



Values in medical ethics

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Abstract

Medical Ethics is a practical subject as well as a branch of moral philosophy. Ethics is an integral part of good medical practice. It is an essential branch of medicine. Ethics deals with the choices we make and our actions in relation to those choices. It deals with choices made by both clinicians and patients and the duties and obligations of clinicians to their patients. Medical ethics also deals with the choices made by society, the distribution of resources and access to health care and the dilemmas arising from them. Ethics deals with the choices we make and our actions in relation to those choices. It deals with choices made by both clinicians and patients and the duties and obligations of clinicians to their patients. Medical ethics also deals with the choices made by society, the distribution of resources and access to health care and the dilemmas arising from them. Our review, emphasizes about values in medical ethics like Autonomy, beneficence, non-maleficence, justice, dignity, truthfulness and honesty.

Keywords: medical ethics, autonomy, beneficence, non-maleficence, justice, dignity, truthfulness, honesty

Introduction

Ethics deals with choices. Where there are no choices there is no need for ethics. There are almost always choices to consider and there is almost always a need for ethics. Any choice we make involves ethics, although sometimes we may not realise or consider it ^[1]. How we live involves choices affecting ourselves and others with both the potential for benefit and for harm (consequences). How we feed ourselves, clothe ourselves, keep ourselves warm, travel to work etc. All these choices have consequences for others. Ethics is also about duties and obligations: to whom we have duties, how extensive they are, how best they may be discharged and how we deal with conflicting duties and obligations. Patients have duties and obligations too, which is why we should respect them as moral agents. Parents have duties of care to their children; and sometimes a clinician's duty to a child patient may conflict with those of the parents, and this needs an ethical approach to resolve. Ethical practice involves a systematic approach to decision making and actions, considering the interests of all affected by the decision.

Six values that commonly apply to medical ethics discussions are:

1. Autonomy
2. Beneficence
3. Non-maleficence
4. Justice
5. Dignity
6. Truthfulness and honesty

1. **Autonomy (Voluntas aegroti suprema lex.):** The patient has the right to refuse or choose their treatment.
2. **Beneficence (Salus aegroti suprema lex.):** A

Practitioner should act in the best interest of the patient.

3. **Non-maleficence (Primum non nocere):** "First, do no harm".
4. **Justice (Fairness and equality):** Concerns the distribution of scarce health resources, and the **decision** of who gets what treatment.
5. **Dignity:** The patient (and the person treating the patient) have the right to dignity.
6. **Truthfulness and honesty:** The concept of informed consent has increased in importance since the historical events of the doctors' Trials of the Nuremberg trials and Tuskegee syphilis.

Autonomy

The term "autonomy" comes from two Greek words, that is, *auto* (auto), which means self, and *nomos* (nomos), which means rule" or law." Literally, autonomy means self-rule. A commonly shared understanding defines autonomy as, "self-governance" or "selfdetermination". It is a concept found in moral, political, and bioethical philosophy. Within these contexts, autonomy is understood as the capacity of a rational individual to make an informed and uncoerced decision. This implies having intellectual capacity to differentiate good from evil/bad and right from wrong. It also means that one has the good will to pursue what is good and right as well as to avoid what is bad and wrong. The assumption of autonomy is that each human being has the right and capacity to make her or his own decisions about medical procedures, treatment, and participation in biomedical research. It empowers one to make his/her own decision or to participate in decision-making process. For an individual to make an autonomous decision, he/she requires adequate information that is understandable

and noncoercive. The concept of autonomy is actualized in asking for informed consent in both clinical care and biomedical research. For consent to be informed, it requires disclosure, understanding, free choice, and competence. In fact, competence is a precondition and a necessity for informed consent in both clinical practice and biomedical research [2].

A historical account on the development of the principle of autonomy in bioethics

The principle of autonomy is historically linked to the work of the German philosopher Immanuel Kant (1724–1804). Kant's most influential arguments are contained in the books, *The Groundwork of the Metaphysics of Morals*. In fact, in his main theory of deontology, he formulated two guiding rules of conduct, which clearly define his concept of autonomy. It is in here that he espouses that moral requirements ought to be based on what he refers to as the categorical imperative. The two rules which comprise the categorical imperative are as follows: act only according to that maxim whereby you can at the same time will that it should become a universal law of humanity and act so that you treat humanity, whether in your own person or that of another, always as an end and never as a means only. In particular, the second formulation of the categorical imperative contends that a human being as a rational being should always be treated as an end in himself/herself and not merely as a means to achieve another person's end. This is because as rational agents, human beings are free agents that are capable of making their own decisions, setting their own goals, and guiding their behavior by reason.

Application of autonomy in clinical/medical practice

In medical literature, the term autonomy is associated with "freedom"-that is, the right of individuals to act and make decisions without external constraints. In other words, autonomy refers to the decision-making dimension of the patient role, and enhancing patient autonomy means helping patients make their own decisions. Key to a patient's ability to make his or her own decisions is information. Information, in this context, enhances autonomy. Patients who actively seek information are generally seen as more autonomous because, in the liberal individualist interpretation, information is seen as a necessary condition for autonomous choice. Autonomy requires health professionals to obtain the informed consent of patients before any medical procedure is performed. Beauchamp and Childress in their seminal work, *Principles of Biomedical Ethics*, define autonomous patients as choosers who act intentionally, with understanding, and without controlling influences that determine their actions. Given the above definition of an autonomous patient, autonomy is supposed to protect vulnerable patients from unwanted interference by health professionals by demanding respect for a patient's integrity. In order to respect the autonomy of patients, health professionals are required to give necessary information that is understandable and allow a competent patient to make a free choice regarding treatment or medical procedure. Before they get consent from the patients or their guardians, they have to explain the medical condition of the patient as well as the benefits and risks of the treatment options. This assumes that patients are rational and reasonable

agents capable of making voluntary decisions. In cases of minors and incompetent patients, they have to respect the wishes of the parents/guardians regarding treatment or medical procedure after disclosing the information. Autonomy also requires health.

Challenges to the universality of autonomy in bioethics

The universal validity of autonomy in Western bioethics has been challenged at several points by non-Western cultures still proud of their communal relations and spiritualistic ethos. Non-Western literature on autonomy suggests the idea that autonomy in the Western sense does not readily apply to other cultural or ethnic groups. It is not the concept of autonomy that is totally alien to non-western cultures; only that while the West emphasizes individual autonomy, non-Western cultures place greater emphasis on cultural, communal, or family autonomy. For many cultures, however, the perception of self and the individual is defined by relationships with others. In non-Western cultures and traditions, family duties and obligations take precedence. For instance, greater value and meaning are given to the interdependence of family and community which transcends self-determination or individual autonomy. This tradition emphasizes the value of a holistic view of a person that affirms the importance of the professionals to maintain confidentiality of medical information that patients provide to health professionals. It is not the prerogative of the health professional to make a decision for the medical benefit of the patient without involving either the patient or his/her guardian since the health professional's obligation to respect autonomy outweighs professional obligations of beneficence.

Beneficence

This principle refers to the duty of physicians to act in the best interests of their patients, i.e., to act for the good of their patients. Thus, when making diagnoses, providing information, or recommending or implementing treatment, the physician should be guided by what he or she believes is best for the patient. To some, beneficence is the essential principle in medicine, the whole point of the medical enterprise. However, this goal leads to the question of who determines the patient's good and on what basis. Indeed, the most common ethical dilemmas in medicine arise when there are disagreements about what constitutes the patient's good and who should decide that, which often leads back to respect for patient autonomy.

Non-maleficence

Maleficence is harm or evil, so the principle of non-maleficence refers to the requirement to avoid harming patients, as expressed in the famous Hippocratic aphorism: "First do no harm." This principle applies to all persons, not only physicians, whereas the principle of beneficence is not a requirement of all persons. Its application to medicine is important in situations where diagnostic tests or therapeutic interventions carry significant risks of harming the patient, or a small risk of causing serious harm, or when not intervening carries great risk. Such situations are fairly common and can serve as teaching opportunities.

Double effect

The principle of double effect-also known as the rule of double effect; the doctrine of double effect, often abbreviated as DDE or PDE, double-effect reasoning; or simply double effect – is a set of ethical criteria which Christian philosophers, and some others, have advocated for evaluating the permissibility of acting when one's otherwise legitimate act (for example, relieving a terminally ill patient's pain) may also cause an effect one would otherwise be obliged to avoid (sedation and a slightly shortened life). The first known example of double-effect reasoning is Thomas Aquinas' treatment of homicidal self-defense, in his work *Summa Theologica*. This set of criteria states that an action having foreseen harmful effects practically inseparable from the good effect is justifiable if the following are true:

1. The nature of the act is itself good, or at least morally neutral;
2. The agent intends the good effect and does not intend the bad effect either as a means to the good or as an end in itself;
3. The good effect outweighs the bad effect in circumstances sufficiently grave to justify causing the bad effect and the agent exercises due diligence to minimize the harm.

Example

The principle of double effect is frequently cited in cases of pregnancy and abortion. A doctor who believes abortion is always morally wrong may still remove the uterus or fallopian tubes of a pregnant woman, knowing the procedure will cause the death of the embryo or fetus, in cases in which the woman is certain to die without the procedure (examples cited include aggressive uterine cancer and ectopic pregnancy). In these cases, the intended effect is to save the woman's life, not to terminate the pregnancy, and the effect of not performing the procedure would result in the greater evil of the death of both the mother and the fetus. In cases of terminally ill patients who would hasten their deaths because of unbearable pain, or whose caregivers would do so for them (euthanasia, medical aid in dying, etc.), a principle of "double effect death" could be applied to justify the deliberate administration of a pain-killer in potentially unsafe doses-not in an attempt to end life but to relieve the pain suffered as it is considered harmful to the patient. The U.S. Supreme Court has voiced support for this principle in its deliberations over the constitutionality of medical aid in dying^[3].

Conflicts between autonomy and beneficence/nonmaleficence

Autonomy can come into conflict with beneficence when patients disagree with recommendations that healthcare professionals believe are in the patient's best interest. When the patient's interests conflict with the patient's welfare, different societies settle the conflict in a wide range of manners. In general, Western medicine defers to the wishes of a mentally competent patient to make their own decisions, even in cases where the medical team believes that they are not acting in their own best interests. However, many other societies prioritize beneficence over autonomy. Examples include when a patient does not want a treatment because of, for example, religious or cultural views. In the

case of euthanasia, the patient, or relatives of a patient, may want to end the life of the patient. Also, the patient may want an unnecessary treatment, as can be the case in hypochondria or with cosmetic surgery; here, the practitioner may be required to balance the desires of the patient for medically unnecessary potential risks against the patient's informed autonomy in the issue. A doctor may want to prefer autonomy because refusal to please the patient's self-determination would harm the doctor-patient relationship. Organ donations can sometimes pose interesting scenarios, in which a patient is classified as a non-heart beating donor (NHBD), where life support fails to restore the heartbeat and is now considered futile but brain death has not occurred. Classifying a patient as a NHBD can qualify someone to be subject to non-therapeutic intensive care, in which treatment is only given to preserve the organs that will be donated and not to preserve the life of the donor. [22] This can bring up ethical issues as some may see respect for the donors wishes to donate their healthy organs as respect for autonomy, while others may view the sustaining of futile treatment during vegetative state maleficence for the patient and the patient's family. Some are worried making this process a worldwide customary measure may dehumanize and take away from the natural process of dying and what it brings along with it. Individuals' capacity for informed decision-making may come into question during resolution of conflicts between autonomy and beneficence. The role of surrogate medical decision-makers is an extension of the principle of autonomy. On the other hand, autonomy and beneficence/non-maleficence may also overlap. For example, a breach of patients' autonomy may cause decreased confidence for medical services in the population and subsequently less willingness to seek help, which in turn may cause inability to perform beneficence. The principles of autonomy and beneficence/non-maleficence may also be expanded to include effects on the relatives of patients or even the medical practitioners, the overall population and economic issues when making medical decisions.

Informed consent

Informed consent in ethics usually refers to the idea that a person must be fully informed about and understand the potential benefits and risks of their choice of treatment. A correlate to "informed consent" is the concept of informed refusal. An uninformed person is at risk of mistakenly making a choice not reflective of his or her values or wishes. It does not specifically mean the process of obtaining consent, or the specific legal requirements, which vary from place to place, for capacity to consent. Patients can elect to make their own medical decisions or can delegate decision-making authority to another party. If the patient is incapacitated, laws around the world designate different processes for obtaining informed consent, typically by having a person appointed by the patient or their next of kin make decisions for them. The value of informed consent is closely related to the values of autonomy and truth telling.

Confidentiality

Confidentiality is commonly applied to conversations between doctors and patients. This concept is commonly known as patient-physician privilege. Legal protections prevent

physicians from revealing their discussions with patients, even under oath in court. Confidentiality is mandated in the United States by the Health Insurance Portability and Accountability Act of 1996 known as HIPAA, specifically the Privacy Rule, and various state laws, some more rigorous than HIPAA. However, numerous exceptions to the rules have been carved out over the years. For example, many states require physicians to report gunshot wounds to the police and impaired drivers to the Department of Motor Vehicles.

Criticisms of orthodox medical ethics

It has been argued that mainstream medical ethics is biased by the assumption of a framework in which individuals are not simply free to contract with one another to provide whatever medical treatment is demanded, subject to the ability to pay. Because a high proportion of medical care is typically provided via the welfare state (ie. Medicare), and because there are legal restrictions on what treatment may be provided and by whom, an automatic divergence may exist between the wishes of patients and the preferences of medical practitioners and other parties.

Importance of communication

Many so-called “ethical conflicts” in medical ethics are traceable back to a lack of communication. Communication breakdowns between patients and their healthcare team, between family members, or between members of the medical community, can all lead to disagreements and strong feelings. These breakdowns should be remedied, and many apparently insurmountable “ethics” problems can be solved with open lines of communication ^[4].

Control and resolution

To ensure that appropriate ethical values are being applied within hospitals, effective hospital accreditation requires that ethical considerations are taken into account, for example with respect to physician integrity, conflict of interest, research ethics and organ transplantation ethics.

Guidelines

There are various ethical guidelines. For example, the Declaration of Helsinki is regarded as authoritative in human research ethics. In the United Kingdom, General Medical Council provides clear overall modern guidance in the form of its ‘Good Medical Practice’ statement. Other organizations, such as the Medical Protection Society and a number of university departments, are often consulted by British doctors regarding issues relating to ethics. The ARRT is an example of an organization which requires its members to adhere to a specific ethical code of conduct.

Ethics committees

Often, simple communication is not enough to resolve a conflict, and a hospital, or organization’s ethics committee must convene to decide a complex matter. These bodies are composed primarily of health care professionals, but may also include philosophers, lay people, and clergy – indeed, in many parts of the world their presence is considered mandatory in order to provide balance. The ARRT ethics committee is such a body which resolves conflicts pertaining to its members.

Cultural concerns

Cultural differences can create difficult medical ethics problems. Some cultures have spiritual or magical theories about the origins and cause of disease, for example, and reconciling these beliefs with the tenets of Western medicine can be very difficult. As different cultures continue to intermingle and more cultures live alongside each other, the healthcare system, which tends to deal with important life events such as birth, death and suffering, increasingly experiences difficult dilemmas that can sometimes lead to cultural clashes and conflict. Efforts to respond in a culturally sensitive manner go hand in hand with a need to distinguish limits to cultural tolerance.

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Culture concerns

As more people from different cultural and religious backgrounds move to other countries, among these, the United States, it is becoming increasingly important to be culturally sensitive to all communities in order to provide the best health care for all people. Lack of cultural knowledge can lead to misunderstandings and even inadequate care, which can lead

to ethical problems. A common complaint patients have is feeling like they are not being heard, or perhaps, understood. Preventing escalating conflict can be accomplished by seeking interpreters, noticing body language and tone of both yourself and the patient as well as attempting to understand the patient's perspective in order to reach an acceptable option. Some believe most medical practitioners in the future will have to be or greatly benefit from being bilingual. In addition to knowing the language, truly understanding culture is best for optimal care. Recently, a practice called 'narrative medicine' has gained some interest as it has a potential for improving patient physician communication and understanding of patient's perspective. Interpreting a patient's stories or day-to-day activities as opposed to standardizing and collecting patient data may help in acquiring a better sense of what each patient needs, individually, with respect to their illness. Without this background information, many physicians are unable to properly understand the cultural differences that may set two different patients apart, and thus, may diagnose or recommend treatments that are culturally insensitive or inappropriate. In short, patient narrative has the potential for uncovering patient information and preferences that may otherwise be overlooked.

Medical humanitarianism

In order to address the underserved, uneducated communities in need of nutrition, housing, and healthcare disparities seen in much of the world today, some argue that we must fall back on ethical values in order to create a foundation to move towards a reasonable understanding, which encourages commitment and motivation to improve factors causing premature death as a goal in a global community. Such factors -such as poverty, environment and education- are said to be out of national or individual control and so this commitment is by default a social and communal responsibility placed on global communities that are able to aid others in need. This is based on the framework of 'provincial globalism,' which seeks a world in which all people have the capability to be healthy. One concern regarding the intersection of medical ethics and humanitarian medical aid is how medical assistance can be as harmful as it is helpful to the community being served. One such example being how political forces may control how foreign humanitarian aid can be utilized in the region it is meant to be provided in. This would be congruous in situations where political strife could lead such aid being used in favor of one group over another. Another example of how foreign humanitarian aid can be misused in its intended community includes the possibility of dissonance forming between a foreign humanitarian aid group and the community being served. Examples of this could include the relationships being viewed between aid workers, style of dress, or the lack of education regarding local culture and customs. Humanitarian practices in areas lacking optimum care can also pose other interesting and difficult ethical dilemmas in terms of beneficence and non-maleficence. Humanitarian practices are based upon providing better medical equipment and care for communities whose country does not provide adequate healthcare. The issues with providing healthcare to communities in need may sometimes be religious or cultural backgrounds keeping people from performing certain

procedures or taking certain drugs. On the other hand, wanting certain procedures done in a specific manner due to religious or cultural belief systems may also occur. The ethical dilemma stems from differences in culture between communities helping those with medical disparities and the societies receiving aid.

Truth telling

Some cultures do not place a great emphasis on informing the patient of the diagnosis, especially when cancer is the diagnosis. American culture rarely used truth-telling especially in medical cases, up until the 1970s. In American medicine, the principle of informed consent now takes precedence over other ethical values, and patients are usually at least asked whether they want to know the diagnosis.

Online business practices

Increasingly, medical researchers are researching activities in online environments such as discussion boards and bulletin boards, and there is concern that the requirements of informed consent and privacy are not as stringently applied as they should be, although some guidelines do exist. The delivery of diagnosis online leads patients to believe that doctors in some parts of the country are at the direct service of drug companies. Finding diagnosis as convenient as what drug still has patent rights on it. Physicians and drug companies are found to be competing for top ten search engine ranks to lower costs of selling these drugs with little to no patient involvement. Another issue that has arisen, however, is the disclosure of information. While researchers wish to quote from the original source in order to argue a point, this can have repercussions. The quotations and other information about the site can be used to identify the site, and researchers have reported cases where members of the site, bloggers and others have used this information as 'clues' in a game in an attempt to identify the site. Some researchers have employed various methods of "heavy disguise," including discussing a different condition from that under study, or even setting up bogus sites (called 'Maryut sites') to ensure that the researched site is not discovered. The term "Maryut site" is a reference to the story of the creation of a decoy site at Maryut Lake to prevent Alexandria Harbor's being bombed during World War II. The process of using a Maryut site would be the following: The researcher creates a fake (or "Maryut") web site that has a structure similar to the research site. The researcher then populates the Maryut site with plausible information. In the research paper, amongst the real information listed, the researcher lists the fake information that is found only in the Maryut site [6].

Guidelines

There is much documentation of the history and necessity of the Declaration of Helsinki. The first code of conduct for research including medical ethics was the Nuremberg Code. This document had large ties to Nazi war crimes, as it was introduced in 1947, so it didn't make much of a difference in terms of regulating practice. This issue called for the creation of the Declaration. There are some stark differences between the Nuremberg Code and the Declaration of Helsinki, including the way it is written. Nuremberg was written in a

very concise manner, with a simple explanation. The Declaration of Helsinki is written with a thorough explanation in mind and including many specific commentaries. In the United Kingdom, General Medical Council provides clear overall modern guidance in the form of its 'Good Medical Practice' statement. [48] Other organizations, such as the Medical Protection Society and a number of university departments, are often consulted by British doctors regarding issues relating to ethics.

Conflicts of interest

Physicians should not allow a conflict of interest to influence medical judgment. In some cases, conflicts are hard to avoid, and doctors have a responsibility to avoid entering such situations. Research has shown that conflicts of interests are very common among both academic physicians and physicians in practice.

Referral

Doctors who receive income from referring patients for medical tests have been shown to refer more patients for medical tests. This practice is proscribed by the American College of Physicians Ethics Manual. Fee splitting and the payments of commissions to attract referrals of patients is considered unethical and unacceptable in most parts of the world.

Vendor relationships

Studies show that doctors can be influenced by drug company inducements, including gifts and food. Industry-sponsored Continuing Medical Education (CME) programs influence prescribing patterns. Many patients surveyed in one study agreed that physician gifts from drug companies influence prescribing practices. A growing movement among physicians is attempting to diminish the influence of pharmaceutical industry marketing upon medical practice, as evidenced by Stanford University's ban on drug company-sponsored lunches and gifts. Other academic institutions that have banned pharmaceutical industry-sponsored gifts and food include the Johns Hopkins Medical Institutions, University of Michigan, University of Pennsylvania, and Yale University.

Treatment of family members

The American Medical Association (AMA) states that "Physicians generally should not treat themselves or members of their immediate family". This code seeks to protect patients and physicians because professional objectivity can be compromised when the physician is treating a loved one. Studies from multiple health organizations have illustrated that physician-family member relationships may cause an increase in diagnostic testing and costs. Many doctors still treat their family members. Doctors who do so must be vigilant not to create conflicts of interest or treat inappropriately. Physicians that treat family members need to be conscious of conflicting expectations and dilemmas when treating relatives, as established medical ethical principles may not be morally imperative when family members are confronted with serious illness.

Futility

In some hospitals, medical futility is referred to as treatment unable to benefit the patient. An important part of practicing good medical ethics is by attempting to avoid futility by practicing non-maleficence. What should be done if there is no chance that a patient will survive or benefit from a potential treatment but the family members insist on advanced care. Previously, some articles defined futility as the patient having less than a one percent chance of surviving. Some of these cases are examined in court. Advance directives include living wills and durable powers of attorney for health care. In many cases, the "expressed wishes" of the patient are documented in these directives, and this provides a framework to guide family members and health care professionals in the decision making process when the patient is incapacitated. Undocumented expressed wishes can also help guide decisions in the absence of advance directives, as in the Quinlan case in Missouri. "Substituted judgment" is the concept that a family member can give consent for treatment if the patient is unable (or unwilling) to give consent themselves. The key question for the decision making surrogate is not, "What would you like to do?", but instead, "What do you think the patient would want in this situation?". Courts have supported family's arbitrary definitions of futility to include simple biological survival, as in the Baby K case (in which the courts ordered a child born with only a brain stem instead of a complete brain to be kept on a ventilator based on the religious belief that all life must be preserved). Baby Doe Law establishes state protection for a disabled child's right to life, ensuring that this right is protected even over the wishes of parents or guardians in cases where they want to withhold treatment [7].

Conclusion

Ethics is an understanding of the nature of conflicts arising from moral imperatives and how best we may deal with them. Specifically it deals with conflicts in potential outcome (consequences of actions) or with duties and obligations. Ethics does NOT decide what is morally right or wrong; rather it considers how we should act best in the light of our duties and obligations as moral agents. Clinicians have specific duties of care to their patients and to society. It is generally held that clinicians should always act in the best interest of their patients; but sometimes there is a conflict between obligations to a patient and those perceived to be owed to the community or to other patients. It may not always be the case that what the clinician believes is in the best interest of the patient is what the patient wishes or will consent to. Central to modern medical ethics is a respect for patient autonomy and the fundamental principle of informed consent.

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