Review Article

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Micro Ethics in Contemporary Clinical Practice

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Abstract

This review article describes and analyses ethical issues in medical practice, particularly those issues encountered by physicians in their relationships with their patients. These relationships often involve ethical conflicts between 2 or more interests, which physicians need to recognize and resolve. The article deals with 4 topics in clinical practice in which ethical conflicts occur: physicians' duty of confidentiality in a digital environment, their responsibilities for dealing with abuses of the human rights of patients, their role in clinical research, and their relationships with commercial enterprises. The ethical policies of the World Medical Association provide the basis for determining appropriate physician conduct on these matters. The article concludes with reflections on the need for international standards of medical ethics.

Keywords: Medical ethics; Physician patient relationship; Research ethics, World medical association.

Introduction

Ethics has long been at the centre of medicine at all times and in all communities. And their interactions with patients, peers and society in general, medical ethics informs doctors. It offers behavioural and decision-making criteria that allow physicians to know what their peers, their patients and society in general are asking of them. It also focuses on major social issues such as abortion, organ transplantation, euthanasia and medical science, that affect the practise of medicine.

From one nation to another, there are major differences in medical ethics, in as much as ethics is based on philosophy, faith and political ideologies. Pioneers of Chinese medical ethics, such as Sun SsuMiao (581-682) and Lu Chih (754-805), derived their influence from the philosophies of Confucian, Buddhist and Taoist.1 Chinese ethicists also merged Confucian with Western medical ethics from Song Guo-Bin (1893-1956).While variations in focus and understanding remain, the concepts of medical ethics are fundamentally the same across societies, as is apparent in the general adoption of the World Medical Association's ethical policies (WMA).[2]

In academic science, medical science and public policy, modern medical ethics deals with various subjects. The focus of this paper will be on selected ethical issues in clinical practise, that is, that emerge from the relationships between doctors and patients and affect them. Topics to be addressed include the duty of confidentiality of physicians in a digital environment, their responsibility to deal with patient human rights abuses, their role in clinical research, and their relationships with business enterprises. The tension between 2 or more competing beliefs or desires is a common theme in these subjects. The paper will be complemented by reflections on the need for international medical ethics guidelines.

Confidentiality

The traditional medical ethical principle of confidentiality, the duty of the physician to protect the personal health information of the patient, has come into increasing struggle over the past decade with a seeming need for records of health information serving administrative, planning and research purposes. Computerization has massively enabled the development and linkage of certain databases and has thereby rendered confidentiality violations much simpler. In response, many governments have adopted laws to regulate health databases. There has been a lot of controversy over these rules: privacy activists condemn the fact that they are more about promoting access to confidential health records than preserving privacy, while managers, researchers and some medical groups criticise the procedural constraints placed by laws on routine medical and research activities.

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Because of the delicate nature of specific genetic knowledge and its economic importance, genetic libraries and biobanks have been of special interest. The WMA introduced a major policy declaration on health databases at its 2002 General Assembly in Washington, DC.[3] The initial catalyst for this policy was the Icelandic Medical Association's request to support its opposition to some aspects of the proposed legislation for the establishment of an inclusive genetic database in that country especially the consent clauses.

In lobbying their governments for laws that safeguard patient records while promoting their sharing for patient treatment and valid administrative and scientific purposes, various national medical associations have been very involved. Several associations have prepared policy guides and related resources to aid their members in interpreting and applying the criteria of database laws in their jurisdictions.[4-6]

For maintaining secrecy, doctors have good explanations. Patients have to share confidential details about doctors and those that may be complete strangers to them in order to access medical treatment, information that they may not expect someone else to encounter. They must have reasonable reason to trust their doctors not to reveal this data. The ethical and legal expectations of secrecy that doctors and other health care practitioners are required to follow are the cornerstone of this trust. Patients may deny personal information without knowing that their revelations would be kept private. In their attempts to deliver successful treatments or to accomplish major public health targets, this will delay doctors.

Physicians still feel the need for restricted dissemination of the clinical records of their patients-to all health care organisations to aid with medical care, to insurance firms and other health benefit billing entities, and to public health, health system management and analysis database administrators. Physicians should as a general rule, favour the needs of the patient above that of anyone. Personal health records access should protect the confidentiality of patients as far as possible. Patients should be aware about how their sensitive health records would be used, and if the details would be identifiable or anonymized, if confidentiality cannot be preserved.

Human Rights Abuses

As they are called upon to deal with the surgical sequelae of torture and cruel punishment, doctors are also among the first to be aware of human rights abuses. However because of interference from states, military or police who sanction or conduct crimes, they frequently find themselves constrained from engaging with these breaches. The ethical dilemma is how to protect the patient in the face of this strain.

The role of doctors in suffering has long been viewed as a severe breach in medical ethics. The 1975 Tokyo WMA Declaration: Guidance for Medical Doctors on Torture and Other Cruel, Inhuman or Abusive Abuse or Punishment in Custody and Incarceration[7] forbids any other involvement on the basis that no medical knowledge other than the laws of humanity must be used."

The Hamburg Declaration on Respect for Medical Doctors Refusing to Engage in or Condonate, the Use of Suffering or Other Types of Barbaric, Inhuman or Degrading Treatment, 8 was accepted by the WMA Assembly in 1997, calling on the medical profession to strongly condemn torture and to support doctors who spoke out against such human rights violations.

A Resolution on the Responsibility of Physicians in Denunciating Acts of Torture or Cruel or Inhuman or Abusive Care, which they are aware of was adopted by the 2003 WMA Assembly in Helsinki,[9] which provides detailed guidelines to physicians in this situation. In fact, in order to ascertain the best interests of the patient, doctors should maintain their professional integrity and should obey, as much as possible, the usual ethical standards of informed consent and privacy. Any infringement of these conditions must be explained and must be reported to the patient.Physicians should report any unjustified interference with the maintenance of their patients to the proper authorities, especially if basic human rights are denied. Global medical organisations are urged by the Resolution to support laws and services to eliminate torture.

If doctors have obligations and are responsible to both their patients and a third person, and if these responsibilities and responsibilities are contradictory, they are in a "dual loyalty" case. Governments, employers (e.g. hospitals and managed health care organisations), insurers, military authorities, police, prison officials and family members are third parties who demand physician allegiance.

The study of the International Dual Loyalty Working Group, a joint effort of Physicians for

Human Rights and the School of Public Health and Primary Health Care, University of Cape Town, South Africa, is a significant reserve for physicians and other health care practitioners engaged in double loyalty circumstances.[10]

Physicians employed in reformatories are facing several wars of double allegiance. The Norwegian Medical Association, in partnership with the WMA, offers a web-based course on human rights and ethics primarily aimed at jail doctors to better recognise and cope with these problems.[11]

In addition to combating gross human rights violations such as torture, doctors are expected to uphold their patients and colleagues' other basic human rights. The rights to life, to freedom from discrimination, to freedom of opinion and of mind, to equal access to public services in one's country and to medical care are particularly important for medical ethics. Promises and codes of medical ethics, such as the Geneva Declaration of the WMA, require doctors not to "allow considerations of age, illness or disability, religion, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social status to intervene between my duty and my patient."

The Physician's Role in Medical Research

In their clinical work, both doctors make use of the findings of medical studies. Physicians must keep up with current studies in their field of practise by Continuing Medical Education (CME)/Continuing Professional Development (CPD) services, medical publications, and contact with competent peers in order to retain their expertise. And if they themselves do not partake in science, doctors need to know how to take the research findings and adapt them to their patients. For professional medical practise, therefore a fundamental familiarity with testing methodology is necessary.

The clinical trial is the most common testing technique for practising physicians. In order to satisfy the statistical criteria of the studies, the rapid growth in the number of ongoing trials in recent years has meant discovering and enrolling ever-larger numbers of participants.Many in charge of the trials, whether they be self-governing doctors or pharmaceutical firms, now rely on many other physicians to recruit patients as test subjects, frequently in various countries.

While such a research contribution is welcomed by the practise of doctors, there are future issues that need to be understood and prevented. In the first place, even though the physician and the researcher are the same person, the part of the physician in the physician - patient relationship varies from the role of the researcher in the research subject relation. The primary responsibility of the practitioner is the patient's wellbeing and well-being, while the primary duty of the researcher is the generation of information, which may or may not contribute to the health and well-being of the research subject. Thus, between the 2 positions, there is a possibility for confrontation. The role of the practitioner must take precedence over the role of the researcher when this happens.

Conflict of interest is another possible concern of merging these 2 positions. Medical research is a well-funded organisation, and often substantial benefits are given to doctors for participation. This can include cash fees for the registration of test subjects, appliances such as computers to transmit research data, invitations to conferences to present research findings, and co-authorship of research outcomes papers. The motive of the doctor in receiving these aids will also struggle against the obligation to provide the best possible care for the patient. It may also struggle with the patient's right to get all the knowledge needed to make a truly educated decision as to whether or not to engage in a clinical trial.

It is important to solve these possible challenges. The physician's professional morals extend to the medical examiner as well. So between the 2 positions, there is no intrinsic disagreement. They should have no problem engaging in research as an important component of their professional practise, as long as doctors appreciate and obey the simple principles of research ethics.

The WMA Declaration of Helsinki,[12] accepted for the first time in 1964 and revised many times afterwards, most recently in 2000, is the basic text of research ethics. A succinct overview of research ethics is the Statement. Other, much more complete, documents have been formed in recent years on research ethics in general (e.g. Council for International Organizations of Medical Sciences, International Ethical Guidelines for Biomedical Research Involving Human Subjects, 1993, revised in 2002)[13] and on precise topics in research ethics (e.g. Nuffield Council on Bioethics [UK], The Ethics of Research Related to Healthcare in Developing Countries, 2002, 2005).[14]

Despite the different scope, length and authorship of these documents, they agree to a very large extent on the basic requirements of research ethics, namely:

- Every suggestion for medical research on

human topics must be studied and approved by an independent ethics committee before it can continue.

- a medical research project involving human subjects must be justifiable on scientific grounds;
- a medical research project must pay to the well-being of humanity in general;
- the risks to the research subjects must not be unreasonable or disproportionate to the expected benefits of the research;
- research on human subjects cannot proceed without their informed consent;
- research subjects have a right to confidentiality with regard to their personal health information;
- research results must be reported accurately;
- Anyone who has knowledge of unethical research has an obligation to disclose this information to the appropriate authorities.

These principles have been incorporated in the laws and/or regulations of many countries and international organizations, including those that deal with the approval of drugs and medical devices.

Not all facets of the ethics of science, such as the general contract. In fields such as biology, neuroscience, and organ and tissue reconstruction, as medical research continues to progress, concerns emerge concerning the ethical acceptability of emerging methods, therapies, and therapies for which no ready-made responses are available. In addition, some major concerns are also subject to unresolved ethical disagreement, such as in what circumstances a placebo arm should be used in a clinical trial and what continued care should be provided to medical research participants. The 10/90 disparity in medical research globally (only 10% of global research funding is focused on health issues impacting 90% of the world's population) is obviously an unsettled ethical question at the global level. When researchers discuss challenges in resource-poor parts of the world, because of contradictions between their ethical perspective and that of the societies where they work, they sometimes face difficulties.All these issues will require much further analysis and discussion before general agreement is achieved.

Physicians and Commercial Enterprises

For well over a decade, the bond between doctors and commercial ventures, particularly pharmaceutical and medical device firms, has been the subject of strong analysis by medical societies, medical journals and the mainstream press. When profit-making firms have become more influential in the financing of medical research and CME/CPD, there has been a rise in the capacity for conflicts of interest in physicians' ties with these companies.

In order to live and prosper, entrepreneurial initiatives such as pharmaceutical and medical device firms are dependent on sales of their products. The more they sell and the higher the price, the more they are successful. Around the same time to avoid or cure sickness, patients use these goods. Many who pay for the goods, whether they be patients, insurers or states, tend to pay as little for them as possible, particularly when affordability issues arise. Physicians are trapped between these two desires in the middle.They want their patients to have a wide variety of effective products which means preferring the suppliers of the products, but they still want their patients to have access to products which will cause the company's profits to be curbed.

Pharmaceutical firms, suppliers of medical instruments and other private organisations also give them gifts and other incentives that vary from free samples to transport and hospitality at educational events to unfair reimbursement for testing programmes in order to gain the approval of doctors. A typical underlying explanation for such a company's extensiveness is to induce the doctor to recommend or use the goods of the company, which may not be the right ones for patients of the doctor. Physicians are then presented with a disagreement between on the one side, their own interests and those of the company, and on the other, the interests of patients, and possibly third-party funders.Many professional medical associations and other medical organisations have created policy and training tools on this issue to discourage these disputes from occurring and to help doctors cope with them as they arise.[15-17] The WMA recently adopted its own series of rules dealing with the financing of medical conferences, donations to doctors, involvement in industry-sponsored resolutions.[18]

The simple general belief behind all these principles is that in any conflicts of interest, the practitioner must give priority to the patient. This ensures that ethical and therapeutic freedom from private considerations be preserved and that partnerships with firms do not result in any activity that is not in the patient's best interests.19In particular, physicians should not rely solely on representatives of pharmaceutical companies or

industry-funded promotional events to provide their medicinal product information and should not ask their patients to participate in industry-sponsored research studies unless the study meets all the ethical requirements of the Helsinki Declaration.

Conclusion

The need for universal medical ethics norms has never been greater in an increasingly globalised environment. In several different countries, clinical trials also include physicians and patients, and if the trials are to obtain clearance, the same ethical standards would apply in both situations. Differences exist beyond the study framework on how general ethical principles are applied, for example in respect to informed consent. In certain nations, people need to be aware about what they need and wish to hear about their medical diagnosis and care choices in order to make informed decisions, while in some countries, terminally ill patients believe like they should not be informed of their prognosis. However, as both physicians and patients migrate in large numbers from country to country, either temporarily or permanently, there is an increasing need to recognize the fundamental similarities of the values of medical ethics everywhere and to reconcile the different applications of these values.

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