UNDERSTANDING MEDICAL ETHICS IN A CONTEMPORARY SOCIETY

***C.O. Osime (FMCS, FICS, LLB, B)**
*Department of Surgery, University of Benin Teaching Hospital, Benin City, Nigeria

Correspondence:
Dr OSIME C.O.
Department of Surgery,
University of Benin Teaching Hospital,
Benin City, Nigeria
EMAIL: clementosime@yahoo.com.

INTRODUCTION

Ethics refer to rules and principles that ensure right conduct and it touches on virtually every facet of life. Medical ethics broadly speaking refers to the medical oaths and codes that prescribe a physician's character, motives and duties which are expected to produce a right conduct and this should guide the members of the medical profession in their dealings with one another, their patients and with their states. It portrays the ideal physician as devoted to his duties vis' a'vis the welfare of the patient, and the advancement of the medical profession and medical knowledge. It also enjoins the physician to show compassion on the patient, but humble enough to understand the limits of his curative powers and the harm he unintentionally cause.[1] This concept is entrenched in the Hippocratic injunction which states "strive to help, but above all, do no harm". Medical ethics is primarily a field of applied ethics; the study of moral values and judgment as they apply to medicine. Medical ethics encompasses its practical application in clinical setting as well as work on its history, philosophy, theology and sociology. Medical etiquette on the other hand refers to conventional laws and customs of courtesy observed between members of the medical profession. These principles are embodied in the Hippocratic Oath, Geneva Convention and handbooks guiding professional practice.[2] A clear understanding of these basic principles will go a long way in reducing the incidence of medical litigations which is fast becoming popular in Nigeria as the World becomes a global village. There a number of issues which are covered in medical ethics and these include physician's paternalistic deceptions and violation of patients confidentiality, the rights of the patient or their surrogates to refuse life sustaining treatments or requires assistance in dying. It also touches on subjects such as drug experiments on children, demented or dying patients and other incompetent or desperate patients. Also covered are subjects like bias-free definition of of health, death, disease, futility of treatment, removal of viable organs from patients who are brain dead or in cardiac arrest, grounds for fetal testing, selection and abortion, involuntary hospitalization and treatment of mentally disturbed people. Another aspect medical ethics looks at is the conflict of interest between physicians and their employers and third party players; public or private.[3]

PRINCIPLES OF MEDICAL ETHICS (VALUES IN MEDICAL ETHICS)

Certain principles are obviously manifest with respect to medical ethics and the physician ought to be familiar with most of these principles and that will serve as a guide in their conducts vis' a'vis patient care. Some of these principles o values are:

Patient's autonomy: Patient's autonomy implies that the patient has the right to decide what shall happen to his own body. This concept is also encouraged by the constitution of the Federal Republic of Nigeria. The medical practitioner must therefore be prepared at all times to respect the patient's wishes even when they appear unreasonable or stupid provided the caregiver has given adequate information to the patient. [4]

Responsibilities and duties of the patients and physicians: The relationship between the patient and the physician is similar to that between a

buyer and the seller. From the onset, it is essential to define what the duties and the responsibilities of each party are. In fact, it is against the background of a breach of that duty by the physician (and the patient is made to suffer injury) that defines the presence of negligence or otherwise. Thus, at the point a physician accepts to see a patient, he must define in his mind, what his duties and responsibilities are. [5]

Beneficence: This implies that the physician at all times must act in the best interest of the patient. The question may be asked: what is the best interest of the patient and who should decide what that best interest is? Whatever the answer is, it must be made to align with the patient's wish. The right of the patient must be respected.

Non-malfeasance: This describes the principle of not causing harm to the patient (or do the least harm possible). The physician should therefore be alert at all times not to cause harm to the patient.

Honesty: This is so vital and a doctor who is honest with his patient at all times earns a lot of respect and allows for a smooth relationship between the doctor and the patient. However, there may be the need to weigh this against situational good; for example when withholding information is appropriate or the context of culture, patient's emotional or cognitive status does not encourage the physician to be absolutely honest at all times.

Confidentiality: This means keeping as top secret your dealings with the patient. It is wrong for a doctor to divulge the information about his patient to another person without the patient's consent.[6] However, there are some exceptions to this general rule. The exceptions include:

- when a patient gives a written and valid consent.
- when the information is divulged to other participating professionals in the management of that patient. For example, if a patient is HIV positive, the doctor is not in error if he tells the nurse who is doing daily dressing for the patient that is HIV positive. In fact, it can be considered a gross misconduct where such a doctor fails to tell other members of the team.
- where it is undesirable to seek the consent, information can be given to a close relative.
- statutory requirement or when the court has ordered that the information be made public.
- When divulging the information is in the public interest.
- When it is in respect of approved research.

I**nformed consent:** Informed consent is the very foundation of the patient-doctor relationship and therefore demands a detailed explanation. This is particularly so because most medical litigations revolve around deficiencies in the process of obtaining informed consent for medical care. Informed consent implies consensus or a meeting of minds and not a mere completion of a form. If the essential ingredients are lacking, then of course informed consent cannot be said to exist; a signed informed consent form notwithstanding. The principles of informed consent is

predicated on the fact that "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an insult for which he is liable in damages.[7] No better description of this basic principles of informed consent than that given by Judge Cordoza in Schloendorf v. Society of New York Hospitals in 1914.[8] The learned Judge helped establish the principle that an operation could not be performed without disclosure of its nature or scope. Except in established emergency cases, it is mandatory for the physician to discuss the operative procedure with the patient and obtain consent to perform the procedure from the patient prior to the event.

The duty of a physician to disclose the risks of a medical procedure, the alternatives methods of treatment, the benefits of the procedure and other such related issues was more extensively explored in the 1960 case of Natanson v. Kline.[9] The court in this case held that a physician "was obligated to make a reasonable disclosure to the appellant of the nature and probable consequences of the suggested or recommended cobalt irradiation treatment, and he was also obligated to make a reasonable disclosure of the dangers within his knowledge which was incident to, or possible in, the treatment he proposed to administer."[10] In this ruling, the physician was obligated to not only discuss details of the intervention but also was required to explore the possible risks of that intervention with the patient.

The story of informed consent, like every part of medicine is dynamic and the physician must keep abreast with current developments with respect to informed consent. The case of Canterbury v. Spence in 1972 gives credence to the dynamic nature of informed consent.[11] In this court ruling, the duty to disclose all significant or material risks was outlined in absolute rather than relative terms. According to the court, all material must be disclosed regarding "the inherent and potential hazards of the proposed treatment, the alternatives to that treatment, if any, and the results likely if the patient remains untreated."[12]

The requirements of informed consent vary from country to country but a broad interpretation of these preceding court decisions would suggest that informed consent requires a full disclosure and discussion of the proposed medical or operative procedure, including its risks, complications, alternatives and their risks, and reasonable expectations. The physician should be aware that informed consent does not imply completion of the consent forms simpliciter. It is a sensitive issue and must never be trivialized. Unfortunately, most doctors do not appreciate the enormity of problems that may result from obtaining consent inappropriately. Recent legal rulings have also given credence to this position of the law regarding informed consent. Informed consent should be considered as the process of a physician communicating with a patient about proposed treatments or procedures during the preoperative period. It is important to note that if a record of the informed consent discussion was not written into the patients chart, including a discussion of the operative procedure, its risks, complications, alternatives and their risks and reasonable expectations, legally speaking, that discussion did not

occur.[12]

The physician must first give information to the patient and the patient can then give consent or otherwise with respect to medical treatment. The doctor must be clear in his mind that the patient clearly understands the issue being discussed; otherwise, it is not informed consent and to that extent, the doctor may be liable in the event of litigations. Also, the physician obtaining the consent, should either be the person that will be administering the treatment (e.g. the consultant surgeon) or another senior member of the team who clearly understands the proposed treatment, otherwise, it is not a valid consent. In Osime et al's study in University of Benin Teaching Hospital, it was only in 4% that the consultant surgeons personally obtained informed consent. In the remaining cases, consent was obtained by junior members of the team who probably did not understand the proposed treatment.[13] It is expected that the patient is given reasonable time to reflect on the discussion and then make up his mind whether to accept the medical procedure or not. For example, except in emergency situations, consent obtained by the surgeon in the operating theatre just before the commencement of surgery will not be considered a valid consent since the patient hadn't any time to think on the proposed treatment so he can properly decide to accept the surgery or not. But the physician must first decide whether the patient has the competence (defined by law) or the capacity (defined by the physician acting in good faith) to give a valid consent. In Nigeria, a person below 18yeras is considered a minor and to that extent lacks the competence to give consent. The parents or guardian will need to give consent for him. (However, recent cases will tend to suggest that it is the ability of the child to fully comprehend the procedure being discussed rather than age alone that should determine whether the child can give consent or not).[14] On the other hand, a 30 year old imbecile lacks the capacity to give informed consent. To treat a patient without his or her consent is considered as assault and the law frowns at that seriously.

Medical reasonableness: It is an aspect that should always be on the doctor's mind. It implies that whatever you intend to do for a patient; you must first consider whether a reasonable man, working under the same circumstance will do what you plan to do if he were faced with a similar situation. For example, if during myomectomy, you feel there is the need to do hysterectomy, you must quickly ask yourself whether another reasonable surgeon working under the same circumstance will do a hysterectomy in that circumstance. The reasonable man's test (also called the Bolam's test), does not consider the extremely intelligent surgeon as the yardstick in this circumstance; rather it talks of the ordinary surgeon, who is considered to be reasonable and acting in good faith.[15] If a doctor is unreasonable in his conducts, whether they are done in good faith or not, it may lead to acts that can be considered as malpractice that may lead to medical litigations.

Best interest of the patient: At all times, whatever we do as doctors should be in the best interest of the patient. However, this must be cautiously adopted considering patient's autonomy. Thus, it is the patient, who has been adequately informed that can determine what is his own best interest and not the doctor. For example, a

doctor may recommend that a patient be transferred to old people's home, but the patient may decide to do to the father's house. In this circumstance, sending the patient to the father's house is "the best interest of the patient".

Principles of double effect: This has to do with a situation when a doctor gives treatment that will produce a desired result, at the same time it produces a negative effect. For example, the 70 years old patient with advanced malignant condition may have the pain relieved by use of narcotics but at the same time he may suffer respiratory depression. Such phenomenon must be clearly explained to the patients.

Continuous medical education: This is an aspect the Medical and Dental Council should take seriously. Ignorance is no excuse in law. Thus a doctor cannot go to court to say he has forgotten how to mange electrolyte derangements and so a patient had to die. Neither will it be acceptable for a doctor to say that the present methods described for cardiopulmonary resuscitation is different from what he learnt in his days in school. The onus is on the doctor to read and develop himself and keep abreast with current developments in medicine to avoid unnecessary and embarrassing medical litigations.

These are some of the values enunciated in medical ethics. The list is by no means exhaustive. It is expected that the doctor should always read and develop himself with respect to what obtains worldwide.

MEDICAL NEGLIGENCE

It is pertinent at this point to talk on what constitutes medical negligence because it is an aspect often neglected and yet it has gotten some doctors into serious mess. Crimes are public wrongs against the state or the public at large. The "people" bring action against the perpetrator of a crime. The purpose of criminal proceedings is to protect the interest of the public and punish the offender.

Torts, in contrast, are private civil wrongs usually between individuals in which the remedy is a common law action for damages. Medical malpractice is a tort that arises from the breech of legal duty one person owes another to act reasonably in a way that will not harm another person or property.[16] But it should be noted however that gross medical malpractice may be considered a criminal offence. Medical Malpractice is injurious or unprofessional treatment or culpable neglect of a patient by a physician or surgeon. Injuries, however, can occur during the course of medical treatment and may be an acceptable risk of the treatment. For malpractice to have occurred, usually one of the following must be shown by the injured patient (plaintiff):

1) Failure of the physician to follow usual practice in
the community.
2) Lack of skill.
3) Ignorance.
4) Alcohol or drug abuse.
5) Failure to tell patients of the treatment risks.
6) Lack of needed equipment, medicine or staff.

The basis of any medical malpractice suit is an assessment of fault that caused an injury to a patient. Fault centres on what is expected of a physician in the practice of medicine. Fault implies that the physician did not have the necessary amount of skill and care and, because of this lack or failure, a patient was injured. Simply put, the doctor is expected to act as a "reasonable" doctor.
To prove that malpractice has occurred, the plaintiff (injured patient) must prove to a jury four basic elements.

Duty

The Doctor - Patient relationship:
The doctor must have incurred a duty to care for the patient. The obligation of a physician to care for a patient arises from establishing a doctor-patient relationship. A physician has no obligation or duty to accept a patient; however, once a doctor accepts a patient, he or she has a duty to adhere to a certain level or standard of care. The doctor-patient relationship can be established casually; a "quick" informal physical, medical prescriptions prescribed over the telephone, or the mere scheduling of an appointment may be sufficient to establish a legal doctor-patient relationship. Once established, this duty or obligation requires that the physician provide care for the patient. It is important that the physician is familiar with this. For example a wrong prescription made via a text message is sufficient to mess up the doctor because that is sufficient proof of the doctor-patient relationship.

Breach of Duty

Negligence: To prove negligence, it must be shown that the doctor didn't conform to the standard of care. Standard care is "reasonable care" as provided by a "reasonable doctor." The doctor must provide to a patient a level of care required under law, "the standard of care." Standard of care may be defined as constituting the skill and care customarily exercised by doctors in the same line of practice under similar circumstances. This standard usually implies that physicians must possess and employ the skill and knowledge of physicians in the same and similar circumstances and with regard to the state of the profession at that time. Because of the wide availability of continuing medical education (CME) information, doctors are increasingly being held to a broad standard of care that would be acceptable nationally.

Causation

Causation suggests that the doctor didn't conform to the standard of care and harm came to the patient. The doctor's negligence must be the reason for or proximate cause of the injury or damage. The plaintiff (injured patient) must establish that a doctor's breach of the standard of care proximately caused an injury. In certain circumstances however, the patient (plaintiff) may plead res ipsor loquitor and under this circumstance, the doctor (defendant) will need to prove that he was not negligent. If the treatment or lack of treatment did not cause the patient's injury, the doctor, is generally, not liable. A direct link must be proven between the alleged negligence and the harm suffered for a plaintiff to win a malpractice case.

Injury suffered

The patient will also need to show that as a result of the breach of the duty of care, he suffered injuries.

WHO REGULATES THE CONDUCTS OF THE MEDICAL DOCTOR?

The Medical and Dental professions in Nigeria are regulated by the Medical and Dental Practitioners Act Cap 221 Laws of Federation of Nigeria 1990

which sets up the Medical and Dental Council of Nigeria with the following responsibilities:

a. determining the standards of knowledge and skill to be attained by persons seeking to become members of the medical or dental profession and reviewing those standards from time to time as circumstances may permit.
b. securing in accordance with provisions of this Law the establishment and maintenance of registers of persons entitled to practice as members of the medical or dental profession and the publication from time to time of lists of those persons;
c. reviewing and preparing from time to time, a statement as to the fcode of conduct which the Council considers desirable for the practice of the professions in Nigeria; and
d. performing the other functions conferred on the Council by this Law.

By provision (c) above, the Council is empowered to make Rules for professional conduct and is also empowered to establish the Medical and Dental practitioners Disciplinary Tribunal and Medical Practitioners Investigating Panel for the enforcement of these Rules of Conduct.[17]

In addition, the various Courts in the Country may be used by the patient to seek redress when he thinks he has not been properly managed. Thus the patient may either use the regular Courts or go through the Nigerian Medical and Dental Council Disciplinary Committee. However, as illustrated by Okonkwo v Nigerian Medical and Dental Council Disciplinary committee, the decisions of the Court of Appeal and Supreme Court supersedes that of the Medical Council.[18] In additrion, the Constitution of the Federal Republic of Nigeria supersedes the regulations of the Nigerian Medical and Dental council and when there are inconsistencies in the regulations contained in the Constitution and that contained in Medical and Dental Council's regulations, the regulations of the Medical and Dental Council will be null and void to the extent of such inconsistencies.[19]

If the Nigerian Medical and Dental Council consider the case of a doctor who has been summoned and such a doctor is found to be at fault, there are a number of options by way of punishment:

admonishing the practitioners;

suspending the practitioner from practice as a medical practitioner or dental surgeon for a period not exceeding six months;

striking the practitioner's name off the relevant register.

On the other hand, the court may award various forms of damages.

CONCLUSION

Medical ethics is as old as the medical profession and its chief function is to ensure that the medical practitioner maintains the right conducts with respect to patient management. It is recommended that the doctor should be familiar with the ethical principles and values. Medical litigations which was initially rare in Nigeria is fast becoming a popular event. With the availability of internet services, the World is a global village and an aggrieved patient in Nigeria may want to replicate what another patient did in the United States of America who was similarly aggrieved. As much as possible, medical litigations should be avoided. If a doctor has mismanaged a patient, it is preferable to opt for alternative dispute resolution rather than litigation. The doctor should be alert at all times and seek to do what is right always regarding patient care because a single act of indiscretion which is taken through the Nigerian

Medical and Dental Council or through the regular Courts may ruin the doctor's entire medical career.

REFERENCES

1. Johnson AR, Siegler M, Winslade WJ. Clinical Ethics: Cases in Medical Ethics, 2nd ed, New York, N.Y. Oxford University Press, 2001.

2. Junkerman C, Schiedermayer DL. Practical Ethics for Students, Interns and Residents: Ashort Reference Manual, 2nd ed, Frederick Mcl University Publishing Group, 1998.

3. Yeatch RM. The Basics of Bioethics, 2nd ed. Upper Saddle River. N.J. Prentice Hall, 2003.

4. Quill Te, Brody H. Physician's recommendations and Patient's Autonomy: Finding a balance between physician power and patient choice. Ann of Int Med 1996; 125: 763-9.

5. Godkin D, Markwell H. The duty to care of healthcare professionals: ethical issues and guidelines for policy development. Toronto: Joint Center for Bioethics, University of Toronto; 2003.

6. Sadan B**.** Patient Data Confidentiality and Patient Rights. International Journal of Medical Informatics. 2001; 62:43-49.

7. 211 NY at 126, 105 NE at 93 (1914).

8. . 211 NY 125, 105 NE 92 (1914).

9. 211 NY 125, 105 NE 92 (1914).

10. 186 Kan at 410, 350 P2d at 1106.

11. 464 F2d at 787 (DC Cir. 1972).

12. Marco CA. Impact of detailed informed consent on Research Subjects' participation: A prospectice randomized trial. J Of Emerg Med 2008; 34:269-275.

13. Osime OC, Okojie O, Osadolor F, Mohammed S. Current practices and medico-legal aspects of pre-operative consent. East African Medical Journal 2004; 81: 331-335.

14. Weisleder P**.** Inconsistency among American States on the Age at Which Minors Can Consent to Substance Abuse Treatment. J Am Acad Psychiatry Law 2007; 35:317-322.

15. Bolam v Friern Hospital Management Committee ([1957] 1 WLR 583)

16. Hoffman AC. Medical malpractice. In Sanbar SS, Gibofsky A, Firestone MH, LeBlang TR, eds. Legal Medicine. 3rd edition. St Louis: Mosby; 1995:129-140.

17. Medical and Dental Practitioners Act Cap 221

(now Cap M8) Laws of Federation of Nigeria 1990.

18. Nigerian Medical and Dental Disciplinary Tribunal V Okonkwo (2001) 4 SCN 78.

19. The 1999 constitution of the federal republic of Nigeria.