Ch. II-3 Ethics in Medicine

Wade Smith, MD, PhD

ISSUE: I want to do the right thing. What defines unethical behavior?

MEDICAL ETHICS: CODES

Ethical physician behavior has been a core principal dating back to ancient Greek times. Asclepius, the Greek God of medicine, was worshiped by the creation of several asclepieions in ancient Greece. The most prominent was in Epidaurus where followers of the God would come for cures, offering sacrifices for entry, and recovering with various treatments including cleansing, resting, and study. Special snakes helped cure patients. The Rod of Asclepius showing 2 snakes wrapped around a staff is a symbol today of modern medicine.

Hippocrates studied and practiced in an asclepieion on the island of Kos. Hippocrates authored his oath centering on ethical physician behavior forming the first widely held admonition of how we should act as medical professionals. More contemporary oaths, the (Louis) Lasagna Oath (for physicians), Florence Nightingale Pledge (for nurses), and Oath of a Pharmacist, all instill a commitment in recent graduates to behave ethically in their practice.

With that basic commitment, modern codes of medical ethics govern current ethical practice. The oldest and most complete for medicine in the U.S. is the Medical Code of Ethics, authored by the American Medical Association. This was first written in 1847 and has been continually updated as new medications, technologies and scientific discoveries have evolved. The Code is available online as an excellent resource and reference to codes of ethical behavior. This code is not binding; it is a guideline with various levels of insistence on compliance carefully worded with “must”, “should” and “may’ directives to help guide individual decisions. Parallel codes for nurses and pharmacists are included in the references.

INSTITUTIONAL CODES OF ETHICS

Each medical institution or hospital system has a code of medical ethics to which you adhere when credentialed. Some institutions simply reference the AMA while others have a detailed code adapted to their own practice. Some religion -based hospitals have certain prohibitions regarding abortion or counseling regarding contraception. Physicians and other healthcare team members who practice within these walls are bound to this.

Within academic medical centers, the University may have its own Code of Ethics that govern non-medical issues like authorship, good-faith and use of grant money. Thus, an academic clinician may be guided by two separate Codes and typically signs acknowledgment of these codes as a condition of employment.

ROLE OF ETHICS COMMITTEES AND CONSULTATON

Ethics committees are charged by the medical center to draft, review and update policies and procedures of an ethical nature. These requirements are mandated by The Joint Commission (TJC). Organ donation, comfort care, and DNR policies are examples of ethically driven policies and procedures.

Hospitals are also required to provide contemporaneous ethics consultation to help healthcare professionals resolve ethical dilemmas that arise in practice. These consultation services are either internal or contracted and should behave just like any other consult for advice. Consonant with consulting, the conclusions of a consult are typically not binding, but some centers take on a managing role of patients on occasion.

An effective ethics consultation service is available at all times and is usually run by a physician. Any healthcare team member should have the authority to request an ethics consult. Additional healthcare professionals may join the ethics consult team including representatives from nursing, social services, clergy and risk management as needed. Some of these consults are straight-forward and addressed by particular hospital policies, while others are more complex. For complex cases, the ethics team typically meets with the interdisciplinary team managing the patient’s care to discuss the

case. Effective consultants then assist in defining the ethical dilemma framing further discussion. The goal of the consultation is to facilitate resolution of the dilemma so medical care can proceed.

Resolution of the dilemma follows formal ethical reasoning along the standard principles of autonomy, beneficence, non-maleficence and justice. However, most consults revolve around autonomy. The other principals are commonly superfluous; each professional wants to benefit a patient, and do no harm. Justice is rarely is applied to an individual patient but does arise in settings of limited resources (disaster engagement and triage for example).

Autonomy is typically central in these consults. Resolving whether the patient has capacity (Chapter 4.9) is a first step to decide who makes medical decisions for the patient. Autonomous patients have this right exclusive of others, while patients without capacity may have surrogates (Chapter 4.24). Often these distinctions are core to the consult. Once this is clarified, then doing what is best for the patient is the ultimate question to answer.

Each consult has nuance. Only through careful consideration of the facts, informed by the experience and knowledge of medicine, and guided by ethical codes of behavior can a team arrive at what is best for the patient. At the conclusion of a consult, the ethics consult team typically documents the discussion in the medical record.

Consultants should be available to the family as well as to answer ethical concerns. Some consults directly involve the family in the discussion. Being available as the situation evolves is helpful to form continuity especially as team members rotate.

UNETHICAL BEHAVIOR

Certain behaviors are intolerable and require immediate referral. These can include workplace violence, working under the influence of alcohol or drugs, sexual encounters with patients, assault of patients, etc. These activities should be reported immediately to supervisors or law enforcement. Illegal activity by definition is unethical; not all unethical activity is illegal, however.

Issues of medical professionalism (Chapter 2.4) can be handled by referral to a professionalism committee. A process is to report this concern via the incident reporting system, but anonymous referrals are also available. Risk managers typically know this process as do the ethics consultants. Simply speaking with the person of concern is an excellent first step, or simply speaking with their supervisor may resolve the problem.

Reporting ethical concerns carries the risk of reappraisal. Retribution or intimidation is unprofessional, unethical and against hospital policies, and can be grounds for loss of credentialing and State licensure. However, many concerns go unreported because of fear. Improving the culture of safety and continuous process improvement across the institution are key methods to cultivate a culture where everyone can speak up for the greater good of the patient. Everyone has a stake in it.

SUGGESTED READING/REFERENCES

AMA Code of Medical Ethics:
https://www.ama-assn.org/delivering-care/ama-code-medical-ethics

ANA Code of Ethics for Nurses:
https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/

APhA code of Ethics for Pharmacists:
https://www.pharmacist.com/code-ethics