Ethics in Medicine - Concept for Public Health

"With great power comes great responsibility," our profession is a breathing example of this adage. While we graduate as doctors, we take the Hippocratic Oath, which emphasizes "Primum non-nocere" meaning "do no harm." Still during the course of our practice, we come across situations that challenge our capacity for judgment to do the minimal amount of harm. Triage is one such situation. When the resources are scarce and situation demands contrast supply, we must be able to pass the correct judgment to make sure that we are using it wisely. Physician-assisted suicide is another end of the spectrum where we must make the decision based on ethical as well as practical standards. Such decisions could be done only if the person has worked ethics and moral integrity. Hence, medical practice is not only a test of knowledge but also the test of the integrity of character of the individual. Treating the person as a whole rather than a particular disease is the need of the hour. The doctor should understand the physical, emotional, and spiritual needs of the patients and take necessary steps for the well-being of the patient. This requires entire time, attention, and patience toward the patients.[1]

I like to explore the American Medical Association code of medical ethics here. When we look at the difference between laws and ethics, ethical responsibilities are far greater than legal aspects of medicine. Ethical standards have the power to change the course of legal obligations in the course of time. American Medical Association covers the ethical responsibilities of physicians broadly in nine different aspects such as social policy issues, inter-professional relationships, hospital relations, confidentiality advertising and communication media relations, physician records, fee and charge, practice matters, professional rights and responsibilities, and lastly but most importantly physician-patient relationship.[2]

Among the social policy ethical codes, it is interesting to discuss the opinion 2.037, which deals with medical futility at the end of life care situations. There has been a long-standing debate in the medical fraternity about the physician-assisted suicide. Recently, Massachusetts Medical Society has testified against the Massachusetts Physician Assisted Suicide Legislation. Although it is difficult to predict whether a person is going to live more than 6 months, it is important to decide what would be a futile intervention and how to make a decision to provide a patient with the intent of comfort and closure. American Medical Society provides a systematic approach towards investigating whether an intervention is futile or not. This includes a recommendation that all health care organizations must adopt a policy for medical futility which should follow a seven step approach.[3]

1. Deliberate and negotiate prior understandings on what constitute a futile care for patient, proxy, physician, and institution
2. Maximum extent of joint decision-making process between physician, institution, patient, and proxy
3. Consultant mediated negotiation of disagreements
4. Involvement of Ethical Committee in irresolvable issues
5. Transfer of care to another physician in the institution is an issue between physician and patient/proxy and the institution supports the patient/proxy's position
6. Transfer of care to another institution is an issue between physician and patient/proxy and the institution supports the physician's position
7. If transfer is not feasible in the condition where there is an irresolvable conflict between physician and patient/proxy and institution supports the physician's position, intervention may not be offered.

Another clause that considers this aspect is Opinion 2.20, which deals with withholding or withdrawing life-sustaining medical treatment. This, in a nutshell, states that the preference of the patient should prevail. According to the principle of autonomy, a physician is expected to respect a patient's decision to forgo any life-sustaining treatment if the patient is competent and has decision-making capacity, or have appointed a surrogate decision maker according to the state law. Substituted judgment by a patient's surrogate should reflect on patient's judgment and preferences, an advanced directive of the patient, and patient's value toward sickness, medical procedures, suffering and death and should be in the best interest of the patient. American Medical Association states four conditions where judicial review or intervention might be needed in case of surrogate decision such as - No surrogate decision maker:

1. No clear advanced directive and dispute among family members
2. Belief of the health care provider that the decision is not what the competent patient would have desired
3. Belief of the health care provider that the decision is not according to the best interest of the patient.

Another clause that explores this aspect is Opinion 2.191, which deals with advance care planning to promote and facilitate decision making for treatment. The discussion helps patient to set preferences about treatment in the case of emergencies and express the values that should govern their care. Encouraging the patients

to share their views and recording them in advance directives help for future reference. Periodic review and discussion of patient's goal in treatment are vital for advance care planning. Physicians have a responsibility to promote dignity and integrity of the patient in their care and provide palliative treatment to alleviate suffering, and these opinions provide an organized structure on which we could stand and make decisions on a constant basis for the benefit of the patient. However, let us not forget that the physician-patient relationship is so sacred and complementary to each other beyond the tenets of any behavioral code.

Dr. Ammu Thampi Susheela

Department of Cardiology, Beth Israel Deaconess Medical Center, Boston, USA

Address for Correspondence:
Dr. Ammu Thampi Susheela, 756 Washington Street, Brookline Massachusetts, 02446, USA. E-mail: tsammu@rediffmail.com

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