

## Issues in Bioethics

### Ethics and Professional Responsibilities

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#### **ABSTRACT**

*The evolution of ethics in medicine has provided the concept of the learned physician who is trained in the scientific method (studying nature and philosophy), and who is wise, modest and humane. The physician's manner, deportment and character should be above reproach, and devotion to the productive art of medicine should supersede any desire for financial gain. Professionalism provides the organizational structure through which the medical doctor performs his/her healing role, and underscores the concept that medical professionals should be moral and devoted to the public good, displaying altruism at the expense of self-interest, and providing accountability. This article examines some of the obligations that arise within this milieu.*

#### **INTRODUCTION**

Today's physicians and surgeons are confronted with numerous ethical and professional dilemmas which could be perplexing. Ethical issues in medicine and healthcare may involve a complex mix beset by scientific, economic, social, cultural, religious, moral and legal considerations. The post-modern physician will therefore require broad-based knowledge of philosophical, religious, and historical precepts, as well as good moral foundations, skills of analysis and communication, capped by ethical sensitivity and good values.

Medical doctors have traditionally filled two overlapping but distinct roles – those of the physician-healer and the physician-professional. Whilst these roles share much common ground, they are drawn from different traditions and entail different sets of obligations. In the eyes of the public, the role of the physician-healer is rarely separated from that of the physician-professional, and so, in practice, medical doctors must function simultaneously in both roles as each supports the integrity of the other.

This article examines the historical precepts that have given rise to the current state of ethics in medicine and medical professionalism, and the consequent obligations that medical doctors have in their combined roles of physician-healer and physician-professional.

#### **The Evolution of Ethics in Medicine in Western Societies**

Ethics has been defined, in a practical way, as choosing the best course of action in the face of conflicting choices (1).

The word actually comes from the Greek word *ethos*, which had two meanings – the older meaning referred to the inner place in human beings which was the source of their actions, while the second meaning referred to the act or habit itself (2). However, since then the word *ethics* has been used to refer to the character of life existing in a community, and the process of reflection about the moral life and the particular value judgements that people have.

Many students of African history and scientists confirm that mankind started in Africa, and that, for many hundreds of centuries thereafter, Africa was in the forefront of all world progress (3). European explorers and archaeologists have found extensive remains of hundreds of ruins in the Niger, Benweni, Limpopo, Nile river valleys, and the Sahara, that bear witness to the existence of civilizations there thousands of years ago. As a part of Africa, ancient Egypt's first appearance on the stage of history occurred about 10 000 - 8000 BC, but it became an organized nation about 6000 BC (4). However, medical interest centres upon a period in the Third Dynasty (5345 - 5307 BC) when Egypt had an ambitious pharaoh called Zoser, who in turn had a chief counsellor and Court Physician named Imhotep. Regarded as the first multi-genius, Imhotep constructed the first step pyramid, and was the first figure of a physician to stand out clearly from the mists of antiquity (5). After his death, Imhotep was deified and later made a universal God of Medicine. His images thus graced the first Temple of Imhotep, mankind's first hospital, where sufferers came from all over the world for prayer, peace, and healing (3).

When Egyptian civilization crossed the Mediterranean to become what could have been the foundation of Greek culture, the teachings of Imhotep were absorbed along with

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the precepts of other great African teachers. Known to the Greeks as Imouthes, Imhotep was recognized as their own Aesculapius (4). Subsequently, in the 4<sup>th</sup> Century BC, the great library of Alexandria was founded in Egypt and later contained a collection of one million volumes, with books gathering the knowledge of the ancient world, including valuable works in science, mathematics, technology, literature, and history (4). Consequently, while medicine long preceded the Greeks, the concept of ethics in medicine in western society began with the Hippocratic Oath, written around the 5<sup>th</sup> Century BC (6,7). The Oath represented an early attempt to put ethical principles into code. The issues addressed:

- 1 \* Professional interrelationships
- 1 \* Documenting in good faith
- 1 \* Reproductive health
- 1 \* Avoiding unnecessary or unsafe treatments
- 1 \* Avoiding improper relationships with patients or their dependents
- 1 \* Maintaining patient confidence (8)

Today's medicine, in fact, derives from two very different cultures in ancient Greece. One was that of Aesculapius and the concept of god-physician that subsumed a culture of magico-religious medicine, and provided ritualistic cures in the temples found throughout the Aegean lands (9). In fact, the symbol of medicine – the staff entwined by a serpent – was the symbol of Aesculapius, the son of Apollo in Greek mythology, who had been taught medicine by the learned and wise Chiron and whose history was perhaps rooted in ancient Egypt and the deification of Imhotep (4).

The other culture was that of empirico-rational medicine, which flourished off the Greek coast of Asia Minor with Hippocrates being its most illustrious leader (9). This culture banished gods from medicine, and replaced that concept with one of diagnosis and prognosis, these being deduced from symptoms. With this novel emphasis on facts and learning from those facts, the art of medicine progressed substantially, giving rise to the concept of the learned physician, one who was also wise, modest and humane (9).

Aristotle, the court-physician's son presumed to have inherited the art of medicine from his father, followed the tradition of Hippocrates. Aristotle taught medicine in his Lyceum, with the precept that the philosopher must begin with medicine and the physician must end with philosophy (9). Regarded as the founder of biology, Aristotle (like Plato who preceded him) distinguished science from the arts – the latter meaning “productive” arts (**techne**), with medicine being one of these. Science and the arts thus differed in the nature of the product – knowledge (science) versus actions (arts).

In a later era, one of the most influential physicians in the history of western medicine, a physician-philosopher living in the 2<sup>nd</sup> Century AD, Galen, espoused that a doctor should not only be trained in the scientific method, but should also study nature and philosophy (10). Galen thought

that motivation by profit was incompatible with any serious devotion to the art of medicine, and so the doctor should subjugate the motive of financial gain on becoming a doctor.

In subsequent eras, the manner and deportment of the physician became important: his character should be above reproach, and he should be fair and be perceived as taking the side of fairness (11). Confidence in the physician was emphasized, as many patients were concerned about trust in the doctor, not only in his knowledge, but also in the character of the person himself.

In the Mediaeval Ages, two outstanding physician-scholars of early modern Europe, Torella and Massa, reinforced the Galenic tradition by espousing the view that a physician should conduct himself so as to win the trust of the patient (12). He should take care of his appearance, be in good trim, well-dressed, clean and without body odour or bad breath. The physician should approach the patient carefully, with a placid countenance, knowing whether or not a joke is called for, and avoiding barbarisms of speech. He should assess the patient's psychological state in deciding how much to tell the patient of his or her condition, but the physician should cover himself by telling the truth to the family on his way out.

Thereafter, in the modern era, the art of medicine was advanced by practical science with the work of the country physician Edward Jenner on vaccination, and later by the dramatic laboratory work of the chemist Louis Pasteur and the district physician Koch (9). Pasteur and Koch inspired in physicians the idea that medicine was made in the laboratory, and so physicians discarded their previous attire of frock-coats in their practices, and began wearing the scientist's laboratory coat (suggesting that they practised up-to-date scientific medicine, fresh from the laboratory).

With scientism becoming the *modus operandi*, individual states began licensing medical practitioners to practise medicine after a prescribed course of study, and began setting the official privileges of the profession in order to promote the well-being of their people and protect their societies from harm (13). The social organization of medicine resulted in the medical profession being granted the privilege of self-regulation, under the rationale that, being learned professionals, a certain level of professional competence would be apparent. Further, it was considered to be in the public's best interest to allow the profession to regulate itself, and that ethical codes of conduct be specified by the profession.

### **The Current State of Ethics in Medicine**

Today, technological advances have accelerated social change as well as altered the way physicians diagnose and treat many patients (14). Many social changes and medical issues have evolved rapidly over the past 50 years, and hence, over the second half of the 20<sup>th</sup> century, the ethical principles of beneficence, non-maleficence, autonomy and justice were highlighted and have been providing the ethical foundations for the practice of medicine in most western countries. With

rapidly increasing knowledge, medicine and medical practice became more complex in their application, with specialties and subspecialties developing to broaden the practice landscape. Accompanying this were fascinating scientific discoveries that were particularly numerous at the cellular level, genetic research, and an increasing use of technology in medicine (15).

These developments broadened the ethical landscape and gave rise to the ethics specialty of Bioethics, with its subdivisions of clinical ethics, research ethics and professional ethics.

Bioethics has arisen since the 1960s as a trans-disciplinary field comprising medicine, law, philosophy, and religious studies. It has emerged as a specialty that provides guides for making moral decisions, expert advice to resolve ethical dilemmas, and standards for assessing actions and policies in medicine, healthcare and biology. The interplay of scientific, economic, social, religious and legal issues in healthcare has presented many bioethical issues over the last 25 years, including euthanasia and physician-assisted suicide, *in vitro* fertilization, genetic engineering, organ donation, abortion, the definition of death, request for futile treatment, the withdrawal of treatment, terminal care, truth-telling, informed consent, confidentiality, the allocation of scarce medical resources, and HIV-related issues. As no single academic discipline is adequate to address the various dimensions of these issues, bioethics and bioethicists have become a familiar part of the healthcare landscape in most developed countries (16).

Clinical ethics (health care ethics or ethical decision-making), by definition, is a practical approach to making ethical decisions in healthcare. It incorporates the four ethical principles that serve to guide healthcare, and is also sensitive to matters of culture, religious beliefs and issues related to law and healthcare. This field has four main subject headings:

- 1 \* Indications for medical intervention
- 1 \* Respect for autonomy and the preferences of patients
- 1 \* Issues in a contextual nature
- 1 \* Quality of life issues

The overarching concern in this field is the rights of patients as underscored by the ethical principle of autonomy (17).

Research ethics (the ethics of human experimentation) is now a universally recognized concept to which all countries involved in the practice of western medicine subscribe. This is important as medical research seeks to provide benefits for the general society by obtaining medical information through experimentation, sometimes involving human subjects. The benefits of such research generally accrue to persons other than the subjects of research, namely, to future patients, to the professionals doing the research and to society in general. Even when the research participant personally benefits, these other persons also benefit from the knowledge produced by the research. Hence, since research endeavours may entail risks for individual participants, research ethics seeks to protect a participant's welfare, while preserving the benefits to society that may accrue from research.

In light of the foregoing, specific ethical codes serve to guide clinical research, including:

- 1 \* That review of proposed research be done by a research ethics committee
- 1 \* That informed consent be provided by competent participants, or permission by guardians for those unable to give consent
- 1 \* That fair selection of research subjects should occur, without taking advantage of vulnerable persons or populations.

Profession has been defined as a vocation or calling, especially one that involves some branch of advanced learning or science. Professional ethics defines the role morality of a profession, and comprises those principles that guide and regulate the conduct between professionals and others with whom they come into contact during their work. Hence, in healthcare, as patients and their relatives may be vulnerable to exploitation in their desperation to obtain a cure or some relief from pain and suffering, the principles enunciated in professional ethics assume even greater importance.

### **The Evolution of Professionalism in Western Societies**

Whilst the tradition of the physician-healer in western society dates back to ancient Greece and the role of the healer has remained fairly constant over time, the origins of professionalism and the concept of the physician-professional are more recent, and have evolved differently in different countries. In cultures influenced by England, the learned professions of medicine, law and theology trace their origins back to the Middle Ages, when these professions arose in guilds and universities that were established during that period (15). However, the professions remained ill-defined and their impact on populations remained very small until the industrial revolution made it possible for the public to pay for services, and science made medicine effective enough to be worth purchasing. Professionalism as a concept was thus developed and joined to the tradition of the healer as a means of organizing and supporting the provision of complex services to the population.

The roles of the healer and the healthcare professional are thus inextricably linked in modern times, and it is therefore difficult to fulfil the role of healer while being unwilling to accept professional obligations. Moreover, the social contract between society and medicine hinges on professionalism, since, while the primary obligation of the physician is to serve as healer, the society has chosen professional status as the way to organize the activities required from medicine and entrusted to the profession. Hence, as the society needs the healer, there must be an organizational framework within which the services of the healer are dispensed (18).

### **Teaching Professionalism**

When the medical profession was smaller and more homogeneous, the confronting issues were simpler and many

common values were shared within the profession. Then, professional values could be imparted during the process of socialization of doctors in training. The profession is more diverse now, and in many countries doctors are from various cultural, ethnic and socio-economic backgrounds. Whilst this current state represents an advance in terms of equity and fairness, it renders the transmission of common values more difficult, and so our current state of affairs requires the teaching of the role of both the healer and the professional. The teaching of professionalism should include several components:

- 1 \* The linked concept of healer and professional
- 1 \* status and the delivery of services
- 1 \* The moral value of professionalism
- 1 \* The concept of altruism
- 1 \* Proper professional behaviour
- 1 \* Knowledge of the philosophical and historical derivations of the profession's code of ethics
- 1 \* Obligations that medical professionals have to society, including addressing the health concerns of society, maintaining competence to practise, being accountable for all decisions, acting in the best interests of patients, and ensuring that the professional's own self-interest is subservient to the welfare of patients and that of the society that has granted him/her the privilege of service (19).

### **Critique of Medical Professionalism**

Strong support exists in the literature for the concept that professions must be moral, meaning that professionals must do right and not wrong. These persons should be devoted to the public good and should represent a positive force in society. Hence, changes that have occurred in the medical profession and in the public's expectations of physicians and surgeons have been extensively documented in books and journals not generally read by doctors – particularly in the fields of social science and bioethics (18).

The early writings on the subject were favourable, as it was felt that the professional would benefit society. Persons had faith in the virtues, morality, and the service commitment of medical doctors, although the negative tension between self-interest and altruism was identified in the literature. During that period, the collegial nature of the medical profession was believed to encourage and foster altruistic behaviour, and the issue of accountability was rarely discussed.

Subsequently, in the mid-1960s and 1970s, the tone of the writings changed, and medical professionalism as a concept was viewed as being flawed, partly because of the inherent conflict between altruism and self-interest. The crisis was not one of technical competence or skill, but rather one of moral standing and authority. The profession was criticized for its emphasis on remuneration, its failure to regulate itself adequately, its structure and organization, its emphasis on technology, its apparent inability to address the problems that society felt were important, and the perception that the profession often puts its own welfare above that of both the society and individual patients (18).

As the medical profession came to be analyzed in economic terms, critics stated that it controlled its own market and was able to create a demand for its services, which it then exploited, while issues of concern to the society, such as accessibility of healthcare, quality, and cost, were felt to be generally ignored by the profession. Hence, the negative tension existing between the profession's ability to promote its own interests and its obligation to serve society was believed to be a fatal flaw in the contract between the profession and the society.

Since the 1980s, however, the medical profession has lost control over its marketplace in many countries, either to the state or to the corporate sector, and so the sociology literature, after examining the difficulty of maintaining the values of altruism and professional services in alternative systems, has returned to the system of professionalism as the preferred way of organizing the delivery of healthcare. However, the public trust in medical doctors and their associations has not improved correspondingly.

### **Issues to be Addressed**

In carrying out its educational, scientific and self-regulatory functions, the medical profession has developed an extensive bureaucracy in universities, hospitals, its licensing body, and in its various associations. Whilst many consider this bureaucracy to be essential, some persons believe that the profession lacks the required will and authority to carry out the many regulatory and disciplinary activities as effectively as current circumstances require. Much of this criticism is related to the closed nature of the process, which has led some to believe that the profession lacks accountability. In fact, in Jamaica, some bureaucrats have called for more lay-persons to be included in the composition of the Medical Council, similar to the proportional cadre that exists in the General Medical Council of the United Kingdom, but some medical professionals are opposed to such a change.

Within this milieu, more medical doctors are becoming employed in the state or corporate sector, while others are being forced to compete in a marketplace that rewards entrepreneurial behaviour. In this plethora of moral, personal and professional obligations, with potential conflicts of interests, in order to protect the role of the healer, the behaviour of medical professionals will have to be not only responsible, but highly exemplary as well.

Medical professionals also have a number of concerns, similar to those of the society, including frustrations in their attempts to deliver ideal healthcare, restrictions in their personal time, financial incentives that strain their personal principles and, in some sectors, a loss of control over their clinical decisions. Dissatisfaction also arises from the new levels of accountability demanded by a more aware public, and the evaluation of outcomes primarily in financial terms (accounting logic). In fact, in the public sector, the application of accounting logic to the physician's activities has affected the professional's decision-making, and has often limited the amount of time allocated to communicate

with, and to treat, individual patients. In all this, therefore, the high cost and increasing complexity of modern medicine that have led to new forms of accountability, as well as instances of financial conflicts of interest, impropriety, and the failure of the profession to identify, and effectively deal with, impaired or dishonest physicians, have complicated further the ethical and professional dilemmas faced by today's practising physicians and surgeons.

Consequently, the medical profession needs to develop a coherent and integrated approach to address these very important issues that have affected the public's perception of its members. More coherent and relevant guidelines have been appearing in a few Caribbean countries, but more effort is needed to emphasize the foundation of altruism, personal morality and good virtues that are required in all members of the profession. Further, physicians and surgeons are accountable not only to their individual patients and colleagues, but also vicariously to other members of society and the state for the impact of their decisions on the community and the society's limited resources. These various levels of responsibility and accountability are now an integral part of professional life and have a broad impact on the practice of medicine.

Whilst more vigorous regulation, formal recertification and revalidation must occur, society should also be mindful of the worries and concerns of the medical profession, as most doctors believe with conviction that they have genuinely served their patients to the best of their abilities. Hence, despite real failings or shortcomings by some individuals and the profession, changes should be instituted with sensitivity and understanding, and the pressures of accounting logic in the public sector should be tempered so that doctors have the time to fully serve the individual patient. An increasing transparency of regulations and disciplinary actions should occur so as not to further jeopardize the public's trust in the healer.

### Charter on Medical Professionalism

With the growing concern in many western countries regarding these matters, broad-based meetings were conducted which confirmed that medical doctors' views on professionalism are similar despite quite diverse systems of healthcare delivery, and so a Charter on Medical Professionalism was developed in 2002 by the European Federation of Internal Medicine, the American College of Physicians – American Society of Internal Medicine (ACP-ASIM), and the American Board of Internal Medicine (ABIM) after several years of work (20). The document is based on the premises that changes in the healthcare system in many western countries threaten the values of professionalism, and that the conditions of medical practice are tempting physicians and surgeons to abandon their commitment to the primacy of patient welfare.

The Charter states three fundamental principles:

- <sup>1</sup> \* Primacy of patient welfare
- <sup>1</sup> \* Patient autonomy
- <sup>1</sup> \* Social justice

The first principle dates back to ancient times in the history of western medicine, while the second principle has evolved over the second half of the 20<sup>th</sup> Century when people began to view the medical doctor as an advisor, and the real centre of patient care was not the doctor's office or the hospital, but rather where people live their lives – in the home and at the workplace (that is, places where persons make the daily choices that determine their health). The third principle calls upon the medical profession to promote a fair distribution of healthcare resources.

The Charter also professes a Set of Commitments to:

- <sup>1</sup> \* Professional competence
- <sup>1</sup> \* Honesty with patients
- <sup>1</sup> \* Patient confidentiality
- <sup>1</sup> \* Maintaining appropriate relations with patients
- <sup>1</sup> \* Improving quality of care
- <sup>1</sup> \* Improving access to care
- <sup>1</sup> \* A just distribution of finite resources
- <sup>1</sup> \* Scientific knowledge
- <sup>1</sup> \* Maintaining trust by managing conflicts of interest
- <sup>1</sup> Professional responsibilities

The ethical underpinnings of doctors' professional relationships individually with patients and collectively with the society, are embedded in these principles and commitments. Hence, physicians and surgeons are challenged to live by these precepts which emphasize service to others. Medical doctors, therefore, have the responsibility to act on these principles and commitments, and should remember that physicians and surgeons cannot function effectively as healers without the trust of the patient and the society.

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