

Medical ethics – dilemmas and challenges

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It is with a great sense of pride and humility that I stand before you as the 43rd President of the Ceylon College of Physicians, in its 52nd year, the oldest Specialty College in Sri Lanka. I thank the past presidents for electing me, and members and Fellows of the College for the trust placed upon me. It is the highest accolade that the College can bestow upon one of its members.

It is an honour and a privilege to follow in the footsteps of all my predecessors, illustrious physicians who have left an admirable legacy across Sri Lanka's medical landscape. They, together with their Councils, have steered the College to the heights that it has reached today as the apex professional body of the Physicians in Sri Lanka. While being mindful of the challenging task ahead of me, I promise you that, together with my Council, I will do my utmost to be worthy of the trust placed upon me.

I take this opportunity to congratulate Dr. Panduka Karunanayake and his Council for the tremendous amount of work carried out during 2018, a year that saw far reaching changes being made to the activities of the College. Thank you Panduka and Team for a job well done.

Ladies and Gentlemen

If I am to paraphrase one of the Greatest Teachers to have walked the Earth and ask any one of you in this august assembly to bring me a fistful of mustard seeds from a household where none has ever visited a physician, I would get the same answer that the Thathagatha received over 2500 years ago. Not only death, but illnesses too, are closely linked with life. Thus, physicians are essential players in the lives of people, a scary and a humbling place for physicians to be.

From time immemorial physicians were expected to provide a cure from disease. Yet, we know that most diseases cannot be cured but lend themselves only to some form of control and management. A physician

however, is not merely a healer. In today's rapidly changing world he is also a team leader, an educator and a researcher.

The many advances in medicine made during the 20th century have given physicians unprecedented powers over life and death. These advances confront physicians daily with difficult decisions regarding patient care. They go beyond scientific knowledge and technical skills and require close cooperation and interaction with all involved with an individual patient's care¹. At times, they lean more towards philosophy, cultural norms and laws.

What I am going to discuss this evening is presented with the aim of stimulating a discussion on some issues to which we have no clear-cut answers. With this in mind I have chosen the topic "Medical Ethics – Dilemmas and Challenges" for my address.

Ladies and Gentlemen:

Ethics, Morals and Laws are not synonyms.

Ethics deals with theories and principles of values² and in essence, are a philosophy. The basic perceptions and justifications of these values are somewhat similar across societies.

Morals refer to customs and normative behaviour of people and will, therefore, vary between societies². What is acceptable to one society may not be so to another. Ethical principles should therefore be applied within such normative behaviours. This distinction necessitates individual societies and countries to define their ethical standards in keeping with the broader ethical principles.

Law is the other aspect that is closely linked with ethics and morals. It is a system of rules to regulate the actions of people³. Compared to both morals and ethics, law is more specific and like religions at times, provide definitive and absolute ruling².

Medical ethics and dilemmas

The basic concept of medical ethics is that the physician has a moral, and at times a legal, obligation

¹ Based on the Presidential address of the Ceylon College of Physicians, delivered at the ceremonial induction on January 4th 2019, at BMICH, Colombo.

to act for the patient's good, using the most up-to-date information available. The question is how to establish that "good," who defines it, and what constitutes it.

Medical ethics in the narrow historical sense refers to a group of guidelines, such as the Oath of Hippocrates (circa 3rd century BC), the Code of Medical Ethics by the English physician-philosopher Thomas Percival (disseminated in 1803), and those later produced by professional medical bodies such as the American Medical Association (AMA)⁴. These were generally written by physicians and were mainly about the ideal relationships between physicians and his peers or patients.

Modern medical ethics began to develop as a separate field in the 1950's during the aftermath of the World War II and were closely linked to that of Research Ethics. Modern medical ethics refer to the application of general and fundamental ethical principles to clinical practice situations. It is more in the form of "applied ethics" and involves adherence to the same values as in the past, but often needs some interpretation². Modern medical ethics do not attempt to provide ready-made answers but demands analysis and reasoning. It requires critical reflection about what should or should not to be done in the context of medical practice and normative behaviour. Unlike in the past, today these principles may be formulated by individuals from disciplines totally different to medicine and are based on concepts derived from biomedical sciences, behavioural sciences, philosophy, religion and law.

The cardinal principles of medical ethics are beneficence and non-maleficence, which directly reflect traditional values, and the two more modern concepts, Autonomy and Justice.

Beneficence is the moral obligation to do good for others, while non-maleficence is the obligation not to harm and to remove or prevent potential harm, especially in the absence of any benefit.

One could argue that non-maleficence or "do no harm" need not even be stated as an ethical principle, but I beg to differ. Permit me to take you to one morning in 1994, to the Out Patients' Department (OPD) of the then General Hospital Anuradhapura. It was the first day of a trade union action by doctors. A patient walks up to the duty medical officer, who is sleepy from a busy admission night and waiting to be relieved at 8 am. She gives her insulin book to the doctor, it was the time when patients had to come to the hospital to get their insulin injections. With a cursory glance at

the proffered book, the medical officer tells the patient that routine work will not be done as there is a strike, and the insulin cannot be prescribed. "Wouldn't my blood sugar levels go up?" asks the patient in trepidation. "What will happen to me if I am brought unconscious?" "There is nothing to worry if that happens" says the medical officer, "we attend to all emergencies during strikes". The patient thinks, looks at the medical officer and says, "Doctor, if you give me the insulin now, I will not need to".

We can cause so much harm without even thinking about it.

The ability to think, choose, decide and act for oneself based on one's intrinsic values constitutes autonomy. To do so, not only must the individual be provided with the necessary information in an easily understood manner, he should also be competent to make an independent decision. The doctor's role includes helping people make decisions that best suit them, in a rational and well-informed way⁵. To do so he must share with patients, in a way they understand, the information they want or need to know about their conditions, its' likely progression, and the treatment options available to them, including associated risks and probabilities⁶.

Autonomy is not the privilege of the patient only. It is universally agreed that the physician's autonomy too must be respected. A physician may refuse a patient's request for a therapy that has no scientific or rational basis, especially if it could be harmful to the patient⁷. A physician may also refuse to implement a patient's decision for a certain treatment if it conflicts with the physician's conscience, for whatever reasons⁷. In such situations, the physician has the right not to treat the patient and to transfer such care to another qualified physician⁷.

Justice ensures that all are treated impartially and equally, irrespective of race, religion and social class i.e. equality. In medicine this becomes a "distributive justice" which takes into consideration the needs, rights, contributions to society, and factors such as economic situations, resource distribution and allocation.

Ethical values, are not limited to these four principles. There are other important values to consider, such as telling the truth, transparency, showing respect for patients and families, and showing respect for patients' own values. Together with integrity, honesty and professionalism, medical ethics provide guidance to physicians when conflicts related to care take place.

Rapid advances in science and technology have made it possible for us to sustain life, long past the time where natural course of events would have ended it. These have resulted in new ethical dilemmas while exacerbating old ones. In the West, this has led to the development of medical ethics as a specialty in its own rights.

Many professional associations have released guidance on medical ethics^{5,7} to help medical practitioners to deal with ethical issues that may arise during patient care. Medical ethicists have begun to play an active role in medical ethics. Hospital Ethics Committees (HECs) have been established in many western countries to assist physicians and patients when faced with ethical dilemmas. By 2016, 100% of hospitals with over 400 beds and >81% of smaller hospitals in the USA had HECs⁸.

While Sri Lanka has the SLMC Guidelines on Ethical Conduct of 2009⁶ which mainly focusses on professional conduct, there are no published guidance by Professional Associations on ethical issues related to clinical practice. Despite mushrooming of research ethics review committees in health care institutions, hospital ethics committees are scarce. In these aspects, we have a long way to go.

Futility of care and withholding aggressive treatment when it is perceived to be futile, are two concepts that have been practiced in medicine for centuries. Medicine is expected to do away with suffering of the sick and to lessen the violence of their diseases. However, it was also acceptable refuse to treat those who are overmastered by their diseases, realizing that in such cases medicine is powerless⁹.

Futility of care is defined as a clinical action serving no useful purpose in attaining a specified goal for a given patient¹⁰. Physicians are not required to offer or to provide interventions that, in their best medical judgment, cannot reasonably be expected to yield the intended clinical benefit or achieve agreed-on goals for care⁷. Withholding care in situations where no benefit can be expected is considered acceptable by many healthcare providers.

Advanced life support, which began in the mid-20th century, is the result of routine use of ventilators, feeding tubes, and other technology to keep patients alive. These life support measures rarely help dying patients to recover and eventually have to be removed¹¹.

Deciding when to remove life support is then up to the treating team. However, this puts physicians in the uncomfortable position of deciding who should live,

who should die and when they should die; tasks ideally in God's domain.

Getting families rationally involved with these decisions, especially when their loved one is in a critical state is not easy. The issues are confounded by somewhat unrealistic expectations of families and their religious and cultural beliefs.

Like with Mr B, an 86-year-old diabetic, paralysed on the left side, bed bound for the last 3 years and brought to hospital with severe pneumonia. He was heavily dependent on his unmarried daughters for his basic self-care needs. In an almost foetal position, he communicates with sign language and that too minimally.

As Mr B's oxygen saturation was poor, he was admitted to the ICU and given non-invasive ventilation. The treating team decided that invasive ventilation – connecting him to a machine to help breathing – would be inappropriate, as given his general condition, it would not be possible to get him off the machine. The team was of the opinion that resuscitating Mr B with CPR, should his heart stops beating, would also be inappropriate and discussed these issues with the daughters. While understanding that their father was very unlikely to recover, the daughters were reluctant to agree for withholding advanced life support or for a Do Not Resuscitate order.

"How can we agree?" asks one. "It would be like committing an anantarika papa karma".

"Can't you connect him to a machine for a few days and see?" asks another.

"Keep him alive for as long as you can" says the third, "he is our only refuge".

For Buddhists, taking a life is a sin and "anantarika papa karma" are heinous sins that bring immediate disaster, resulting in the person going straight to hell in his next life with no hope of redemption. Intentionally killing one's father is one such "anatraika papa karma". Sociocultural aspects add to these religious issues. In a culturally paternalistic society losing the father or the husband can be devastating, even though such a person may not be able to provide meaningful support or protection.

That there is a difference, but a very clear difference, between making a patient comfortable and killing him, is at times difficult to grasp and comprehend. For the treating team, it is also an issue with distributive justice. In an extremely resource

limited setting, giving an ICU bed with advanced life support to a person who obviously will not benefit would deprive another who would clearly benefit from such care and get back to a productive life.

Mr B's situation illustrates the moral debate between scientific, metaphysical, religious, cultural and economic facts. Reconciling with the Western notions of autonomy, beneficence, non-maleficence and justice when faced with such a situation is extremely challenging.

The relevant statement in the Sri Lanka Medical Council's Guidelines on Ethical Conduct for Medical and Dental Practitioners state: "Euthanasia whether active or passive is illegal in Sri Lanka and this includes withdrawal of life support or notices stating, "Do not resuscitate" (DNR)⁶. Yet, Euthanasia which is Physician assisted suicide or "mercy killing", is not the same as withdrawing life support or DNR.

The directive of the Sri Lanka Medical Council adds to the dilemma and leaves the medical team with no option but to go ahead with futile treatment and perform cardiopulmonary resuscitation if Mr B gets a cardiac arrest. Doing otherwise, even if it is in the patient's best interest, would be deemed illegal.

The time has now come for us to critically look at these issues. It is also imperative that we make very clear, the fine distinction between withholding aggressive, futile care and continuing care or treatment measures that would make a person comfortable. The latter is essential to relieve the suffering of a patient, especially when a cure is not an option.

It is also the time for us to look at who should be making these decisions. Is it the patients or their families? Or should it be us? One could argue that it is both unrealistic and unfair to expect patients or families to make decisions based on such complex technical aspects. In most instances, they may lack the knowledge to do so.

A major paradigm shift in modern western medical ethics in the physician-patient relationship is the dramatic change from paternalism to autonomy. While this has removed from the physician the monopoly on decision-making, it expects him to facilitate any desired action acceptable to a person's own judgement and in accordance with his own choice, even though it might cause harm.

Respecting this autonomy allows a competent and informed individual to accept or refuse treatment without having to explain why. The granting of

autonomy requires that we recognize and accept the free choice of each person even if that choice seems inappropriate, foolish or life-endangering.

Permit me, at this point, to introduce to you to Mrs A, a 32-year-old mother of two young children, the youngest only 18 months. She was diagnosed with invasive breast carcinoma almost a year ago, with spread to axillary lymph nodes. The breast lump was deemed inoperable and she was offered chemotherapy. As she was told that there was no definitive cure but it will give her few more extra months, Mrs A opted to go for alternative treatment.

"Chemotherapy kills too" says Mrs A. "This wedamahattaya told me that he will cure me. At least I now had a chance. It also meant that I could stay at home with my children. If I am to live only a few months, I would rather do it this way."

During the last year she has seen 3 different practitioners of alternative medicine. All have failed to deliver. Despite failures with these practitioners, she persists with them, well aware that the cancer has spread. She sees practitioners of the Western system for other ailments but is adamant in her refusal to take chemotherapy. "They give me hope" she says, "but you don't".

An aspect unique mainly to the Eastern countries such as Sri Lanka is the existence of established alternative healthcare systems that runs parallel to the Western healthcare system. There is also a greater emphasis on the powers of the unseen to cure diseases. These systems are at times more holistic in their approaches to patients and are more attuned to cultural norms. Moreover, the physicians practicing the alternative systems of medicine speak the language of the people. Our patients access all these systems, sometimes simultaneously.

Mrs A's story illustrates the dilemmas we face when two culturally different treatment systems coexist. More importantly, it illustrates the need to use our words with care. When any problem can be presented as a soluble challenge or as a proverbial death sentence, why do we mostly choose the latter? Elementary psychology tells us, that fear is not a good way to mobilise a persons' inner resources and will dissipate hope. Yet we continue to do so, and by doing so, undermine intelligent decision making and push patients towards unproven therapies.

It is time for us to rethink how we talk to our patients about their illnesses, especially when these

are chronic, debilitating or terminal. While providing accurate information we may need to rephrase our words to give them some hope instead of nothing, for hope is at times, all what a person has. Giving bad news in a more positive way is also in line with the Eastern ways of doing things where we approach and deal with unpleasant issues in a roundabout manner.

The more common situation that most of us encounter is when the family tells us not to inform the patient of the diagnosis, especially when it is a terminal illness. The desire to protect a loved one from unpleasant information is not unnatural. What can we do then? Do we respect the patient's autonomy – or do we respect the family's request, and skirt around the issue? How can we discuss treatment options with a patient, when he is unaware of the disease or its prognosis? Such major involvement of families, however, is not in keeping with the Western concept of autonomy.

The Western world's espousal of autonomy is not universally accepted. In many Eastern societies, families play a major role in decision making and autonomy then becomes collective, rather than individualistic. In countries such as Taiwan, when different treatment options are considered especially for those with terminal illnesses, the family members such as the husband or the father, are consulted first rather than the patient. Once the family decides on the best course of action, the patient maybe advised in a disguised way to prevent anxiety.

The medical system all of us practice originated in the West. The modern medical ethics that we are taught and expected to practice have their origins also in the West and are in accordance with their cultural and societal norms. Mrs A and Mr B illustrate the conflicts we face when cultural and societal norms and beliefs conflict with science, especially when it is not an exact science. They also illustrate the problems that arise when we try to apply Western ethical principles directly to a different society with different norms, values and beliefs. To face such conflicts effectively, scientific knowledge and technical skills alone are inadequate, one must also be “culturally competent”.

Cultural competence in healthcare

Cultural competence is having a set of learned skills, knowledge or assumptions which will be helpful to deal with cultural issues encountered in practice¹². In healthcare this involves understanding the importance and effects of social and cultural influences on patients' health beliefs and behaviours, healthcare

provisions and access to ensure quality of delivery to diverse patient populations¹³. Such competence provides a person with the ability to be respectful and responsive to health beliefs and practices, and cultural and linguistic needs of diverse groups of people. Cultural competence also allows one to seamlessly incorporate cultural values to modern medicine, as we have done successfully with organ donations.

Yet, in many situations, we still tend to believe that biomedical science is always right, and that “non-scientific” belief systems should be disregarded. The paternalistic and hierarchical relationship that we see between doctors and patients, makes such an approach very easy. Yet the cultural nuances are important if we are to provide care in a holistic manner and attend to feelings and emotions of patients in addition to their symptoms.

Holistic approach in healthcare delivery

The concepts of holism and holistic approach to treatment are not new. The word Holistic is believed to have its origin in the Sanskrit word “Sarvah” meaning “whole or intact”. The origins of holistic approach to treatment are found in writings older than 5000 years, describing the Ayurvedic approaches to treatment.

Holistic health care is a system of comprehensive patient care that considers the physical, emotional, social, economic, and spiritual needs of the person. It also considers his response to illness; and the effect of the illness on the ability to meet self-care needs¹⁴. Holistic approach involves teams, each member providing the aspect of care he is competent to do so within the cultural, societal and economic boundaries. The members may not necessarily be medical, and this may necessitate dialogues that go beyond scientific knowledge – an interdisciplinary approach to health.

With these aspects of care in mind, our theme for the year will be “**Beyond Knowledge – Across boundaries – Towards Holistic Care**”.

I have only barely scratched the surface of ethical dilemmas we face daily. What I have shared with you are some issues and dilemmas most of us present here today, both physicians and others, would have encountered at some time in our lives. Some of us may have been on both sides of the divide and will know that there are no absolute rights or wrongs in any such situation.

None of the concepts discussed are new. They have been in existence before modern high-tech medicine changed the medical landscape of our times. We simply need to re-think our approach to patients, we MUST re-think.

Medicine has powers, but not unlimited powers. Our Founders understood this well and enshrined it in the official motto of the College. The Sanskrit phrase, 'Arogyam, Shanthi, Sukham', and its closest English translation 'Cure, Relief, Comfort', is the universal motto of healing and caring for the sick. When curative powers of medicine fail, Arogyam becomes elusive and Shanthi and Sukham take centre stage. While we continue to search for these elusive cures, we need to remind ourselves continuously, that treatment of a patient is not only a Science but is a mixture of both Science and Art.

The College has played, and will continue to play, a pivotal role in enhancing knowledge and technical skills of physicians in this land. It is now time for us to go beyond.

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