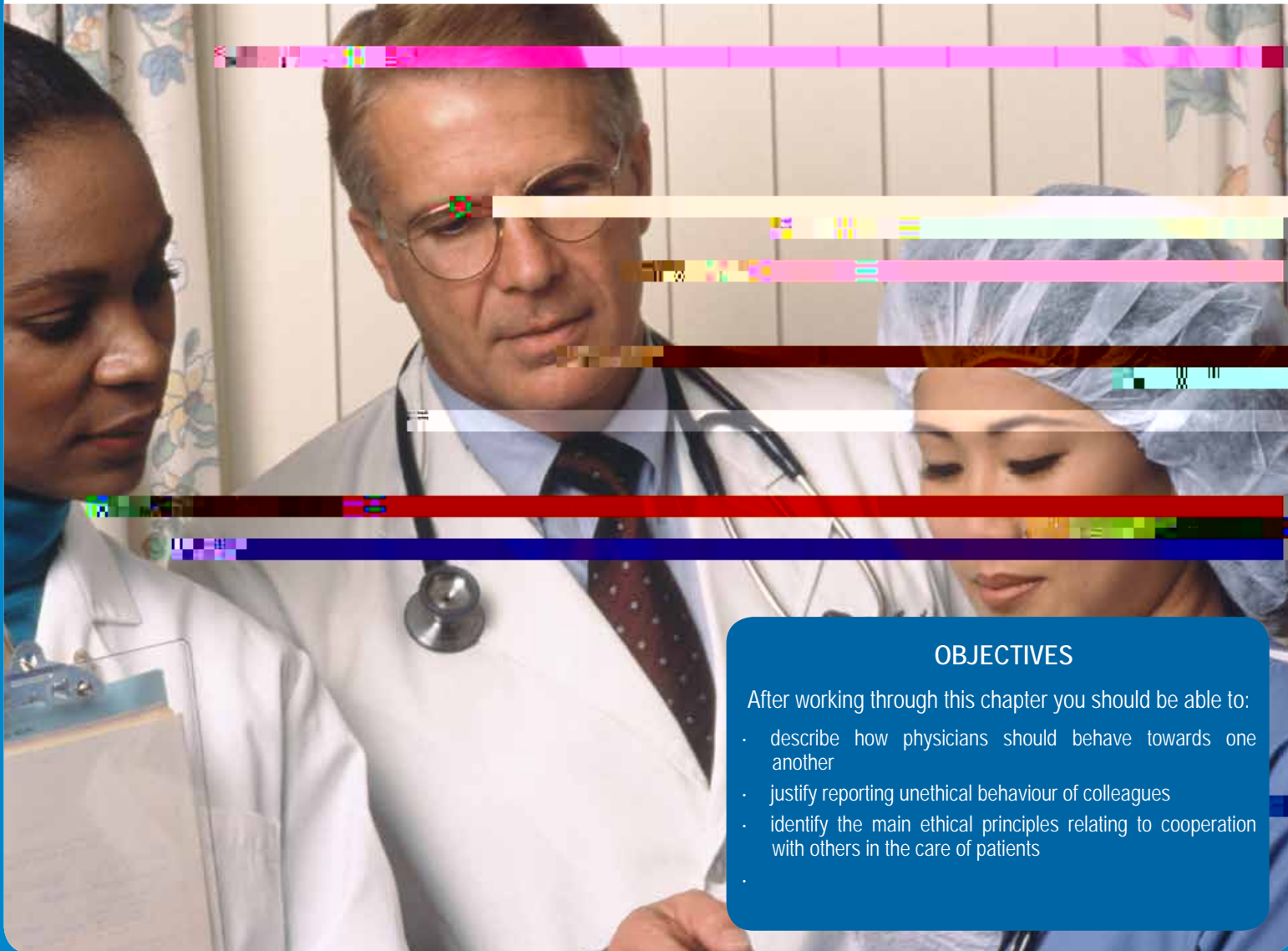
and regions.” The document encourages individual physicians and medical associations to educate patients and communities about the potential consequences of global warming for health and to

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CHAPTER FOUR – PHYSICIANS AND COLLEAGUES



OBJECTIVES

After working through this chapter you should be able to:

- describe how physicians should behave towards one another
- justify reporting unethical behaviour of colleagues
- identify the main ethical principles relating to cooperation with others in the care of patients
-

This chapter will deal with ethical issues that arise in both internal and external hierarchies. Some issues are common to both; others are found only in one or the other. Many of these issues are relatively new, since they result from recent changes in medicine and health-care. A brief description of these changes is in order, since they pose major challenges to the traditional exercise of medical authority.

With the rapid growth in scientific knowledge and its clinical

about who was in charge and who should prevail when conflict occurred, the cooperative model can give rise to disputes about appropriate patient care.

Developments such as these are changing the ‘rules of the game’ for the relationships of physicians with their medical colleagues and other health professionals. The remainder of this chapter will identify some problematic aspects of these relationships and suggest ways of dealing with them.

RELATIONSHIPS WITH PHYSICIAN COLLEAGUES, TEACHERS AND STUDENTS

As members of the medical profession, physicians have traditionally been expected to treat each other more as family members than as strangers or even as friends. The WMA [Declaration of Geneva](#) includes the pledge, “My colleagues will be my sisters and brothers.” The interpretation of this requirement has varied from country to country and over time. For example, where fee-for-service was the principal or only form of remuneration for physicians, there was a strong tradition of ‘professional courtesy’ whereby physicians did not charge their colleagues for medical treatment. This practice has declined in countries where third-party reimbursement is available.

Besides the positive requirements to treat one’s colleagues respectfully and to work cooperatively to maximize patient care, the WMA [International Code of Medical Ethics](#) contains two restrictions on physicians’ relationships with one another: (1) paying or receiving any fee or any other consideration solely to procure the referral of a patient; and (2) stealing patients from colleagues. A third obligation, to report unethical or incompetent behaviour by colleagues, is discussed below.

In the Hippocratic tradition of medical ethics, physicians owe special respect to their teachers. The [Declaration of Geneva](#) puts it this way: “I will give to my teachers the respect and gratitude that is their

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students to question or refuse such orders, teachers need to ensure that they are not requiring students to act unethically. In many medical schools, there are class representatives or medical student associations that, among their other roles, may be able to raise concerns about ethical

issues in medical education. Students concerned about ethical aspects of their education should

discuss the matter with your and/or the offender's supervisor and leave the decision about further action to that person. If this tactic is not practical or does not succeed, then it may be necessary to take

which is usually the case in a hospital, should, wherever possible, have one physician coordinating the care who can keep the patient informed about his or her overall progress and help the patient make decisions.

Whereas relationships among physicians are governed by generally well-formulated and understood rules, relationships between physicians and other healthcare professionals are in a state of flux and there is considerable disagreement about what their respective roles should be. As noted above, many nurses, pharmacists, physiotherapists and other professionals consider themselves to be more competent in their areas of patient care than are physicians and see no reason why they should not be treated as equals to physicians. They favour a team approach to patient care in which the views of all caregivers are given equal consideration, and they consider themselves accountable to the patient, not to the physician. Many physicians, on the other hand, feel that even if the team approach is adopted, there has to be one person in charge, and physicians are best suited for that role given their education and experience.

Although some physicians may resist challenges to their traditional, almost absolute, authority, it seems certain that their role will change in response to claims by both patients and other healthcare providers for greater participation in medical decision-making. Physicians will have to be able to justify their recommendations to others and persuade them to accept these recommendations. In addition to these communication skills, physicians will need to be able to resolve conflicts that arise among the different participants in the care of the patient.

A particular challenge to cooperation in the best interests of patients results from their recourse to traditional or alternative health providers ('healers'). These individuals are consulted by a large proportion of

the population in Africa and Asia and increasingly so in Europe and the Americas. Although some would consider the two approaches as complementary, in many situations they may be in conflict. Since at least some of the traditional and alternative interventions have therapeutic effects and are sought out by patients, physicians should explore ways of cooperation with their practitioners. How this can be done will vary from one country to another and from one type of practitioner to another. In all such interactions the well-being of patients should be the primary consideration.

CONFLICT RESOLUTION

Although physicians can experience many different types of conflicts with other physicians and healthcare providers, for example, over office procedures or remuneration, the focus here will be on conflicts about patient care. Ideally, healthcare decisions will reflect agreement among the patient, physicians and all others involved in the patient's care. However, uncertainty and diverse viewpoints can give rise to disagreement about the goals of care or the means of achieving those goals.

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patient. Since both types of conflicts are ethical in nature, their resolution can benefit from the advice of a clinical ethics committee or an ethics consultant where such resources are available.

The following guidelines can be useful for resolving such conflicts:

- Conflicts should be resolved as informally as possible, for example, through direct negotiation between the persons who disagree, moving to more formal procedures only when informal measures have been unsuccessful.
- The opinions of all those directly involved should be elicited and given respectful consideration.
- The informed choice of the patient, or authorized substitute decision-maker, regarding treatment should be the primary consideration in resolving disputes.
- If the dispute is about which options the patient should be offered, a broader rather than a narrower range of options is usually preferable. If a preferred treatment is not available because of resource limitations, the patient should normally be informed of this.
- If, after reasonable effort, agreement or compromise cannot be reached through dialogue, the decision of the person with the right or responsibility for making the decision should be accepted. If it is unclear or disputed who has the right or responsibility to make the decision, mediation, arbitration or adjudication should be sought.

If healthcare providers cannot support the decision that prevails as a matter of professional judgment or personal conscience, they should be allowed to withdraw from the case but the decision-making should remain with the person of whom the patient has the greatest confidence.

CHAPTER FIVE – ETHICS AND MEDICAL RESEARCH



OBJECTIVES

After working through this chapter you should be able to:

- identify the main principles of research ethics
- know how to balance research and clinical care
- satisfy the requirements of ethics review committees

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IMPORTANCE OF MEDICAL RESEARCH

Medicine is not an exact science in the way that mathematics and physics are. It does have many general principles that are valid most of the time, but every patient is different and what is an effective

treatment for 90% of the population may not work for the other 10%. Thus, medicine is inherently experimental. Even the most widely accepted treatments need to be monitored and evaluated to determine whether

they are effective for specific patients and, for that matter, for patients in general. This is one of the functions of medical research.

Another, perhaps better known, function is the development of new treatments, especially drugs, medical devices and surgical

"...medicine is inherently experimental"

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techniques. Great progress has been made in this area over the past 50 years and today there is more medical research underway than ever before. Nevertheless, there are still many unanswered questions about the functioning of the human body, the causes of diseases (both familiar and novel ones) and the best ways to prevent or cure them. Medical research is the only means of answering these questions.

In addition to seeking a better understanding of human physiology, medical research investigates a wide variety of other factors in human health, including patterns of disease (epidemiology), the organization, funding and delivery of healthcare (health systems research), social and cultural aspects of health (medical sociology and anthropology), law (legal medicine) and ethics (medical ethics). The importance of these types of research is being increasingly recognized by funding agencies, many of which have specific programs for non-physiological medical research.

RESEARCH IN MEDICAL PRACTICE

All physicians make use of the results of medical research in their clinical practice. To maintain their competence, physicians must keep up with the current research in their area of practice through Continuing Medical Education/ Continuing Professional Development programs, medical journals and interaction with knowledgeable colleagues. Even if they do not engage in research themselves, physicians must know how to interpret the results of research and apply them to their patients. Thus, a basic familiarity with research methods is essential for competent medical practice. The best way to gain this familiarity

"Even if they do not engage in research themselves, physicians must know how to interpret the results of research and apply them to their patients."

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is to take part in a research project, either as a medical student or following qualification.

The most common method of research for practising physicians is the clinical trial. Before a new drug can be approved by government-mandated regulatory authorities, it must undergo extensive testing for safety and efficacy. The process begins with laboratory studies followed by testing on animals. If this proves promising, the four steps, or phases, of clinical research, are next:

- Phase one research, usually conducted on a relatively small number of healthy volunteers, who are often paid for their participation, is intended to determine what dosage of the drug is required to produce a response in the human body, how the body processes the drug, and whether the drug produces toxic or harmful effects.
- Phase two research is conducted on a group of patients who have the disease that the drug is intended to treat. Its goals are to determine whether the drug has any beneficial effect on the disease and has any harmful side effects.
- Phase three research is the clinical trial, in which the drug is administered to a large number of patients and compared to another drug, if there is one for the condition in question, and/or to a placebo. Where possible, such trials are 'double-blinded', i.e., neither research subjects nor their physicians know who is receiving which drug or placebo.
- Phase four research takes place after the drug is licensed and

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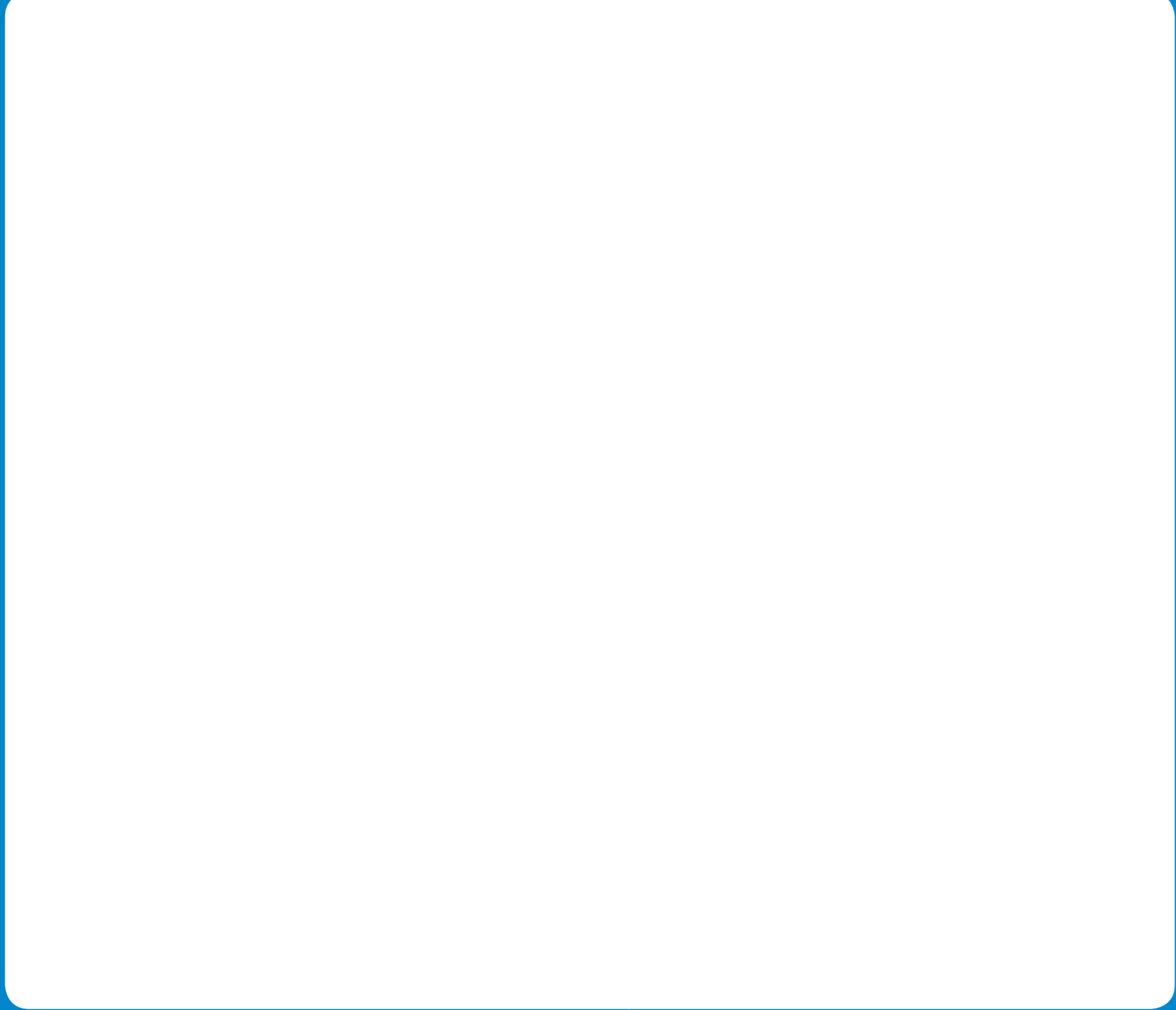
to receive all the necessary information to make a fully informed decision whether or not to participate in a research study.

These potential problems can be overcome. The ethical values of the physician – compassion, competence, autonomy – apply to the medical researcher as well. So there is no inherent conflict between the two roles. As long as physicians understand and follow the basic rules of research ethics, they should have no difficulty participating in research as an integral component of their clinical practice.

ETHICAL REQUIREMENTS

The basic principles of research ethics are well established. It was not always so, however. Many prominent medical researchers in the 19th and 20th centuries conducted experiments on patients without their consent and with little if any concern for the patients' well-being. Although there were some statements of research ethics dating from the early 20th century, they did not prevent physicians in Nazi Germany and elsewhere from performing research on subjects that clearly violated

part of the researchers. The ethics committee may approve the project as presented, require changes before it can start, or refuse approval altogether. The committee has a further role of monitoring projects that are underway to ensure that the researchers fulfil their obligations and it can if necessary stop a project because of serious unexpected adverse events.



the form being signed but must involve a careful oral explanation of the project and all that participation in it will mean to the research subject. Moreover, research subjects should be informed that they are free to withdraw their consent to participate at any time, even after the project has begun, without any sort of reprisal from the researchers or other physicians and without any compromise of their healthcare (paragraph 31).

Confidentiality

As with patients in clinical care, research subjects have a right to privacy with regard to their personal health information. Unlike clinical care, however, research requires the disclosure of personal health information

“...research subjects have a right to privacy with regard to their personal health information”

to others, including the wider scientific community and sometimes the general public. In order to protect privacy, researchers must ensure that they obtain the informed consent of research subjects to use their personal health information for research purposes, which requires that the subjects are told in advance about the uses to which their information is going to be put. As a general rule, the information should be de-identified and should be stored and transmitted securely. The WMA [Declaration on Ethical Considerations Regarding Health Databases](#) provides further guidance on this topic.

Conflict of Roles

It was noted earlier in this chapter that the physician's role in the physician-patient relationship is different from the researcher's role in the researcher-research subject relationship, even if the physician and the researcher are the same person. Paragraph 14 of the [DoH](#) specifies that in such cases, the physician role must take

precedence. This means, among other things, that the physician must be prepared to recommend that the patient not take part in a research project if the patient seems to be doing well with the current treatment and the project requires that patients be randomized to different treatments and/or to a placebo. Only if the physician, on solid scientific grounds, is truly uncertain whether the patient's current treatment is as suitable as a proposed new treatment, or even a placebo, should the physician ask the patient to take part in the research project.

Honest Reporting of Results

It should not be necessary to require that research results be reported accurately, but unfortunately there have been numerous recent accounts of dishonest practices in the publication of research results. Problems include *plagiarism*, data fabrication, duplicate publication and 'gift' authorship. Such practices may benefit the researcher, at least until they are discovered, but they can cause great harm to patients, who may be given incorrect treatments based on inaccurate or false research reports, and to other researchers, who may waste much time and resources trying to follow up the studies.

“...there have been numerous recent accounts of dishonest practices in the publication of research results”

Whistle-blowing

In order to prevent unethical research from occurring, or to expose it after the fact, anyone who has knowledge of such behaviour has an obligation to disclose this information to the appropriate authorities. Unfortunately, such whistle-blowing is not always appreciated or even acted on, and whistle-blowers are sometimes punished or avoided for trying to expose wrong-doing. This attitude seems to

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 rh' i Zkr̃b.Zm̃' 'La^I ahnq̃ 'ghmZ' k^'rh' ^gkhé
 Z'lg̃^] 'gnf' [^k'h_ i Zrb̃gr̃h'ZI 'I n[é'\\rh' I lg̃\\^
 rab' \\hnq̃ 'éZ] 'a^k'rh' i k^I I nk^i Zrb̃gr̃h'rh'
 Z' k^% ^kaZi I 'Z' Zlg̃l' m̃ra^l̃ [^I ñlg̃m̃k^I rh'
 La^I ahnq̃ '\\Zk^_næ' f' hg̃l̃h'k'ra^i Zrb̃gr̃h'lg̃'
 ra^I m] r' _hk'ing^qi ^\\m̃] 'Z] o^k' ^'o^agr̃h'Zg]
 [^i k^i Zk^' rh'Z] hi rikZi [b̃] \\hkk^\\r̃b^Z\\r̃b̃g'
 ?lg̃Zæ% a^I ahnq̃ '\\hf f' ng̃bZm̃'rh'a^k'
 i Zrb̃gr̃h'ra^'k^I neh'h_ 'ra^'k^I ^ZKa'ZI 'ra^r'
 [\\hf' ^ZoZl̃ [é' :



OF PHYSICIANS

This Manual has focused on the duties and responsibilities of physicians, and indeed that is the main substance of medical ethics. However, like all human beings, physicians have rights as well as responsibilities, and medical ethics would be incomplete if it did not consider how physicians should be treated by others, whether patients, society or colleagues. This perspective on medical ethics has become increasingly important as physicians in many countries are experiencing great frustration in practising their profession, whether because of limited resources, government and/or corporate micro-management of healthcare delivery, sensationalist media reports of medical errors and unethical physician conduct, or challenges to their authority and skills by patients and other healthcare providers.

Medical ethics has in the past considered the rights of physicians as well as their responsibilities. Previous codes of ethics such as the 1847 version of the American Medical Association's Code included sections on the obligations of patients and of the public to the profession. Most of these obligations are outmoded, for example, "The obedience of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them." However, the statement, "The public ought... to entertain a just appreciation of medical qualifications... [and] to afford every encouragement and facility for the acquisition of medical education..." is still valid. Rather than revising and updating these sections, however, the AMA eventually eliminated them from its Code of Ethics.

Over the years the WMA has adopted several policy statements on the rights of physicians and the corresponding responsibilities of others, especially governments, to respect these rights:

- The 1984 [Statement on Freedom to Attend Medical Meetings](#) asserts that "there should... be no barriers which will prevent physicians from attending meetings of the WMA, or other medical meetings, wherever such meetings are convened."
- The 2006 [Statement on Professional Responsibility for Standards of Medical Care](#) declares that "any judgement on a physician's professional conduct or performance must incorporate evaluation bwards rRathT*[(6 physicianjorspecysi181 44.o

"Physicians who are working, either permanently or temporarily, in a country other than their home country... be treated fairly in relation to other physicians in that country (for example, equal opportunity career options and equal payment for the same work)."

Although such advocacy on behalf of physicians is necessary, given the threats and challenges listed above, physicians sometimes need also to be reminded of the privileges they enjoy.

**"...physicians
sometimes need also
to be reminded of the
privileges they enjoy."**

Public surveys in many countries have consistently shown that physicians are among the most highly regarded and trusted occupational groups. They generally receive higher than average remuneration (much higher in some countries). They still have a great deal of clinical autonomy, although not as much as previously. Many are engaged in an exciting search for new knowledge through participation in research. Most important, they provide services that are of inestimable value to individual patients, particularly those who are vulnerable and most in need, and to society in general. Few occupations have the potential to be more satisfying than medicine, considering the benefits that physicians provide – relief of pain and suffering, cure of illnesses, and comfort of the dying. Fulfilment of their ethical duties may be a

THE FUTURE OF MEDICAL ETHICS

This Manual has focussed on the current state of medical ethics, although with numerous references to its past. However, the present is constantly slipping away and it is necessary to anticipate the future if we are not to be always behind the times. The future of medical ethics will depend in large part on the future of medicine. In the first decades of the 21st century, medicine is evolving at a very rapid pace and it is difficult to predict how it will be practised by the time today's first-year medical students complete their training,



such as (reagent). The term *hierarchy* is also used to refer to the leaders of an organization.

Justice – fair treatment of individuals and groups. As Chapter Three points out, there are different understandings of what constitutes fair treatment in healthcare.

Managed healthcare – an organizational approach to healthcare in which governments, corporations or insurance companies decide what services will be provided, who will provide them (specialist physicians, general practitioner physicians, nurses, other health professionals, etc.), where they will be provided (clinics, hospitals, the patient's home, etc.), and other related matters.

– literally, not doing wrong. Physicians and medical researchers are to avoid inflicting harm on patients and research subjects.

Palliative care – an approach to the care of patients, especially those who are likely to die in the relatively near future from serious, incurable disease, that focuses on the patient's quality of life, especially pain control. It can be provided in hospitals, special institutions for dying patients (commonly called hospices), or in the patient's home.

Physician – an individual who is qualified to practise medicine. In some countries, physicians are distinguished from surgeons, and the term 'doctor' is used to designate both. However, 'doctor' is used by members of other health professions, such as dentists and veterinarians, as well as by all those who have obtained a Ph.D. or other 'doctoral' degree. The term 'medical doctor' is more precise but not widely used. The WMA uses the term 'physician' for all those who are qualified to practise medicine, no matter what their speciality, and this Manual does the same.

Plagiarism – a form of dishonest behaviour whereby a person copies the work of someone else, for example, all or part of a published article, and submits it as if it were the person's own work (i.e., without indicating its source).

Pluralistic – having several or many different approaches or features: the opposite of singular or uniform.

Profess – to state a belief or a promise in public. It is the basis of the terms 'profession', 'professional' and 'professionalism'.

Rational – based on the human capacity for reasoning, i.e., to be able to consider the arguments for and against a particular action and to make a

APPENDIX C

APPENDIX D – STRENGTHENING ETHICS TEACHING IN MEDICAL SCHOOLS

Some medical schools have very little ethics teaching while others have highly developed programs. Even in the latter ones, however, there is always room for improvement. Here is a process that can be initiated by anyone, whether medical student or faculty member, who wants to strengthen the teaching of medical ethics in his or her institution.

- 1.

APPENDIX E – ADDITIONAL CASE STUDIES

<HGMK: <>I MØ>: =OB<>:
MH: 'M>:G: @>K

LZKZ 'b*'. 'r^AZK 'hē' 'La^'d' 'l'g'Z' rhp' g'p' a^k^
I^q'nZēZi I Znēh' Zk^ [^hf' l'g' f' h^k^Zg] f' h^k^
_k^j n^g'm' La^ \hf' 'l' r'h' r'hnk^ \b'Zi d'g' 'h'k^Z'
i k^l' \k^b' n'g' 'h'k^h'k^Zē \h'g'r'Z^ \i' r'w^l' 'r'h' i' k'h'm^ \m^a^k^
_k'h'f' i' k^'g'Zg^r' 'l'g' \Zi^ \i' a^'b' r^a^ \o^b' n'f' 'h'Z' I^q'nZē
Zi I Znēh' i' k^'g'Zg^r' p' h'nē' m^k^f' 'l'g'Zm^ 'a^k^ \n^Z'r'g'
Zg] f' Zd^ \b'o^'k^r'] b' \b'n'ē'r'h' 'l'g'] Z^anl [Zg] ' LZKZ'
m^'ē' r'h'n' r^a'Zm^l' a^'] h^l' 'g'h'm'p' Zg'm^a^k^i' Zk^'g'r'h' r'h'
d'g'h'p' r^a'Zm^l' a^'p' l'ē' [^nl' l'g' ' \h'g'r'Z^ \i' r'w^l' [^Znl' ^'
r^a^r' p' l'ē'r^a'g'd' r^a'Zm^l' a^' l'g'm'g] I' r'h' 'a'Z'o^ \i' ^q'p' l'ē'a'Z'
[hr' _k^'g'] ' R'h'n' Zk^ \i' n'l' i' b' \b'n'l' 'h' _LZKZi' f' h'r'w^l' [n'm'
r'h'n' Z] f' l'ē'a^'k^] ^m^k^f' 'l'g'Z'r'g' r'h' Zoh'ē' i' k^'g'Zg^r' .
R'h'n' Z] o'b^ \a^'k^ r'h' \hf' ^' r'h' r^a^ \l'g' b' p' l'ē'a^'k^
i' Zk^'g'r'h' _h'k^Z' ^'g^k^Zē] b' \n'l' i' l'g' h' _r^a^ \b'l' n^'p' l'ē'a'
r'h'n' 'Mak^ \Z'r' l' ē'm^k^l' a^'k^m^k'g'l' 'Z'ē'g^'Zg] i' m^'ē'
r'h'n' r^a'Zm^l' a^' r'k^b'] r'h' i' i' ^Zd' r'h' a^'k^i' Zk^'g'r'h' Z[h'n'm^a^
b'l' n^' [n'm'm^a^r' k^'n'l' ^'] r'h'] b' \n'l' i' l'ē'h'
G'h'p' p' a'Zm^l' a'h'n'ē' r'h'n'] h8

: 'I K>F : MNK> : B? : GM#

F Zq'p ZI [hkg] n'k'g' r^a^ +, k] p^ ^d' h_ i' k^'g'Zg^r' .
A^ \b' o^'g'r'Zm^] [^Znl' ^' a'b' 'ē'g' I' Zk^ \o^'k^r' .
l'ē' f' Zm'k^ \i' F h^k^h'o^'k^%a^ \i' n_ \k^l' _k'h'f' \^k^ [k^Zē
[ē^] l'g'] [^Znl' ^' a'b' o^'l' i' ^ē'r'h' l' n^ \b' i' r'ē'ng'l' n^] ē'
B'r'h' 'ng'ē' \ē' r^a'Zm^a^p' l'ē'Z^ \m^Zē' I' n'kolō^ \r^a^g^q'm'
_p' p^ ^d' l' 'B'a^] h^l' %a^ p' l'ē'i' k'h [Z[ē' [^l' ^o^'k^ē'
aZg] b'Zi i' ^'] [h'r^a'f' ^'g'r^ē' Zg] i' a'r'l' b'Zē' .
F Zq'l' \h'g] l'ē'ng' p' h'k^ ^g'l' p' a^g^a^] ^o^'ē'i' l' .
Z' i' ^k^b'n'l' 'l'g' _l'ng' h_ r^a^ \i' [h'p' ^ē' B'r'f' b'am^] ^'
i' h'l' i' l'ē' r'h' ^'q'r'Z^ \m^a^ \l'g' _ē'f' ^'] i' Zk'r'h' _r^a^ \i' [h'p' ^ē'
h' i' ^k^r'w^'ē' %p' a'b'a' p' h'nē' i' k^l' ^k'o^ \a'b' l' f' Zē' \a'Zg^ \^'
h_] n'kolōZē' A'b' i' Zk^'g'r'h' k^'n'l' ^' r'h' \h'g'l' ^g'm^ [^Znl' ^'
r^a^r'] h'g'h'm'p' Zg'm^ F Zq' r'h' i' n_ \k^l' _k'h'f' r^a^ \h' i' ^k^r'w^'
Zg] r^a^r' i' ^'ē'r^a'Zm^a'b' j' n^Z'ē'n' h_ ē' p' l'ē'g^o^'k^ [^'
i' n_ \b' b'g'r'h' : I' r^a^ \r^k^Z'r'g' i' a'r'l' b'Zē' g' r'h'n' r^a'g'd' r^a'Zm'
r^a^ \h' i' ^k^r'w^'g'l' a'h'n'ē' [^'] h'g^%Zg] r'h'n' p' h'g] ^k^a'h'p'
r'h'] ^Zē'p' l'ē'a' r^a^ \i' Zk^'g'r'h' k^'n'l' Zē

* Suggested by Dr. Gerald Neitzke and Ms. Mareike Moeller, Medizinische

A Թ՝ Ե՞ ? >< M Ի G #

F K`L`b`f` Zkbb`] Zg]` ra^`Zra^k`h`rp` h`l` \ahhe`
 \alq`k`g`'A`^`b`'rk`^Zm`]lq`r`h`nk`\`d`b`_`h`k`Z`k`Z`k`^`_`h`k`f`
 h`_`i`g`^`nf` hgjz`'ra`Z`m`b`'h`_`m`g`'Z`l`h`h`l`z`m`]p`l`a`':`B`-`L`'
 A`b`]`d`h`]`m`l`n`k`^`l`n`e`h`]`a`h`p`'ra`Z`m`a`^`b`]`l`q`]`^`]`:
 A Թ & i` h`l` l`b`^`'F` K`L`]`Z`r`l`'ra`Z`m`a`^`p` Z`g`m`'r`h`]`^`l`b`^`
 a`b`]`^`e`b`Z`g`]`p`a`g`'a`^`p` l`e`m`t`e`a`b`]`p`b`^`Z`[`h`n`m`a`^`
 l`q`_`^`l`r`b`g`'R`h`n`]`l`q`]`b`Z`m`'ra`Z`m`b`^`h`n`q`]`[`^`d`^`&` Z`o`l`q`]`
 `h`k`a`b`]`p`b`^`r`h`'i`k`h`m`^`m`a`^`k`]`e``k`h`f`]`l`q`_`^`l`r`b`g`'
 ;`^`l`b`^`l`%`b`r`p` h`n`q`]`^`l`b`]`h`k`z`g`m`_`h`k`a`^`k`r`h`'a`Z`o`^`Z`g`'
 A Թ`m`l`m`a`^`k`]`e`']`l`q`]`^`l`Z`l`^`h`_`Z`'i`h`l` l`b`^`m`l`n`k`^`l`n`e`h`]`a`^`
 p`h`n`q`'ra`g`'a`Z`o`^`ra`^`h`i`]`h`k`n`g`l`m`'r`h`'n`z`d`^`]`k`n`]`r`h`'
]`d`p`]`]`h`p`g`'ra`^`h`n`r`f`k`^`Z`d`'h`_`ra`^`]`b`^`Z`l`^`Z`g`]`:

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