Medical ethics
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Medical ethics is a system of moral principles that apply values to the practice of clinical medicine and in scientific research. Medical ethics allow for people, regardless of race, gender, or religion to be guaranteed quality and principled care.[3] This applies to both the living and nonliving, such as medical research on cadavers. It creates an obvious guideline to follow. Medical ethics is based on a set of values that professionals can refer to in the case of any confusion or conflict. These values include the respect for autonomy, non-maleficence, beneficence, and justice.[2] These tenets allow doctors, care providers, and families to create a treatment plan and work towards the same common goal without any conflict.[5] It is important to note that these four values are of equal worth.[1]

The term medical ethics first dates back to 1803, when English author and physician Thomas Percivall published a document describing the requirements and expectations of medical professionals within medical facilities. The Code of Ethics was then adapted in 1847, relying heavily on Percival’s words.[6] Over the years in 1903, 1912, and 1947, revisions have been made to the original document.[9] The practice of Medical Ethics is widely accepted and practiced throughout the world.[10]

There are several other codes of conduct. The Hippocratic Oath discusses basic principles for medical professionals. This document dates back to the fifth century BCE. Both The Declaration of Helsinki (1964) and The Nuremberg Code (1947) are two well-known and well-respected documents contributing to medical ethics. Other important markings in the history of Medical Ethics include Roe v. Wade in 1973 and the development of Hemodialysis in the 1960s. As this field continues to develop and change throughout history, the focus remains on fair, balanced, and moral thinking. Medical ethics encompasses a practical application in clinical settings as well as scholarly work on its history, philosophy, and sociology.

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History

Historically, Western medical ethics may be traced to guidelines on the duty of physicians in antiquity, such as the Hippocratic Oath, and early Christian teachings. The first code of medical ethics, Formula Comitii Architectorum, was published in the 5th century, during the reign of the Ostrogothic king Theodoric the Great. In the medieval and early modern period, the field is indebted to Islamic scholarship such as Ishaq ibn Ali al-Rahawi (who wrote the Conduct of a Physician, the first book dedicated to medical ethics), Avicenna’s Canon of Medicine and Muhammad ibn Zakariya ar-Razi (known as Rhazes in the West), Jewish thinkers such as Maimonides, Roman Catholic scholastic thinkers such as Thomas Aquinas, and the case-oriented analysis (casuistry) of Catholic moral theology. These intellectual traditions continue in Catholic, Islamic and Jewish medical ethics.

By the 18th and 19th centuries, medical ethics emerged as a more self-conscious discourse. In England, Thomas Percival, a physician and author, crafted the first modern code of medical ethics. He drew up a pamphlet with the code in 1794 and wrote an expanded version in 1803, in which he coined the expressions “medical ethics” and “medical jurisprudence.” However, there are some who see Percival’s guidelines that relate to physician consultations as being excessively protective of the home physician’s reputation. Jeffrey Berlin is one such critic who considers Percival’s codes of physician consultations as being an early example of the anti-competitive, “guilt”-like nature of the physician community.

In 1815, the Apothecaries Act was passed by the Parliament of the United Kingdom. It introduced compulsory apprenticeship and formal qualifications for the apothecaries of the day under the license of the Society of Apothecaries. This was the beginning of regulation of the medical profession in the UK.

In 1847, the American Medical Association adopted its first code of ethics, with this being based in large part upon Percival’s work. While the secularized field borrowed largely from Catholic medical ethics, in the 20th century a distinctively liberal Protestant approach was articulated by thinkers such as Joseph Fletcher. In the 1960s and 1970s, building upon liberal theory and procedural justice, much of the discourse of medical ethics went through a dramatic shift and largely reconfigured itself into bioethics.

Well-known medical ethics cases include:

- Albert Klugman's dermatology experiments
- Deep sleep therapy
- Doctors' Trial
- Greenberg v. Miami Children's Hospital Research Institute
- Henrietta Lacks
- Chester M. Southam's Cancer Injection Study
- Human radiation experiments
- Jesse Gelsinger
- Moore v. Regents of the University of California
- Surgical removal of body parts to try to improve mental health
- Medical Experimentation on Black Americans
- Milgram experiment
- Radioactive iodine experiments
- The Monster Study
- Plutonium injections
- The David Reimer case
- The Stanford Prison Experiment
- Tuskegee syphilis experiment
- Willowbrook State School
- Yanomami blood sample collection
- Darkness in El Dorado

Since the 1970s, the growing influence of ethics in contemporary medicine can be seen in the increasing use of Institutional Review Boards to evaluate experiments on human subjects, the establishment of hospital ethics committees, the expansion of the role of clinician ethicists, and the integration of ethics into many medical school curricula.

Values

A common framework used in the analysis of medical ethics is the "four principles" approach postulated by Tom Beauchamp and James Childress in their textbook Principles of biomedical ethics. It recognizes four basic moral principles, which are to be judged and weighed against each other, with attention given to the scope of their application. The four principles are:

- Respect for autonomy – the patient has the right to refuse or choose their treatment. (Voluntas aegroti suprema lex.)
- Beneficence – a practitioner should act in the best interest of the patient. (Salus aegroti suprema lex.)
- Non-maleficence – to not be the cause of harm. Also, “Utility” - to promote more good than harm
- Justice – concerns the distribution of scarce health resources, and the decision of who gets what treatment (fairness and equality). (Iustitia.)

Other values that are sometimes discussed include:

- Respect for persons – the patient (and the person treating the patient) have the right to be treated with dignity.
- Truthfulness and honesty – the concept of informed consent has increased in importance since the historical events of the Doctors' Trial of the Nuremberg trials and Tuskegee syphilis experiment.

Values such as these do not give answers as to how to handle a particular situation, but provide a useful framework for understanding conflicts.
When moral values are in conflict, the result may be an ethical dilemma or crisis. Sometimes, no good solution to a dilemma in medical ethics exists, and, on occasion, the values of the medical community (i.e., the hospital and its staff) conflict with the values of the individual patient, family, or larger non-medical community. Conflicts can also arise between health care providers, or among family members. Some argue for example, that the principles of autonomy and beneficence clash when patients refuse blood transfusions, considering them life-saving; and truth-telling was not emphasized to a large extent before the HIV era.

**Autonomy**

The principle of autonomy views the rights of an individual to self-determination. This is rooted in society's respect for individuals' ability to make informed decisions about personal matters. Autonomy has become more important as social values have shifted to define medical quality in terms of outcomes that are important to the patient rather than medical professionals. The increasing importance of autonomy can be seen as a social reaction to a "paternalistic" tradition within healthcare. Some have questioned whether the backlash against historically excessive paternalism in favor of patient autonomy has inhibited the proper use of paternalism to the detriment of outcomes for some patients. Respect for autonomy is the basis for informed consent and advance directives.

The definition of Autonomy is the ability of an individual to make a rational, un-influenced decision. Therefore, it can be said that autonomy is a general indicator of health. The progression of many terminal diseases are characterized by loss of autonomy, in various manners. For example, dementia almost always results in the loss of autonomy. Dementia is a chronic and progressive disease that attacks the brain and affects the ability to make judgments, can induce memory loss, cause a decrease in rational thinking and affect orientation. This makes autonomy an indicator for both personal well-being, and for the well-being of the profession. This has implications for the consideration of medical ethics: "is the aim of health care to do good, and benefit from it?"; or "is the aim of health care to do good to others, and have them, and society, benefit from this?". (Ethics — by definition — tries to find a beneficial balance between the activities of the individual and its effects on a collective.) The right of patients to make decisions about their medical care without their health care provider trying to influence the decision. By considering autonomy as a gauge parameter for (self) health care, the medical and ethical perspective both benefit from the implied reference to health.

Psychiatrists and clinical psychologists are often asked to evaluate a patient's capacity for making life-and-death decisions at the end of life. Persons with a psychiatric condition such as delirium or clinical depression may lack capacity to make end-of-life decisions. For these persons, a request to refuse treatment may be taken in the context of their condition. Unless there is a clear advance directive to the contrary, persons lacking mental capacity are treated according to their best interests. This will involve an assessment involving people who know the person best to what decisions the person would have made had they not lost capacity. Persons with the mental capacity to make end-of-life decisions may refuse treatment with the understanding that it may shorten their life. Psychiatrists and psychologists may be involved to support decision making.

**Beneficence**

The term beneficence refers to actions that promote the well being of others. In the medical context, this means taking actions that serve the best interests of patients. However, uncertainty surrounds the precise definition of which practices do in fact help patients.

James Childress and Tom Beauchamp in *Principle of Biomedical Ethics* (1978) identify beneficence as one of the core values of healthcare ethics. Some scholars, such as Edmund Pellegrino, argue that beneficence is the only fundamental principle of medical ethics. They argue that healing should be the sole purpose of medicine, and that endeavors like cosmetic surgery and euthanasia fall beyond its purview.

**Non-maleficence**

The concept of non-maleficence is embodied by the phrase, "first, do no harm," or the Latin, *primum non nocere*. Many consider that should be the main or primary consideration (hence *primum*): that it is more important not to harm your patient, than to do them good. This is partly because enthusiastic practitioners are prone to using treatments that they believe will do good, without first having evaluated them adequately to ensure they do no (or only acceptable levels of) harm. Much harm has been done to patients as a result, as in the saying, "The treatment was a success, but the patient died." It is not only more important to do no harm than to do good; it is also important to know how likely it is that your treatment will harm a patient. So a physician should go further than not prescribing medications they know to be harmful—he or she should not prescribe medications (or otherwise treat the patient) unless s/he knows that the treatment is unlikely to be harmful; or at the very least, that patient understands the risks and benefits, and that the likely benefits outweigh the likely risks.

In practice, however, many treatments carry some risk of harm. In some circumstances, e.g., in desperate situations where the outcome without treatment will be grave, risky treatments that stand a high chance of harming the patient will be justified, as the risk of not treating is also very likely to do harm. So the principle of non-maleficence is not absolute, and balances against the principle of beneficence (doing good), as the effects of the two principles together often give rise to a double effect (further described in next section).

Depending on the cultural consensus conditioning (expressed by its religious, political and legal social system) the legal definition of non-maleficence differs. Violation of non-maleficence is the subject of medical malpractice litigation. Regulations therefore differ over time, per nation.

**Double effect**

*Double effect* refers to two types of consequences that may be produced by a single action, and in medical ethics it is usually regarded as the combined effect of beneficence and non-maleficence.
A commonly cited example of this phenomenon is the use of morphine or other analgesics in the dying patient. Such use of morphine can have the beneficial effect of easing the pain and suffering of the patient while simultaneously having the maleficient effect of shortening the life of the patient through suppression of the respiratory system.\[26\]

**Respect for human rights**

The human rights era started with the formation of the United Nations in 1945, which was charged with the promotion of human rights. The Universal Declaration of Human Rights (1948) was the first major document to define human rights. Medical doctors have an ethical duty to protect the human rights and human dignity of the patient so the advent of a document that defines human rights has had its effect on medical ethics.\[21\] Most codes of medical ethics now require respect for the human rights of the patient.

The Council of Europe promotes the rule of law and observance of human rights in Europe. The Council of Europe adopted the European Convention on Human Rights and Biomedicine (1997) to create a uniform code of medical ethics for its 47 member-states. The Convention applies international human rights law to medical ethics. It provides special protection of physical integrity for those who are unable to consent, which includes children.

No organ or tissue removal may be carried out on a person who does not have the capacity to consent under Article 5.\[21\]

As of December 2013, the Convention had been ratified or acceded to by twenty-nine member-states of the Council of Europe.\[23\]

The United Nations Educational, Scientific and Cultural Organization (UNESCO) also promotes the protection of human rights and human dignity. According to UNESCO, "Declarations are another means of defining norms, which are not subject to ratification. Like recommendations, they set forth universal principles to which the community of States wished to attribute the greatest possible authority and to afford the broadest possible support." UNESCO adopted the Universal Declaration on Human Rights and Biomedicine to advance the application of international human rights law in medical ethics. The Declaration provides special protection of human rights for incompetent persons.

In applying and advancing scientific knowledge, medical practice and associated technologies, human vulnerability should be taken into account. Individuals and groups of special vulnerability should be protected and the personal integrity of such individuals respected.\[24\]

**Conflicts**

**Between autonomy and beneficence/non-maleficence**

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.

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.

**Euthanasia**

There is disagreement among American physicians as to whether the non-maleficence principle excludes the practice of euthanasia. Euthanasia is currently legal in the states of Washington DC, California, Colorado, Oregon, Vermont and Washington. Around the world there are different organizations that campaign to change legislation about the issue of physician assisted death, or PAD. Examples of such organizations are the Hemlock Society of the United States and the Dignity in Dying campaign in the United Kingdom. These groups believe that doctors should be given the right to end a patient's life only if the patient is conscious enough to decide for themselves, is knowledgeable about the possibility of alternative care, and has willingly asked to end their life or requested access to the means to do so.

This argument is disputed in other parts of the world. For example, in the state of Louisiana, giving advice or supplying the means to end a person's life is considered a criminal act and can be charged as a felony. In state courts this crime is comparable to manslaughter. The same laws apply in the states of Mississippi and Nebraska.\[28\]

**Informed consent**

https://en.wikipedia.org/wiki/Medical_ethics
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. 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.

A correlate to "informed consent" is the concept of informed refusal.

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 America by HIPAA laws, 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. Confidentiality is also challenged in cases involving the diagnosis of a sexually transmitted disease in a patient who refuses to reveal the diagnosis to a spouse, and in the termination of a pregnancy in an underage patient, without the knowledge of the patient's parents. Many states in the U.S. have laws governing parental notification in underage abortion.[30][31]

Traditionally, medical ethics has viewed the duty of confidentiality as a relatively non-negotiable tenet of medical practice. More recently, critics like Jacob Appel have argued for a more nuanced approach to the duty that acknowledges the need for flexibility in many cases.[32]

Confidentiality is an important issue in primary care ethics, where physicians care for many patients from the same family and community, and where third parties often request information from the considerable medical database typically gathered in primary health care.

Criticism of orthodoxy

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

Fabian Tassano has questioned the idea that beneficence might in some cases have priority over autonomy. He has argued that violations of autonomy are more likely to reflect the interests of the state or of the supplier group than the interests of the patient.[33]

Routine regulatory professional bodies or the courts of law are valid social recourses.

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.

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 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 simple explanation. The Declaration of Helsinki is written with thorough explanation in mind and including many specific commentaries.[34]

In the United Kingdom, General Medical Council provides clear overall modern guidance in the form of its 'Good Medical Practice' statement.[35] Other organisations, such as the Medical Protection Society and a number of university departments, are often consulted by British doctors regarding issues relating to ethics.

Ethics committees

Often, simple communication is not enough to resolve a conflict, and a hospital ethics committee must convene to decide a complex matter.

These bodies are composed primarily of healthcare 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.

With respect to the expected composition of such bodies in the USA, Europe and Australia, the following applies.[36]
U.S. recommendations suggest that Research and Ethical Boards (REBs) should have five or more members, including at least one scientist, one non-scientist, and one person not affiliated with the institution. The REB should include people knowledgeable in the law and standards of practice and professional conduct. Special memberships are advocated for handicapped or disabled concerns, if required by the protocol under review.

The European Forum for Good Clinical Practice (EFCGP) suggests that REBs include two practicing physicians who share experience in biomedical research and are independent from the institution where the research is conducted; one lay person, one lawyer; and one paramedical professional, e.g. nurse or pharmacist. They recommend that a quorum include both sexes from a wide age range and reflect the cultural makeup of the local community.

The 1996 Australian Health Ethics Committee recommendations were entitled, "Membership Generally of Institutional Ethics Committees". They suggest a chairperson be preferably someone not employed or otherwise connected with the institution. Members should include a person with knowledge and experience in professional care, counselling or treatment of humans; a minister of religion or equivalent, e.g. Aboriginal elder; a layman; a laywoman; a lawyer and, in the case of a hospital-based ethics committee, a nurse.

The assignment of philosophers or religious clerics will reflect the importance attached by the society to the basic values involved. An example from Sweden with Torbjörn Tammjo on a couple of such committees indicates secular trends gaining influence.

Medical ethics in an online world

In increasing frequency, 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.[230] One 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.[246] Some researchers have employed various methods of 'heavy disguise',[246] including discussing a different condition from that under study,[256] or even setting up bogus sites (called 'Maryut sites') to ensure that the researched site is not discovered.[251]

Cultural concerns

Culture differences can create difficult medical ethics problems. Some cultures have spiritual or magical theories about the origins of disease, for example, and reconciling these beliefs with the tenets of Western medicine can be difficult.

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. Additionally, The WMA International Code of Medical Ethics explicitly states, "A physician shall...report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception."[239] There is also the conflict with physicians who are tempted to report made up incidents or make an incident worse than what it was for their own personal motives. In vice versa, a physician might be hesitant to report an incident because of a personal friendship he or she may have with his colleague.[239]

Online business practices and privacy

Healthcare websites have the responsibility to ensure that the private medical records of their online visitors are secure from being marketed and monetized into the hands of drug companies, occupation records, insurers. 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.[246] 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.[246]

With the expansion of internet healthcare platforms, online practitioner legitimacy and privacy accountability face unique challenges such as e-paparazzi, online information brokers, industrial spies, unlicensed information providers that work outside of traditional medical codes for profit. The American Medical Association (AMA) states that medical websites have the responsibility to ensure the health care privacy of online visitors and protect patient records from being marketed and monetized into the hands of insurance companies, employers, and marketers. [40] With the rapid unification of healthcare, business practices, computer science and e-commerce to create these online diagnostic websites, efforts to maintain health care system's ethical confidentiality standard need to keep up as well. Over the next few years, the Department of Health and Human Services have stated that they will be working towards lawfully protecting the online privacy and digital transfers of patient Electronic Medical Records (EMR) under the Health Insurance Portability and Accountability Act (HIPAA).[41]

Humanitarian medical volunteerism

One concern regarding the intersection of medical ethics and humanitarian medical aid is how much 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.

**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. The Pew Charitable Trusts has announced the Prescription Project for "academic medical centers, professional medical societies and public and private payers to end conflicts of interest resulting from the $12 billion spent annually on pharmaceutical marketing".

**Referral**

For example, 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 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.

**Sexual relationships**

Sexual relationships between doctors and patients can create ethical conflicts, since sexual consent may conflict with the fiduciary responsibility of the physician. Out of the many disciplines in current medicine, there are studies that have been conducted in order to ascertain the occurrence of Doctor-Patient sexual misconduct. Results from studies appear to indicate that certain disciplines are more likely to be offenders than others. Psychiatrists and Obstetrician-Gynecologists for example, are two disciplines noted for having a higher rate of sexual misconduct. The violation of ethical conduct between doctors and patients also has an association with the age and sex of doctor and patient. Male physicians aged 40–49 and 50–59 years are two groups that have been found to be more likely to have been reported for sexual misconduct, while women aged 20–39 have been found to make up a significant portion of reported victims of sexual misconduct. Doctors who enter into sexual relationships with patients face the threats of losing their medical license and prosecution. In the early 1990s, it was estimated that 2.9% of doctors had violated this rule. Sexual relationships between physicians and patients' relatives may also be prohibited in some jurisdictions, although this prohibition is highly controversial.

**Futility**

The concept of medical futility has been an important topic in discussions of medical ethics. What should be done if there is no chance that a patient will survive 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. (See also Do Not Resuscitate and cardiopulmonary resuscitation) 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).

In some hospitals, medical futility is referred to as "non-beneficial care."

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
See also

- Applied ethics
- Bioethics
- The Citadel
- Clinical Ethics
- Clinical governance
- Empathy
- Ethics of circumcision
- Euthanasia
- Evidence-based medical ethics
- Fee splitting
- Hastings Center
- Health ethics
- Hippocratic Oath
- Human radiation experiments
- Jewish medical ethics
- Yeshiva University Medical Ethics Society
- Joint Commission International, JCI
- MacLean Center for Clinical Medical Ethics
- Medical Code of Ethics
- Medical Law International
- Medical law
- Medical torture
  - Pharmacological torture
- Military medical ethics
- Nursing ethics
- Patient abuse
- Philosophy of Healthcare
- Political abuse of psychiatry
- Project MKULTRA
- Research ethics consultation
- Resources for clinical ethics consultation
- Right to health
- Seven Sins of Medicine
- U.S. patients' bill of rights
- UN Principles of Medical Ethics
- Unethical human experimentation
- World Medical Association

Reproductive medicine

- Abortion / Abortion debate
- Eugenics
- Gene splicing
- Human cloning
- Human genetic engineering

Medical research

- Animal testing
- Children in clinical research
- CIOMS Guidelines
- Clinical equipoise
- Clinical research ethics
- Declaration of Geneva
- Declaration of Helsinki
- Declaration of Tokyo
- Ethical problems using children in clinical trials
- First-in-man study
- Good clinical practice
- Health Insurance Portability and Accountability Act
- Institutional Review Board
- Nuremberg Code
- Research ethics consultation
- Universal Declaration of Human Rights

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52. American Medical Association Journal of Ethics May 2012, Volume 14, Number 5. 396-397

   (https://www.worldcat.org/oclc/10727310)
   (https://www.worldcat.org/oclc/23654449)

Further reading

- Linacre Quarterly
- A History and Theory of Informed Consent by Ruth Faden

https://en.wikipedia.org/wiki/Medical_ethics 9/6/2017
External links

- Program for Biomedical Ethics, Yale University
  (http://www.biomedicalethics.yale.edu)
- The Hastings Center (http://www.thehastingscenter.org), an independent, nonpartisan, and nonprofit bioethics research institute founded in 1969
- Ethical Decision-Making at the End of Life
  (http://www.wilsoncenter.org/index.cfm?topic_id=116811&fuseaction=topics.event_summary&event_id=30395
  -- video and summary of event held at the Woodrow Wilson International Center for Scholars, March 2008
- German Reference Centre for Ethics in the Life Sciences (DRZE)
  (http://www.drze.de/?la=en)
- BEKIS - the Bioethics Communication and Information System
  (http://bekis.drze.de/)
- Thesaurus Ethics in the Life Sciences
  (http://www.drze.de/BEKIT/thesaurus/?la=en)
- BMJournals.com (http://jme.bmjournals.com/) – An international peer review journal for health professionals and researchers in medical ethics
- NYU School of Medicine Division of Medical Ethics
  (http://pophealth.med.nyu.edu/divisions/medical-ethics/)
- Johns Hopkins Berman Institute of Bioethics
  (http://www.bioethicsinstitute.org)
- International Association of Bioethics (http://www.bioethicsinternational.org/lab-2.0/index.php?show=index)
- WHO Global bioethics calendar
  (http://www.who.int/ethics/events/en/)
- The Dark History of Medical Experimentation from the Nazis to Tuskegee to Puerto Rico
  (http://www.democracynow.org/2010/10/5/the_dark_history_of_medica
  – video report by Democracy Now!)
- American National Reference Center for Bioethics Literature
  (http://bioethics.georgetown.edu)
- Bioethics for Latin America and Colombia
  (http://www.bioetiacaumbogesc.edu.co/english/)
- EURETHICS (European database on ethics in medicine) and
  ENDEBIT (European database on ethics in non-medical technologies)
- German Reference Centre for Ethics in the Life Sciences (DRZE)
  (http://www.drze.de/)
- BELIT: an extensive world-wide bibliographic directory of literature
  in the area of bioethics, containing references to monographs, grey
  literature, legal documents, journal articles, newspaper articles and
  book contributions (http://www.drze.de/BELIT/?la=en)
- BioEthicWorld: A bioethics information site (http://bioethicworld.org)
- Medical Ethics (http://ocw.nd.edu/philosophy/medical-ethics) –
  OpenCourseWare from the University of Notre Dame featuring audio
  lectures and other resources.
- BEKIS The Bioethics Communication and Information System
  (http://bekis.drze.de/)
- Nutritional Genomics (NuGO) Bioethics Online Tool
  (http://nuigo.dife.de/bot/)
- http://www.bioethics.upenn.edu/
- Bioethics
  (https://dmooztools.net/Society/Philosophy/Ethics/Applied/Bioethics/)
  at DMOZ
- Universal Declaration on the Human Genome and Human Rights
- International Declaration on Human Genetic Data
- Universal Declaration on Bioethics and Human Rights
- The Bio-Medical Ethics Reference Server at Stanford University
- UNESCO Bioethics Section (http://www.unesco.org/bioethics)
- Moral Matters in Medicine (http://www.moralmatters.co.uk)
- Medical Ethics
  (http://www.medethics.org/it/articles/JME/JME01/JME011.asp)
  from the Encyclopedia of Jewish Medical Ethics by Avraham
  Steinberg
- The Clinic for Boundaries Studies
  (http://www.professionalboundaries.org.uk), a UK service providing
  education on ethics and professional boundary violations


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