

Chapter V

The Medical Relationship: Autonomy and Beneficence

“The only freedom that deserves the name is that of pursuing our own good in our own way, so long as we do not attempt to deprive others of theirs, or impede their efforts to obtain it. Each is the proper guardian of his own health, whether bodily, or mental, or spiritual. Mankind are the greater gainers by suffering each other to live as seems good to themselves, than by compelling each to live as seems good to the rest”

-- John Stuart Mill (1859)

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The relationship between doctors and patients has undergone a revolutionary transformation from a traditional ethic of medical paternalism to the contemporary emphasis on patient autonomy and patient rights. Patient autonomy and the doctrine of informed consent define the new paradigm of medical practice. After examining the history and philosophical basis of this transformation, we consider an alternative more Confucian model of medical decision-making that aims to better balance physician authority and patient autonomy and also emphasizes the centrality of the family in the medical context. We conclude by relating this model to Islamic medical ethics and multicultural context.

24. The Genealogy of Medical Ethics: 1847 to 2001

The relationship between doctors and patients has undergone a revolutionary transformation from a traditional ethic of medical paternalism to the contemporary emphasis on patient autonomy and patient rights. The transformation in the West from the physician's role as a benevolent, paternalistic authority figure to a medical relationship emphasizing patient autonomy and patient rights is nowhere more evident than in the recent history of codes of medical ethics.

Article 1 section 1 of the 1847 Code of the American Medical Association (AMA)¹ nicely captures the moral stance of the classic paternalism of the “Hippocratic tradition:”

Art. I.-*Duties of Physicians to their Patients.*

§ 1. A Physician should not only be ever ready to obey the calls of the sick, but his mind ought also to be imbued with the greatness of his mission, and the responsibility he habitually incurs in its discharge. Those obligations are the more deep and enduring, because there is no tribunal other than his own conscience, to adjudge penalties for carelessness or neglect. Physicians should, therefore, minister to the sick with due impressions of the importance of their office; reflecting that the ease, the health, and the lives of those committed to their charge, depend on their skill, attention and fidelity. They should study, also, in their deportment, so to unite *tenderness* with *firmness*, and *condescension* with *authority*, as to inspire the minds of their patients with gratitude, respect and confidence. (italics in original)

By 1957 the AMA Code of Ethics had changed substantially.² Rather than focusing on uniting “*tenderness and firmness*, and *condescension with authority*,” the focus was shifting to one emphasizing respect for human dignity.

Here is the 1957 version of the AMA First Principle:

Section 1: The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

In the 1980 version of the *AMA Principles of Medical Ethics*,³ we find a deceptively simple and concise statement of the first principle of medical ethics:

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

The language of the AMA Code has first shifted from the “duties of physicians” (1847) to “principles of medical ethics” (1957); second, the core principles are reduced to the two principles of compassion and respect (1980). Equally striking is the shift from the “greatness of his mission” and the “deep and enduring” obligations (1847) to the more minimal and basic commitment to provide “competent medical service” (1980). In addition, Article IV of the 1980 Code adds the language of “patient rights” to the 1957 Code:

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

The shift to a focus on principles of ethics, respect for dignity, and respect for rights, is a significant and fundamental ethical shift. In contrast to the one-page statement of

¹ The American Medical Association 1847 Code of Medical Ethics is based on and borrows liberally from Percival’s *Medical Ethics* written in 1803 (DevCom, 1987).

The entire AMA 1847 Code of Medical Ethics is available at <http://www.ama-assn.org/ama/upload/mm/369/1847code.pdf>

² American Medical Association, AMA, Principles of Medical Ethics, 1957 (see Appendix A) http://www.ama-assn.org/ama/upload/mm/369/1957_principles.pdf

³ AMA Principles of Medical Ethics, June 1980 (see Appendix A) http://www.ama-assn.org/ama1/pub/upload/mm/369/1980_principles.pdf

abstract principles in the 1980 Code, the 1847 Code is a substantial document over 20 pages long, and sets out in significant detail the obligations and responsibilities of physicians and of patients. Indeed, the description of the obligations of patients in the 1847 Code is also revealing. Consider Section 1 of Article II:

ART. II. - *Obligations of Patients to their Physicians.*

§ 1. The members of the medical profession, upon whom are enjoined the performance of so many important and arduous duties towards the community, and who are required to make so many sacrifices of comfort, ease, and health, for the welfare of those who avail themselves of their services, certainly *have a right to expect and require*, that their patients should entertain a just sense of the duties which they owe to their medical attendants. (emphasis added)

Here we find the assertion of “a right” but it is a right of physicians that patients show due attention to the duties *they owe* to physicians. In the preamble to the 1847 Code this is emphasized as well: “As it is the duty of a physician to advise, *so has he a right to be attentively and respectfully listened to*” (emphasis added). Every single mention of rights in the 1847 code asserts the rights and prerogatives of physicians. Of course, rights of patients may be assumed but they are not mentioned. The rights of patients are protected by the benevolence of physicians. It is quite clear that it would be inappropriate for patients to assert and stand up for their rights. In section 6 of Article II of the 1847 Code, we find an explicit statement that patients owe unquestioning obedience to their physicians:

§ 6. The obedience of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them. A failure in one particular may render an otherwise judicious treatment dangerous, and even fatal. This remark is equally applicable to diet, drink, and exercise. As patients become convalescent they are very apt to suppose that the rules prescribed for them may be disregarded, and the consequence but too often, is a relapse. Patients should never allow themselves to be persuaded to take any medicine whatever, that may be recommended to them by the self-constituted doctors and doctresses, who are so frequently met with, and who pretend to possess infallible remedies for the cure of every disease. However simple some of their prescriptions may appear to be, it often happens that they are productive of much mischief, and in all cases they are injurious, by contravening the plan of treatment adopted by the physician.

Contemporary physicians may appreciate some of the sentiment expressed here. Non-compliance by patients with doctor’s orders has surely always been a source of frustration for doctors everywhere. Again, however, the language used and the emphasis are in striking contrast to contemporary sensibilities: Patients have an obligation of “obedience” to physicians and patients should disregard their own “crude opinions” as to the adequacy of medical advice. Patients also have an obligation to avoid alternative remedies, and alternative medicine generally, when they are not authorized by a duly certified physician. Furthermore, the deference by patients to physicians does not end when health is restored (and monetary payment is made):

§ 10. A patient should, after his recovery, entertain a just and enduring sense of the value of the services rendered him by his physician; for these are of such a character, that no mere pecuniary acknowledgment can repay or cancel them.

The 1847 AMA code focuses on the mutual obligations and responsibilities of patients and physicians, with substantial and lengthy description of each. By 1980, the detailed AMA statement of mutual obligations is replaced by the simplest possible statement of principles and a complete reorientation towards patient rights. Since 1980, the focus on the priority of the patient and patient rights has been strengthened even further. In the current AMA 2001 Code of the first principle of medical ethics, for example, the link between respect for the dignity of patients and respect for rights is now made explicit:⁴

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

The differences in emphasis and orientation can really only be captured by the statements themselves. I have for this reason quoted from these codes at length. The 1847 Code is too long to be quoted in its entirety (it is over 20 pages long), but it is readily available on the website of the American Medical Association.⁵

Starting in the 1950s, and taking full shape by 2001, there was a shift in emphasis from a conception of medical authority based on *paternalistic but benevolent authority* to an emphasis on *respect for patient dignity and rights*. This shift in the focus of medical ethics is found in many countries and cultural contexts, but it is not universal, and the emphasis on rights in particular has been resisted, especially in some Asian countries, where an insistence on maintaining a focus on obligations and responsibilities has been emphasized and defended. For example, the current physician's ethical pledge from the Singapore Medical Association emphasizes the responsibility and the "conscience and dignity" of the profession and a dedication to "the service of humanity" and "the health of my patients," but does not mention patient rights at all.⁶ Similarly, the Japanese statement of Principles of Medical Ethics emphasizes a concern for patients and a respect for their individuality, but it also forgoes any reference to patient rights. The emphasis is instead on compassionate care and earning the trust of patients.⁷ The Indian Medical Association (IMA) Code of Medical Ethics, 2002,⁸ also does not reference patient's rights; and in its tone it resembles the AMA 1847 Code in emphasizing, as its First Principle, the physician's duty to "uphold the dignity and honor of his profession." The Indian IMA code goes on to state,

Whosoever chooses his profession, assumes the obligation to conduct himself in accordance with its ideals. A physician should be an upright man, instructed in the art of healings. He shall keep himself pure in character and be diligent in caring for the sick; he should be modest, sober, patient, prompt in discharging his duty without anxiety; conducting himself with propriety in his profession and in the actions of his life.

The IMA Code also emphasizes the physician's responsibility and the duty to both earn and deserve the patient's trust. The IMA code is an explicitly more Hippocratic vision of

⁴ AMA Principles of Medical Ethics, 2001 (see Appendix A)

<http://www.ama-assn.org/ama/pub/category/2512.html>

http://www.ama-assn.org/ama/upload/mm/369/2001_principles.pdf

⁵ See footnote 1

⁶ Singapore Medical Association, <http://www.sma.org.sg/cmep/> (see Appendix A)

⁷ Japanese Medical Association, Principles of Medical Ethics, 2005

http://www.med.or.jp/english/02_princ.html (see Appendix A)

⁸ Indian Code of Medical Ethics, see <http://www.imanational.com/his/chapter1.asp>
http://www.imanational.com/modern_oath.asp (see Appendix A)

medical practice that is based on a sense of responsibility, of devotion and duty. The goal is to truly deserve the trust of one's patients and to dedicate oneself to the care of humanity. This is a noble vision indeed, but it is also noteworthy in its exclusion of talk of respecting the rights of patients.

In comparing the codes of medical ethics in different cultures and countries one of the most thorough statements of ethical principles is found in the current South African Medical Association (SAMA) Code of Medical ethics.⁹ It consists of nine pages of four columns outlining the reciprocal and corollary *rights* and *responsibilities* of *doctors* and *patients*. In spirit, the SAMA Code most fully captures the sentiment of the 1847 AMA Code that both patients and physicians have obligations in the medical settings, but it adds to this a robust contemporary focus on the rights of patients. The SAMA Code's egalitarian vision of reciprocal rights and responsibilities, as the ideal model of the physician-patient relationship, reflects a real balance of rights and responsibilities. Indeed, it may best capture a more deliberative and shared decision-making model of the patient-physician relationship, which is defended in the final section below.

In closing this discussion of different medical codes, we should note the commonality in all of these codes. They all emphasize

- the compassionate and caring nature of medicine;
- the importance of respecting the privacy and confidentiality of patients;
- the social duties and responsibilities of physicians;
- the duties of physicians to other medical professionals;
- the importance of medical training and of continuing education;
- the virtues of professionalism;
- the necessity of practicing medicine within the constraints of the law; and
- the priority of the patient over other considerations, including monetary considerations.

Despite vast cultural differences, the nature of the medical profession itself determines near universal ethical constraints on medical practice. The only core issue in dispute is over the legitimacy of an ethic of benevolent medical paternalism as opposed to a focus on respect for the autonomy and rights of patients. In exploring this issue, we look at the specific objections to medical paternalism and the origin and basis of principles of informed consent and patient autonomy. These are substantive philosophical issues, and we need to see whether the *reasons and arguments* do indeed support a patient-centered and autonomy-based conception of medical ethics.

Clearly a major reason for the shift in Western medical ethics is the more egalitarian ethic that has struck down hierarchical relationships in general. Relationships of authority, of course, still exist but the exercise of authority increasingly must be softened by a due regard to the underlying dignity and equality of humanity. I leave aside this significant background cultural shift in the structure of social relations and focus instead on two shifts in the medical relationship in particular. The first is the decline of the principle of therapeutic privilege and the second is the role of medical research in undermining the classic model of authoritarian paternalism.

25. Physician Authority and Therapeutic Privilege

⁹ SAMA – South African Medical Association <http://www.samedical.org/page.asp?pageid=13>

One of the more significant features of the paternalistic approach is the practice of non-disclosure of bad medical news. It was common to insist that full disclosure can actually harm the prognosis of patients, and thus it is medically contra-indicated. The 1847 AMA Code of Ethics makes this point with its usual eloquence.

Art. 1 § 4: A physician should not be forward to make gloomy prognostications because they savor of empiricism, by magnifying the importance of his services in the treatment or cure of the disease. But he should not fail, on proper occasions, to give to the friends of the patient timely notice of danger, when it really occurs; and even to the patient himself, if absolutely necessary. This office, however, is so peculiarly alarming when executed by him, that it ought to be declined whenever it can be assigned to any other person of sufficient judgment and delicacy. For, the physician should be the minister of hope and comfort to the sick; that, by such cordials to the drooping spirit, he may smooth the bed of death, revive expiring life, and counteract the depressing influence of those maladies which often disturb the tranquility of the most resigned, in their last moments. The life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician. It is, therefore, a sacred duty to guard himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his spirits.

The principle guiding disclosure here is essentially therapeutic, and thus the practice of non-disclosure is based on therapeutic privilege. The goal is to keep the patients spirits high, to be “the minister of hope and comfort,” and to avoid “gloomy prognostications,” unless “absolutely necessary.” The justification for non-disclosure is that a blunt empirical disclosure of the medical facts can actually harm the patient.

These harms come in two forms. First, the attitude of the patient itself has a therapeutic effect, and so “the life of a sick person can be shortened not only by the acts, but also by the words or the manner of a physician.” Second, a straightforward account of a patient’s probable fate and perhaps clearly terminal condition unnecessarily darkens the last days of life. The physician should “smooth the bed of death . . . and counteract the depressing influence of those maladies which often disturb the tranquility of the most resigned, in their last moments.” For these two reasons, “it is, therefore, a sacred duty to guard himself carefully in this respect, and to avoid all things which have a tendency to discourage the patient and to depress his spirits.” This duty to decide what the patient needs to know, and to protect the patient from depressing news, is thus clearly aimed at the patient’s own health and peace of mind.

This principle of therapeutic privilege has been under sustained attack for at least the last 30 years.¹⁰ The first and most obvious problem is that it makes widely sweeping and overbroad psychological generalizations. Some patients may become so despondent and depressed when given an honest diagnosis that disclosure is a medical harm, but it is implausible to claim that this is true of all patients, or even most patients. First, most people have a remarkable ability to retain hope in light of even the most improbable odds of recovery. Second, the research on death and dying documents a range of responses to a dire diagnosis, including denial, anger, depression, “bargaining” with fate, and even

¹⁰ For the objections to paternalistic non-disclosure, see Allen Buchanan “Medical Paternalism” (Philosophy and Public Affairs, Vol. 7, 1978, pp. 370-390).

acceptance of death.¹¹ Different people respond differently, and most people go through at least some of these different responses—as stages, so to speak—as they come to terms with the reality of their own imminent death. There is little evidence of any significant proportion of patients losing all hope and sinking into suicidal depression or listless despondency. It is much more likely that patients will steel themselves to “beat the odds” and survive despite the doctor’s “gloomy prognostications.” So at the very most, therapeutic privilege would warrant doctors withholding (or candy-coating) information *sometimes* from *some* patients.

The second problem with the doctrine of non-disclosure based on therapeutic privilege is that it does not distinguish specific medical harm from harm overall. In the case of a terminal diagnosis it is simply not true that what you don’t know won’t hurt you. Keeping the dying patient ignorant but as cheery and happy as is possible, even if this does indeed delay death (which is doubtful), may not in fact serve the overall best interest of the patient. The patient’s interest maybe better served by coming to terms with death and using the remaining time as he or she sees fit. Even if I die sooner, I may seize the time I have left and use it in ways that serve my particular needs and values. The denial of the reality of death is more of a social pathology than anything else, and to many observers it has seemed that “therapeutic privilege” perhaps served to protect physicians from facing and dealing with the depressing reality of their dying patients. At any rate, there is simply no empirical evidence that it is actually medically therapeutic at all, and non-disclosure is usually actually harmful to the patients overall interests. Although giving bad medical news is extremely hard and difficult, there seems little doubt that only with full disclosure can a patient come to terms with their death, share this last experience with their loved ones, and figure out how they want to spend their remaining days.

26. Medical Research and Consent

The doctor’s charge to help, and above all not to harm, patients may seem too obvious to be worth stating. One of my favorite medical cartoons has a friend telling a patient in the waiting room, “Don’t worry, a doctor’s first rule is to not harm their patients.” The patient responds, “What worries me is that they need a Rule for that!” One clear source of this classic limit on physician authority is that, in addition to the immediate medical end of helping patients, the doctor also has a natural desire to try new medical procedures; but doing so actually involves experimenting on one’s patients. On the other hand, if new approaches are not tried, there will be no medical progress, which is itself detrimental to patients. There is thus always a tension between using already established procedures and trying new approaches. But in fighting disease and illness, physicians must stay focused on the primacy of the particular patient that is in their immediate care. When is it ethical to try new approaches with unknown risks? When is it ethical to essentially mix medical care and medical research?

The doctrine of informed consent was first born in the context of medical research where the patient’s interests and the physician-researcher’s interests can so easily come into conflict. It was also born out of the legacy of the Nazis’ doctors and their clearly unethical experimentation on human subjects. It is not just Nazis, however, who are

¹¹ Jessica Mitford *The American Way of Death* (Simon and Schuster, 1963), and Elisabeth Kubler-Ross *On Death and Dying* (Macmillan Publishing Company, 1969).

tempted by the clearly unethical. The unethical, and racist Tuskegee syphilis experiments in the United States are another clear example of research interest overwhelming patient interest.¹² Informed consent for medical research began as a necessary research protocol to protect human subjects, and it has since spread to a more general requirement for all medical procedures.

Indeed, in the research environment, the paternalistic model of benevolent authoritarianism is especially out of place. Experimental procedures are by their very nature more risky than established procedures, and indeed might not benefit the patient at all. The Hippocratic imperative that physicians use *their own best judgment* to help, but above all to not harm, their patients is simply out of place. The aim of the research is to establish which procedures are beneficial and which are harmful. Consequently, in a research setting, patients are also experimental subjects, and thus their consent is a necessary tool that helps to protect them from excessive experimental zeal, or that simply allows them the opportunity to weigh the risks and benefits for themselves.

One reason that the principle of medical paternalism gave way to the principle of informed consent was the need for consent to medical research. As new treatments for previously hopeless diseases were developed, physicians needed to get the consent of patients for clinical trials. If one considers that cancers were the main area where physicians typically argued for non-disclosure, and the avalanche of treatments for cancers that have been developed in the past 50 years, it is not surprising that attitudes to non-disclosure of cancer also changed. In a modern, advanced medical system, the prognosis for all diseases has improved remarkably. Full disclosure is rarely a death sentence anymore, and so the need to protect patients from the news of their own certain death has slipped away. Whatever the diagnosis, there is now almost always some basis for hope, and this significantly mitigates the potential shock and trauma of disclosure.

Similarly, consent to surgery, with full disclosure of risks, is necessary to avoid liability and so the new treatments, often involving surgery, brought in their wake the need for informed consent. In addition, there are always new pharmacological treatments for virtually every condition. Here again disclosure is necessary. Patients need to know the possible side-effects, and weigh these against the potential benefits. As research and new treatments merged seamlessly together, informed consent becomes a part of medicine (at least for any invasive or new treatment).

This shift in the ethics of medicine is an especially clear example of the relationship between ethical principles and particular circumstances. The progress of medicine itself causes a contextual shift that has led to a substantial change in medical ethics. This shift is truly remarkable in its extent. In 1962, in the Oken Survey, only 12% of physicians disclosed a diagnosis of cancer. This is despite the fact that 87% of the general public and thus patients even then wanted to know if they had cancer. By 1979, in the Novak Study, we see a complete change in physician behavior with 98% of physicians reporting that their usual policy was full disclosure of cancer and all serious medical conditions.¹³ The reasons for this transformation of medical practice are now clear. First, we have seen that the doctrine of therapeutic privilege lacks a sound basis, and second that the

¹² For the Tuskegee Experiments see: <http://www.cdc.gov/tuskegee/timeline.htm>

¹³ Oken D. "What to tell cancer patients" in the *Journal of the American Medical Association* (JAMA) 175, 1961, pp. 1120-8. Novack D H, Plumer R, Smith R I, Ochitill H, Morrow G, Bennett J M, "Changes in physicians' attitudes toward telling the cancer patient" in JAMA 241, 1979, pp. 897-900.

development and success of medicine brought with it a need for routine consent. The practice of non-disclosure was in fact an unnecessary fetter on medical research.

27. The Physician-Patient Relationship Reconsidered

Classic medical paternalism has two core elements: First, the main duty of a physician is to help (*the principle of beneficence*), but above all do no harm (*the principle of non-maleficence*); and second, the physician is the judge of what is a benefit or harm to the patient (*the principle of physician authority*). In the new patient-centered approach to medicine, respect for patient autonomy replaces the physician's authority.¹⁴ In this new paradigm the first duty is to respect patient autonomy and self-determination. In judging beneficence and non-maleficence, the physician must base these judgments on *the particular patient's own values*; and second, the patient is the final judge of his or her own best interests, and thus of what is a benefit and what is a harm (*the principle of autonomy and informed consent*). In addition, under the classical Hippocratic model, the fundamental goal of medicine is to *preserve life*; death is always considered a harm, and it is thus a defeat of medical practice. As we shall see in chapter VII, the patient-centered approach the goal of medicine also shifts the fundamental goal of medicine to preserving the dignity of dying patients. This usually involves saving lives and restoring health, but it may involve allowing a *death with dignity*. Death is part of life, and dying is not always a harm to the patient; on the contrary, it is sometimes a release from a medical fate worse than death.

The case for the anti-paternalist, patient autonomy approach is based on both utilitarian (consequentialist) considerations and Kantian deontological considerations.¹⁵ As for the consequences, the argument is as follows: The patient is the best judge of his or her interests. As an empirical matter, it is just false that physicians are likely to know their patient's best interests better than the patient. Obviously the interests of patients are not uniform, and modern medicine often offers multiple options each with slightly different probabilities of benefits and distinct risks and side effects. There is no one correct answer to be discerned by the superior wisdom and experience of physicians. Physicians are the best judges of the medical information but patients are the best judge of the weight of the values at stake, and it is thus their judgment that should determine the course of treatment. In addition, self-determination is itself a value that is promoted by a patient centered approach. Deciding what happens to oneself in one's own life, according to one's own best judgment, is itself a basic and fundamental value. Even if I make mistakes, it is my life; and so, if I so choose, it is my mistake to make. Taking charge of and responsibility for one's own life is also an intrinsic good and this intrinsic good is undermined by physician paternalism.

The Kantian deontologist, on the other hand, will emphasize this second point in a slightly different way. For the Kantian, the problem with paternalism is that it does not

¹⁴ The classic text of contemporary medical ethics that systematically sets out the new paradigm is Thomas L. Beauchamp and James F. Childress's *Principles of Biomedical Ethics* (Oxford University Press, 5th edition, 2001). From its first edition in 1979 to its most recent edition in 200?, it has shaped the foundations of western medical ethics and it also has had an international impact defining the very field of biomedical ethics. The *Principles of Biomedical Ethics* set out the "four principles" model of medical ethics. The four principles are respect for autonomy, non-maleficence, beneficence, and justice.

¹⁵ See Boylan *Basic Ethics*, Chapters Three and Four on Utilitarian or Consequentialist theories and Kantian Ethics. Also see Alan Goldman on anti-paternalism (get reference).

treat patients as equal moral persons. The physician puts himself or herself above the patient, and overrides the patient's judgment by means of coercion or deception. Coercion and deception are paradigmatic ways of manipulating people, and thus treating people as mere means and not as ends-in-themselves. Since patients are persons with the same moral status and dignity as physicians, physicians have no right to ignore a patient's own views of what he or she wants. Patient's rights thus show respect for the fundamental equality and dignity of the patient.

Of course, respect for the patient self-determination assumes that the patient is first of all *competent* and second of all *informed*. When patients are under duress or inadequately informed, their choices may not reflect what their best interest at all. Indeed when patients are incompetent, then they lack the preconditions for autonomous choice and thus we do not respect them as a self-determining person by honoring their request. Medical paternalism is most clearly questionable in cases where the patient is clearly competent and fully informed. There will be countless cases, however, where the patient's level of competence is not so clear or the extent of understanding is less than perfect. In the morass of these normal cases the physician must decide whether some degree of paternalism is called for. This is no easy or simple matter. The broad distinction between paternalism and autonomy seems overly simplistic.

Ezekiel and Linda Emanuel have argued that we actually need to distinguish four models of the physician-patient relationship: The Paternalistic Model, The Informational Model, The Interpretive Model, and the Deliberative Model.¹⁶ We have discussed the paternalistic model at length; it is the distinction between the other three models that is now of interest.

According to *The Informational Model*, the physician presents the medical information and the patient supplies the values that govern deliberation and makes the decision. This model assumes that the patient's values are clear and well-defined and that the medical information provided by the physician is essentially value-neutral. Both of these assumptions are problematic. Indeed, merely presenting the medical facts does not even include a physician's recommendation, which is necessarily value-laden. If a physician were to simply report the medical facts, the patient would surely respond, "What do you think I should do?"

The Interpretive Model is more plausible in that it recognizes that in the medical context the physician must play a more active role in helping patients form and articulate their values. When faced with a difficult medical decision, the real consequences, the costs and benefits, of the different options typically will be unclear. Patients thus need help figuring out what they in fact want. Physicians here play the role of a medical advisor and counselor helping patients formulate their own values.

The last model is *The Deliberative Model* and it most fully blends the principles of beneficence and autonomy. On the deliberative model, the physician even more actively helps the patient shape their medically related values, and the goal is explicitly to have the patient affirm the *most justified and appropriate* set of medical values. This model recognizes that a patient's preferences are not clearly fixed and that they are instead always developing and, one hopes, improving. In a medical context, one's preferences will naturally develop and adjust to the new situation. As a result, even if the physician

¹⁶ See Ezekiel J. Emanuel and Linda L. Emanuel "Four Models of the Physician-Patient Relationship" in *JAMA* 267:16, 1992, pp. 2221-26.

does not have the paternalistic role of a parent, ideally they should take on the role of a trusted advisor. The physician's goal is to work through difficult medical situations with patients and help them figure out what is really the *best* course of action. This last model attempts to blend respect for autonomy and a realistic medical paternalism; it provides a high ideal for physicians to meet.

The deliberative model always runs the risk of being too paternalistic, but it also rightly treats autonomy as more than simple preference satisfaction; autonomy is an achievement based on critical thought and reflection. On the other hand, it is an advantage of the interpretive model that it more starkly emphasizes that distinction between the physician's values and the patient's own values; the interpretive physician helps patients articulate their values but does not second-guess their patients. Which of these two models is "the best model" surely depends on the particular individuals involved, the prior relationship between physician and patient, and the particular medical issue under consideration. What seems clear, however, is that although the old ethic of medical paternalism is clearly dated, the physician's role is not captured by the unrealistic informative model, which artificially distinguishes facts and values. As the medical relationship evolves to more fully respect patient autonomy and patient rights, physicians must still exercise judgment that is rooted in their special expertise and experience. As the medical patriarch recedes into history, the contemporary physician must assume the more difficult role of a trusted and benevolent advisor.

28. The Elements of Informed Consent

To be more explicit, informed consent is supposed to involve an explicit authorization by a competent patient, with substantial understanding, to a particular procedure.¹⁷ In practice, informed consent involves specific procedures, like the common disclosure and consent form, which serve to cover legal liability more than they capture autonomous consent. The classic elements of truly autonomous informed consent are: 1. Competence, 2. Disclosure, 3. Understanding, 4. Voluntariness, and 5. Consent. A more revealing and complete account of the process of obtaining informed consent has been set out by Beauchamp and Childress:¹⁸

Threshold Elements or Preconditions:

1. Competence of the patient to understand and decide
2. Voluntariness in deciding on a plan

Informational Elements:

3. Disclosure of all relevant information
4. Recommendation of a course of treatment
5. Understanding of disclosure and recommendation

Consent (or Refusal) Elements:

6. Patient's Decision
7. Authorization of Physician's actions or omissions

This account has the merits of completeness and also of capturing the *process* of informed consent. It also captures the distinct role of physician and patient in this

¹⁷ This description is taken from a United States court case "Mohr v. Williams," see Beauchamp and Childress, p. 143.

¹⁸ This summary is from Beauchamp and Childress p. 78. In this sections and the next, I am indebted to Beauchamp and Childress excellent discussion of these issues.

process. The patient must be competent, understand the information provided, make a voluntary decision, and explicitly authorize the physician's action (or inaction). The physician has the essential medical role of diagnosing the condition and recommending a course of action, and also of full disclosure of all relevant medical information. The physician also has the additional tasks of determining competence and voluntariness, accessing understanding, making a recommendation that reflects the patient's overall values, and accepting and acting on the patient's authorized decision. These additional tasks raise difficult issues of assessment, and, on some occasions, the incredibly difficult task of following a patient's directive that seems clearly wrong and mistaken.

Informed consent appears to be a simple idea but if one only scratches the surface we see that it is a complex and difficult issue. There are, for example, three distinct standards of disclosure: the professional practice standard, the reasonable person standard, and the subjective standard.¹⁹ *The professional practice standard* is a basic legal liability standard that requires physicians to meet the established standards of their profession. It is an obvious minimal requirement of any profession that one meets the basic standards of professionalism. This standard, however, is no help at all in setting the standards of a profession because it assumes that the standards are already set. For example, in 1847 the professional practice standard is one of therapeutic privilege. The point of informed consent is to set a new standard for the profession and so some other criterion is needed. *The reasonable person standard* requires instead that one disclose as much information as a reasonable person (or in this case a reasonable patient) would want for the purpose of deciding on the procedure in question. The reasonable person standard provides a good baseline for setting a general professional standard, but it does not distinguish the different needs and desires of particular patients. Some patients want more information and some want clear recommendations. In addition, some patients can understand much more information than other patients. In practice, how much information it is appropriate to disclose depends largely on the individual capacities and desires of each patient. *The subjective standard* of disclosure rejects the idea that there is an objective body of information that should be provided to each patient, and maintains instead that the information disclosed should match the subjective preferences of the particular patient. Although this is obviously correct in theory, it is inadequate and impractical professional standard. The professional standard needs to set a baseline that must be met for an informed consent, and this standard then provides a point of reference for consideration of legal liability. The baseline for informed consent and for a professional standard of disclosure is the reasonable patient standard, but physicians should also be sensitive to and responsive to the subjective needs of each of their patients.

Now the point that we want to emphasize here is that the disclosure of pertinent information is inescapably a matter for the discretion and judgment of physicians. The physicians are the medical expert after all and so they must decide what information is medically relevant. Furthermore, we see that they must also decide how much information the particular patient can understand and how much the patient wants to know. The judgment and authority of physicians in the physician-patient relationship is really inescapable.

¹⁹ See Beauchamp and Childress, pp. 80-83.

The requirement that the patient understand the information also seems simple but it is even more complicated than disclosure.²⁰ The patient must understand the diagnosis, the alternatives, the nature and likely outcomes of the different alternatives, including the probable risks and benefits, and the recommendation and its basis. First of all, quite clearly, the patient usually cannot and does not need to have the same depth of understanding as the physician. The physician thus must decide on a *level of complexity* that is suitable for sufficient understanding to make an informed decision. There is also a limit on how much information a patient can take in and understand. More information is simply not always better than less. *Information overload* can be as much of an obstacle to understanding as insufficient information. There are additional problems associated with presenting information in an appropriate manner. The physician needs to make sure that the patient *appreciates the risks* in light of the sometimes overwhelming benefits. When it comes to presenting risks and benefits, there are well-known *framing effects*. Patients respond differently to the statement “this procedure has a 99% survival rate” than to the statement “one out of every 100 patients dies during this procedure.” There is often simply no “neutral” way to frame risks.

Related to this issue is the fact that competent patients sometimes make irrational decisions.²¹ In some cases, an irrational decision will be the result of the way that the patient frames the risks and the benefits. Related to this are other common forms of “irrationality.” It is common to have an excessive *bias toward the present*; that is people tend to discount future harms and benefits relative to more immediate harms and benefits. When the probability of the future harm or benefit is high, however, this discounting of the future is irrational (and will likely later be regretted). In the medical context, this discounting of the future is often related to a disproportionate *fear of surgery*. There are real risks associated with surgery but all too often we are simply (naturally) emotionally averse to “going under the knife.” This is irrational in the sense that the aversion is unrelated to the real harm and risks associated with the surgery in question and it thus blocks a balanced weighing of risks and benefits. In addition, *denial or wishful thinking* is an all too common aspect of human reasoning. Even when a person seems to clearly understand the probability of a serious harm, for example, they will firmly believe that “it won’t happen to me.” Similarly, a patient’s belief that he or she will beat the odds, and be the two percent that will recover, is completely out of touch with the reality of the probabilities (even if it is psychologically helpful and comforting). These four common forms of “irrationality” (1. framing effects, 2. bias toward the present, 3. fear of surgery, 4. denial or wishful thinking) complicate the process of informed consent.

First if one agrees that these are common factors that distort decision making, so that patient’s decisions do not reflect the patients own best interest, then one of the rationales for informed consent is undermined: in these situations patients are likely to systematically misjudge their own best interest. Second, the physician must thus decide how much to influence the patient’s decision so that it is not irrational in these ways. And this brings us to the issue of voluntariness.

²⁰ See Beauchamp and Childress, pp. 88-93

²¹ Dan W. Brock and Steven A Wartman, “When Competent Patients Make Irrational Choices,” *The New England Journal of Medicine*, no 22, May 31, 1990; 1595-99. Also see Julian Savulesca and Richard W. Momeyer “Should Informed Consent Be Based on Rational Beliefs?” in Boylan ed. *Medical Ethics* (Prentice Hall, 2000).

It is clear that outright coercion and explicit deception undermine consent and thus probably do not respect patient autonomy. Informed consent thus presupposes that the decision is voluntary and not coerced. The use of force or of a credible threat of a significant harm to extract a particular decision from a patient clearly amounts to coercion. On the other hand, influencing a patient's decision by appealing to the merits of a proposal and the reasons for the proposal is not coercion. Between "rational persuasion" and outright coercion, we have manipulation of one person by another.²² It may be very hard to draw a distinction between manipulation and persuasion when trying to convince a competent patient to make a more rational decision. If one is convinced that a competent patient is making an irrational decision, then of course one will want to persuade the patient to change their mind and make the rational decision. Although an appeal to good reasons will be relevant, it is actually hard to distinguish a simple appeal to reasons from more manipulative techniques. For example to counteract "irrational fears" or "future discounting," one easy way is to emphasize the countervailing reasons by using "framing effects" to one's advantage and by generally appealing to the patient's emotional sensitivities. Indeed, it may be futile and silly to limit oneself to reason when battling irrationality! And so the only (rational) thing for a concerned person to do is to use the very same (irrational) tools of persuasion to bring the patient to his or her senses. Paradoxically, perhaps, the best way to bring an irrational person around to reason may involve irrational means. Insofar as autonomy includes being guided by good reasons, we here respect patient autonomy by trying to restore it. So when patients irrationally reject sound medical advice, it will not be uncommon to go beyond appeals to reason in an attempt to "talk some sense into them." As long as the physician does not resort to outright deception or coercion, the use of persuasion to help a patient appreciate good reasons does not seem unduly paternalistic.

More to the point, however, despite the high ideal of respect for patient autonomy, manipulating patients so that they choose what is in their best interest is all too common, and thoroughly understandable. The use of manipulation as a form of persuasion is most justified when the patient's initial decision is most clearly irrational given the patient's own overall values. Although we should always be wary of manipulation, we should also be wary of letting a patient act on a decision that they will later surely regret. This is a clear conflict between respect for autonomy and the principle of beneficence and we suspect that there is not any simple rule that resolves this conflict. In practice, doctors must balance the concern for the interests of the patient and respect for the autonomy of the patient.

Medical paternalism is most problematic when we have a competent and well informed patient. The less competent or the less informed the patient, the more reasonable is a paternalistic concern on the part of another for the patient's good. Indeed, paternalism toward children is required, and it also justified when dealing with a patient that is incompetent to make the particular decision in question. Even with a competent patient, medical paternalism is also more plausible when it involves a refusal of a request to do something harmful. There is a substantial difference between coercing competent persons to do something for their own good, and refusing to do something when one believes that the request is irrational. We will call the former active paternalism and the latter passive paternalism. If I operate on a competent patient, without the patient's

²² For a fuller discussion of these distinctions, see Beauchamp and Childress, pp. 93-98.

consent but for the patient's own good, then this is a case of active paternalism. If I refuse to perform an operation on a competent patient, when the patient is demanding it, for the sake of the patient's own good, then this is a case of passive paternalism.²³

With these distinctions in mind, we can see that medical paternalism is still common practice. Whenever a patient is incompetent and requesting something harmful, we do and should paternalistically look after their interests. In addition it is often the apparent irrationality of the patient's request that is the initial basis for the assumption of incompetence! Even when a patient seems to be competent and informed, the practice of passive paternalism is common place and often unquestioned. Physicians routinely use their own judgment to veto patient requests for medical care. Physicians also use various means of persuasion that go beyond mere appeals to reason that function in fact to manipulate patients to make more rational decisions, and this too involves a paternalistic role.

Respect for autonomy includes the requirement not to deceive patients, to disclose their condition and the risks of treatment, and to get a patient's consent before treatment. Physicians should not deceive or coerce competent patients to receive medical care against their will. But prior to the applicability of the constraint of getting informed consent, physicians must first determine patient competence and understanding, and physicians also control the nature and force of the presentation of medical information. In addition, they are also free to refuse to honor a patient's request whenever they think that it is wrong and not in the patient's interest. In this way we see that medical paternalism and patient autonomy are carefully balanced and that there is a significant gap between the reality and the rhetoric of the new paradigm of patient autonomy. We exaggerate when we declare the death of the old paradigm of medical paternalism for in all of these ways it is alive and flourishing in medical practice.

29. The Right to Refuse and Proxy Consent

We have seen that the doctrine of informed consent in medical ethics is based on the principle of respect for autonomy. In United States law, however, the right to informed consent was in fact based on the common law doctrine of assault and battery. Let me explain. The courts have long held that persons should be free of constraint by others unless there is some clear legal reason and authority that restricts their liberty. Here is a particular clear statement of this principle:

"No right is more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference from others, unless by clear and unquestionable authority of law" –Judge Cordoza *Union Pacific R. Co. v. Botsford*; USSC (1891)

This common law principle naturally extends to the medical setting:

"Every human being of adult years and sound mind has a right to determine what will be done to his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable for damages"
Schloendorff v. Society of NY Hospital; NY Court of Appeals, (1914)

In this simple statement, we get a clear sense of why the right of refusal is so much more demanding than the right to demand medical care. If respect for patient autonomy were

²³ On justified paternalism, and for an argument that active paternalism on competent patients is common in hospitals and often unproblematic, see Beauchamp and Childress, pp. 176-94; especially pp. 185-87.

the only consideration, then the right to demand treatment (other things equal) should be equivalent to the right to refuse. But when we focus instead on the assaultive nature of treating someone without consent, the basis for the distinction between refusals and requests is crystal clear. You can demand that a doctor not assault you for the same reason that you can demand this of any other person. But you cannot generally demand in the same way that others assist you in your ends. Physicians of course have a special duty to aid, but the duty to aid others does not include a duty to assist them in harming themselves. The common law of assault and battery thus provides a clear basis for the distinctive right to refuse treatment. The doctrine of informed consent grew out of this original common law doctrine because non-disclosure is in many ways like coerced consent. To avoid legal liability physicians needed to get explicit and informed authorization for treatment – thus the origin of the now ubiquitous consent forms that cover liability but add little to truly autonomous informed consent.

This distinction between an autonomy-based medical ethic and common law right to refuse care is significant when it comes to the broader question of the nature of a right to die. An autonomy-based right to die adds significant support to the right of competent patients to hasten their death by means of physician assisted suicide or perhaps even voluntary active euthanasia. The common law battery right to refuse does not include a right to hasten one's death by active means. In addition, the position of the American Medical Association, and other medical association, which opposes the right of competent and informed dying patients to hasten their deaths (when the patients thinks that this is best) is essentially a paternalistic prerogative to override a patient's considered judgment. There is no doubt of the benevolent intentions of doctors when they insist on denying this right to their patients. But it is also clear that here too, medical paternalism is alive and strong. (Hastening death raises many substantive and difficult issues, however, and we examine this issue at length in Chapter VII.)

Substituted Judgment Standard. Before the famous legal case of Karen Ann Quinlan, the right to refuse life-prolonging treatment was either based on the common law of battery, or respect for different religious beliefs. The Jehovah's Witnesses right to refuse life-saving blood transfusions is also based on religious freedom. The Quinlan case was new in that it involved a patient in a persistent vegetative state, and it thus raised clearly the issue of the rights of incompetent patients and surrogate decision making.²⁴ (The nature of persistent vegetative states is explained and examined in Chapter VI and the right to refuse life saving care is discussed in Chapter VII.) Since Quinlan was clearly incapable of making decisions, the court held that the "only practical way" to prevent the loss of the right of informed consent, and its corollary right of refusal, was to allow her guardian and family to decide "whether she would exercise it in these circumstances." This is now referred to as a "Substituted Judgment" and it is a *judgment of what the patient would choose, for her incompetent self, if competent*. The crucial question is "What would the patient want?" not "What do you want for the patient?" In some cases a patient has left a "living will" which is a document that allows them to state while they are still competent what they would prefer if they are ever incompetent. In most cases, however, we must rely on prior statements that suggest the patient's preferences, and the known values and principles of the patient. This standard thus

²⁴ Quinlan Case, New Jersey Supreme Court (1976)

presupposes that the patient was once competent and that we have a sense of what the patient would want. It is clearly not appropriate for patients that were never competent.²⁵

Best Interest Standard. In cases where the patient was never competent and in cases where we do not know what the patient would want, we must use the best interest standard instead. The *best interest standard* attempts to make an objective judgment of the net benefits and burdens of treatment or continued care. The question here becomes "*Is the care beneficial or harmful to the patient's overall interests?*" Judgments of an incompetent patient's best interest inescapably include "quality of life" judgments, but they still exclude any judgment of the "social worth" of the patient. A judgment of a patient's best interest is also supposed to exclude economic considerations. Thus the only clear basis for an objective judgment, of patients' best interest, is their pain and suffering. One clear problem with the best interest standard is that it is often really hard to judge the quality of life of incompetent patients. For an even clearer problem, what are the interests of a patient that is still alive but that lacks all conscious awareness? We often assume that we should just "err on the side of life" – But does continued biological life always have positive worth? (We return to this issue in Chapter VI.)

There are also interesting puzzles raised by the substituted judgment standard. Prior statements are often insufficiently reflective, informed, and much too general to specify a determinant outcome in a particular case. More importantly, what are we to say about cases where the prior preferences of the once competent patient do not necessarily reflect current interests of the now incompetent patient. The incompetent patient often simply does not have the interests and concerns that motivated the prior directive. This is likely in cases of significant dementia and permanent brain damage. As result, some have claimed that the standard of surrogate decision making should always be the best interests, the current and future welfare of the patient, and not past preferences that do not reflect the current person's interests.²⁶

This is a difficult problem that raises deep issues, but the best response to this legitimate concern is that the authority of the person's preference, when they were competent, derives from the person's prior status as an autonomous, responsible agent with moral values, principles and goals. We thus show *respect for persons* by honoring their autonomous and informed choices when they were competent. This response is simply an appeal to the principle of respect for autonomy. It thus takes clear sides on the issue of the priority of respect for autonomy over the value of beneficence. The problem is that, in a case where the person has forever lost competence, it is more plausible to maintain that beneficence, which is responsive to the current preferences of the now incompetent patient, makes more sense than respecting the past preferences of the patient when competent. There is no clear answer to these questions, and in practice these decisions are left in the hands of proxies and the medical team.

Family Consent. In hard cases involving incompetent patients, the family is usually the official proxy or surrogate. The focus on the family as surrogate decision makers for incompetent patients radically understates the more pervasive role of the family in all medical decision making. In common medical practice, however, the family

²⁵ See Buchanan "The Limits of Proxy Decision-Making"

²⁶ See Dresser and Robertson "Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach" in *Law, Medicine & Health* 17.3 (Fall 1989) pp. 234-44. For a response, see Rhoden "The Limits of Objectivity" *North Carolina Review* 68.5 (June 1990) pp. 845-65.

members are always included in the medical decision-making process. One of the curiosities of the contemporary discussions of medical ethics (in the West) is the scant attention that is given to the role of the family. In practice the patient is usually embedded in family relationships, and the medical discussions are often with family members as much as with the patient. In thinking about the deliberative process, it is not just the patient and the physician that need to be included; the patient's family is typically also involved in negotiating the patient's treatment. The individualism of Western medical ethics, which is so explicit in the literature of bioethics, does not in fact accurately reflect the ethical attitudes of patients and physicians or the clinical practice of medicine.

Furthermore, it is increasingly common knowledge that (in the United States at least) living wills directing withdrawal of care are routinely set aside when the family expresses a clear preference for continued care. In these cases, if the medical team agrees with the family, then they will follow the family's directive. But if the patient's prior directive seems more reasonable, the physician will negotiate with the family and try to get them to agree to the patient's prior directive. This process of negotiation is a particular explicit example of the deliberative model of shared decision-making outlined above – rarely is the family's preference simply ignored or dismissed out of hand. When family members are overridden by physicians, it is as a last step after much mediation. Here again the reality and rhetoric of patient autonomy come apart.

Another context in which the preferences of the autonomous individual are routinely overridden is in obtaining consent for organ donation. In the United States, even if a person has an organ donor card, organs are not harvested at death without the consent of relatives. If even one family member objects to organ donation, this is often sufficient to prevent donation. We see here again in practice a clear mismatch between the individualist, autonomy-focused orientation of biomedical ethics and the reality of medical practice. (In chapter VI, we explore in depth the issue of consent in organ donation) Of course people are embedded in relationships, and physicians respect these connections and give them significant weight. Unlike Western medical ethics, Confucian ethics emphasizes the centrality and importance of relationships.

30. Family Consent and the Confucian Paradigm

East Asian medical ethics, with its foundations in Confucian Ethics, is family-centered and tends to be paternalistic.²⁷ As a result, it is claimed, Asian models of the patient-physician relationship conflict with the Western autonomy-centered model of informed consent. There are two issues here: one is medical paternalism and the other is the role of family. First paternalism: it is noteworthy that the Asian arguments for medical paternalism are no different from the arguments for paternalism that, as recently as 1970, were widely accepted in the West too. The difference here is a substantive disagreement, not a cultural difference. For example, whether or not the disclosure of a diagnosis of cancer is directly harmful to the prognosis of the patient and thus contrary to medical benevolence is a substantive matter. As we have discussed, many factors and

²⁷ I would like to thank Ya-li Cong for discussions of Chinese medical ethics. For a more complete account, see her "Bioethics in China" in Peppin and Cherry, editors, *Annals of Bioethics: Regional Perspectives in Bioethics* (Swets & Zeitlinger, 2003). I have also benefited from Darryl Macer's "Japanese Bioethics" in the same volume.

reasons contributed to the move away from paternalistic approach to medicine. Some of the more important reasons were (i) the need for informed consent for cancer research on human subjects, (ii) the improved prognosis for the successful treatment of cancer, (iii) a better understanding of the dying process, and (iv) the empirical evidence that disclosure does not affect morbidity and mortality outcomes. In light of these factors (and others) the argument, from patient-harm for paternalistic non-disclosure, simply was not sustainable.

However, even with the recognition of an individual right to informed consent (and thus disclosure), the physician-patient relationship is not best understood on a narrow rights-based, autonomy model. We have seen that even when rights provide background conditions specifying the basic conditions of a relationship, a focus on rights often mischaracterizes the cooperative nature of the relationship. Patient and physician share a common goal: maintaining or restoring the patient's health, if possible, and, when the patient cannot be cured, the relief of suffering and a good death. In addition to a shared goal, like other relationships, the patient-physician relationship is one of distinct roles and responsibilities. The physicians bring to the relationship medical expertise and experience with disease, healing, and death. The patients bring a personal awareness of their symptoms, important information about their past, their medical and family history, their personal habits, and of course their values and preferences.

The patient depends on the physician as a medical expert, an authority, and this requires both knowledge (including continuing education) and the virtue of discernment in daily practice. In Asian bioethics, the art of medicine is often referred to as the "art of compassion." Compassion and care for patients is the core virtue of medicine. Patients, however, must trust physicians with their lives, and with deeply personal information. We expose ourselves to our physicians like no other person, and we do so because we trust them to respect our privacy by honoring the principle of confidentiality. To maintain this trust, physicians must scrupulously and conscientiously maintain their professional integrity. Most obviously, physicians should avoid conflicts of interest based either in economic incentives or professional ambitions. Knowledge and Discernment, Compassion, Trustworthiness, and Integrity are the core virtues of physicians, which we simply take for granted when we hand ourselves into their care.²⁸

Patients also must be honest with their physicians. It is imperative to fully disclose everything that may be relevant to one's condition. It is for the physician, and not the patient, to decide what is and what is not relevant, and thus all questions should be answered as fully as possible. The second responsibility of patients is compliance with the course of treatment. Physicians cannot help patients if patients are not willing to help themselves. Non-compliance of course hurts the patient most, but it also wastes precious medical resources, including the time of physicians that could have been spent caring for others. The patient should conscientiously follow the treatment decision, but the patient's preferences and values must also shape the treatment recommendation.

Assuming that we have a competent patient, the "deliberative model" of the patient-physician relationship is clearly the most appropriate (sect. 6). This is a model of shared decision making, which is increasingly popular with medical ethicists. Most models of shared medical decision making emphasize the "fact-value" division of labor between the

²⁸ See, for example, Beauchamp and Childress, *Principles of Biomedical Ethics*, 5th edition (Oxford, 2001); chapter 2 on "Moral Character," which discusses virtues and ideals in professional roles.

physician and patient.”²⁹ We turn to physicians for medical advice, and it is thus obvious that the physician is the source of medical information – the facts. But it is the patient’s own values that must direct and determine the decision about the course of treatment. There is clearly something to this idea but this division between facts and values, in the medical context, is really quite artificial.

First, if one has turned to medical expertise, it is clear that the value of health and avoiding suffering are obviously shared values. In practice, doctors routinely make recommendations based on straight-forward consideration about medical outcomes and the obvious goal of not being sick (or avoiding suffering). It is only in the more difficult cases, with differential treatment options, each with distinct risks of side-effects, that more subtle value considerations are necessary. Second, ideally physicians do know their patient’s basic values, and thus they can still make recommendations that are most likely to reflect their particular values. Physicians do not, and should not, just give medical facts and let their patients decide. They must make specific recommendations and patients would be surprised indeed if they did not.

Third, and most importantly, when a patient is first confronted with a medical crisis, they often simply do not know what they want to do. When facing a novel situation, physicians should help guide their patients in thinking through the medical options and thereby also help them form their distinctly medical values. It is not as if we come to a serious medical decision with clear pre-formed preferences about medical outcomes and risks. We don’t know what it is like to endure various types of available treatments, we don’t know how to weigh the risks, and we don’t know how we will react to various forms of treatment and disability. Furthermore, it is a commonplace that how alternatives are presented (framing) shapes judgments of risk and benefit; for example, even competent people have irrational fears of surgery and post surgical pain. Physicians will inevitably frame choices in ways that they believe are in the best interest of patients. Nothing is gained by denying this, and it is in fact much better to face these obvious facts head on.

Of course, physician should not force patients to endure treatments that they steadfastly reject. When the deliberation has come to an end, they ought to defer to the patient’s judgment. But doctors will, and they should, share the wisdom of their experience -- especially when it involves their judgments of our best interests. What they should conscientiously avoid is imposing their own preferences, and especially their moral or religious values on to their patients. Although this is sometimes a fine and difficult line to draw, it is the ideal to be aimed for -- and it involves nothing less than the art of compassion.

The ideology of autonomy, understood as radical individualism and independent self-determination is unrealistic, and it does not reflect medical practice in the East or West. The ideology of the authoritarian paternalistic physician dispensing medical orders to passive and uninformed patients is equally misguided. The medical relationship should reflect the nature of the relationship itself and to do so is to recognize and embrace a deliberative model of shared decision-making. Patients should respect the physician’s medical authority and experience. Physicians should be responsive to the values of the

²⁹ See Ezekiel J. and Linda L Emanuel, “Four Models of the Physician Patient Relationship” in the *Journal of the American Medical Association* 267, no 16, April 1992: 2221-26. Also see our discussion, Chapter II, section 5.

individual patient, but should also help them choose sensibly when faced with novel and difficult decisions of life, death, and disability. Respect for autonomy does not mean simply deferring to superficial initial preference of patients. If autonomy is worthy of respect it requires at least a rational, informed and reasoned, self-determination. When facing illness, disability, and mortality, a patient may need a caring physician to guide them through. The ideal physician does much more than provide the medical facts and leave the decision to be made by a scared and vulnerable patient.

The second element of Confucian bioethics is its family-centered conception of informed consent. One of the problems with Western medical ethics is the absence of the family from the center of the discussion. We have the individual patient, the physician, and society as the prime players. In reality, we have the patient and family, the physician and medical team, and an extending web of social relations that includes day to day associates, the insurance pool and distant strangers. The individualized model of physician and patient bears little resemblance to the medical reality with its interdependent and interconnected web of relationships. The Confucian relational model more accurately reflects the complex social dynamic of medical ethics. As part of the medical team, we have the attending physician, nursing staff, consulting physicians, medical specialists, psychiatric consultants, social workers, staff clergy, risk management staff, and perhaps medical ethics staff. On the patient side, we have the central role of the family in medical decision-making. If a family member is at hand, they are inevitably and naturally part of the medical discussion and decision making. We have husbands and wives and domestic partners, the parents of an adult son or daughter, the adult son or daughter of a parent, as well as siblings, cousins, and even close friends, filling the waiting rooms and sitting with patients.

The real difference is that in countries like China this reality is more clearly acknowledged, and more importantly the families themselves are often more clearly structured and defined. It is common in China, for example, to inform the family of the patient's condition prior to informing the patient. The family will then inform the patient ideally with the physician standing by to answer questions or clarify any misunderstanding. How and when and how much information is disclosed is left to the discretion of the family, not the physician. Patients, however, are aware of these practices and tacitly consent to them. Indeed, in the case of a close family it would be disruptive to treat the family as if they were mere outsiders. In the West too we adjust and respond to the clear expectations of our patients. A husband or wife is fully included in medical discussions with a patient, and is often informed first of the patient's condition. This is taken for granted and not even much noticed. The difference is not one of basic principle; it is simply a matter of different family structures and differential patient expectations. Given the cultural expectations, we would not have a disagreement of principle unless the patient objected to the common practice and requested privacy or confidentiality. The autonomy model of informed consent can fully accommodate a family-centered culture, as long as the individual family members accept their particular roles in the family.

Some might object, that as a result of the cultural expectations, there is no real opportunity to dissent and thus there is not really meaningful tacit consent. The extent to which one accepts rather than simply being trapped in a family role is hard to tell. But this is equally true of family dynamics everywhere. The more important question is

whether the dynamic of family-based decision-making indeed helps the patient who is facing serious illness and perhaps death. Informed consent is supposed to protect the interests and values of patients. As long as family-based medical decision-making respects the patient's interests and deeper values, it is indeed only a Western fetishism of individualism that would reject the aid and comfort of loved ones.

We need to distinguish, however, individualism and patient rights. Patient's rights are an important check on the power of physicians. This is most clearly the case in medical research but also when the physician is fulfilling the dual roles of physician and researcher (sect. 3). Here the clear and explicit rights of research subjects have proved necessary to protect the interests of patients. In addition, although we recognize that the ideal physician-patient relationship is not captured by rights talk; rights are still relevant when the interests of the parties in a relationship come apart. A simple and commonplace example may help here. Consider this recent example of physician indifference and the power of patient's rights to redirect a doctor's attention:

Gloria Erlich saw a neurosurgeon for back pain. He told Mrs. Erlich she needed a myelogram, a scan of the spine that requires a spinal tap to inject dye into the spinal cord. She told him that she had had one, at his request, just a few months before and that the films should have been with her medical records. But the doctor said he could not locate them and asked her to have another one. Months went by, with the doctor telling Mrs. Erlich he could do nothing for her without a myelogram and her saying she had had one and asking why he could not just find it. Finally, she said that perhaps she should contact a lawyer. "Within half an hour, they found it," she said. "It was irretrievable until I said the word 'lawyer.'"³⁰

Contemporary Confucian skepticism about patient rights seems to assume that all physicians will live up to the Confucian ideal. In the day to day bustle of medicine, however, patient's interests and physician's attention can all too easily come apart. When they do come apart, the enforceable legal rights of patients are a powerful tool for restoring a healthy relationship. If the Western autonomy-based medical ethic is too individualistic and ignores the complex structure of relationships, the rejection of patient's rights is too communitarian and ignores the power structure in relationships. What is needed is more of a balance with responsibilities founded on relationships and rights that respect each person in the relationship.

31. Professional Ethics and the Muslim Patient

Although most of medical decisions facing a Muslim patient are similar to any other patient, the basic approach of Islamic medical ethics is focused on the Sharia and is thus different in important ways from the Western rights-based orientation. In the modern pluralistic world, the non-Muslim physician should be aware of the basic values and principles that shape Islamic medical ethics. Some issues will inevitably be more difficult for the non-Muslim physician. Clearly, when it comes to medical questions associated with the Ramadan fast or medical fitness for the Haaj, the personal experiences and more intimate knowledge of Islam of the Muslim physician will surely be a benefit to Muslim patients. In addition, there is a commonality of values and

³⁰ "When the Doctor Is in, but You Wish He Weren't" Health Section, *New York Times*, November 30, 2005.

concerns typically shared by Muslims that facilitate the patient-physician relationship. For these reasons Muslim patients prefer Muslim physicians, but when this is not possible the non-Muslim physician can still have a basic understanding of Sharia principles (see chapter II) and the particular concerns of Muslim patients.

In addition to the five Pillars of Islam that shape day to day life, a significant feature of some Muslim cultures is the seclusion of women, or if not seclusion, at least a clear separation between women and men. As a rule, a Muslim patient will always prefer a Muslim physician, because a Muslim physician will have a better understanding of the Islamic worldview, and the Sharia, and so this preference is entirely reasonable. The strictness of gender roles in Islam, however, complicates this preference. Although there is a preference for a Muslim physician, it is more important to have a same sex physician than it is to have a Muslim physician. So the first choice is a same sex Muslim physician, and the second choice is for a same sex non-Muslim physician. The third choice would be for an opposite sex Muslim physician, and last an opposite sex non-Muslim physician.

Female patients are extremely reluctant to disrobe and be examined by a male physician. It is hard to overestimate the clinical significance of this reluctance. In many traditional Muslim societies there are very few women doctors and so this reluctance in practice is a barrier to access to timely medical care. The presence of female nurses and assistants can help significantly in mitigating this problem. If other women are present, and assisting with the examination, the situation is less troubling and less embarrassing for the patient. In general, embarrassment is a significant barrier to an open clinical consultation. It is more difficult for the patient to relax and speak freely during the medical history, to talk about any medical problems, and to hear the physician's recommendations. These problems will be especially acute when it comes to gynecological exams, sexually transmitted diseases, and breast exams. As a result many core medical issues may simply go untreated.

An additional complication, in some Islamic countries and cultures, the husband must consent before his wife can be treated by a physician. Even in countries where the husband's consent is not *officially* required, the woman is often *expected* to get the consent of her husband or her mother-in-law. In addition, many women must rely on their husbands to finance medical care. These are all additional barriers to women's access to health care, and they also often will limit a woman's ability to speak confidentially with her physician.³¹ Muslim physicians are supposed to keep extremely

³¹ I would like to thank Alexandra Battestin for her research assistance on this issue.

For more information on Muslim women and health care, see the following sources:

- Bahar, Zuhail, Hale Okcay, Seyda Ozbicakci, Ayse Beser, Besti Ustun and Meryen Ozturk (2005). *The Effects of Islam and Traditional Practices on Women's Health and Reproduction. Nursing Ethics* 12 (6) 557-570.
- Elnekave, Eldad and Revital Gross (2004). *The healthcare experiences of Arab Israeli women in a reformed healthcare system. Health Policy* 69(1) 101-116.
- Hampshire, Kate (2002). *Networks of nomads: negotiating access to health resources among pastoralist women in Chad. Social Science & Medicine* 54(7) 1025-1037.
- Hedayat, Kayar M. and Roya Pirzadeh (2001). *Issues in Islamic Biomedical Ethics: A Primer for the Pediatrician. Pediatrics* 108(4) 965-971.
- Lawrence, Paul and Cathy Rozmus (2001) *Culturally Sensitive Care of the Muslim Patient. Journal of Transcultural Nursing* 12(3) 228-233.
- Mernissi, Fatima (1987). *Beyond the Veil: Male-Female Dynamics in Modern Muslim Society.* Indianapolis: Indiana University Press.

high standards of patient confidentiality, and so the issue here is not so much principles of medical ethics but the reality of medical practice. These practical issues are rooted in cultural realities that involve the gender roles of traditional societies -- and there are thus no easy solutions.

Since gender roles involve deep seated cultural pattern, these issues are not easy to address. Clearly, an awareness of the situation is only a small first step. At present much can be accomplished by training more female Muslim doctors and nurses. This major structural change, however, does not provide any immediate clinical solution in predominately non-Muslim countries. A more immediate and practical solution is for non-Muslim female doctors and nurses to explicitly welcome Muslim women into their practices and also developing a rudimentary understanding of the Sharia and Islamic medical ethics. Indeed, all doctors and nurses that serve Muslim patients should have at least a basic understanding of Islam.

On the most basic level, morality for a Muslim involves submission to God, and not an assertion of autonomy and individuality. In Western philosophy, Kant emphasized that the autonomy of the will is the source of morality and the basis of human dignity. For Kant enlightenment simply involves thinking for oneself about moral matters rather than deference to authority, which Kant describes as a self-imposed immaturity. John Stuart Mill, arguing from a utilitarian framework, emphasizes the value of individuality

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- Roberts, Kimberly S. (2003). *Providing Culturally Sensitive Care to the Childbearing Islamic Family: Part II. Advances in Neonatal Care* 3(5) 250-255.

It is also important to realize that the status of women in Islamic societies is based more on tradition and some controversial Hadith than on the Quran. As we saw in Chapter II in the discussion of the prohibition on images of Muhammad, tradition can take on a life of its own with little basis in Sharia. Many scholars defending a more progressive role for women in Islam argue that patriarchal traditions, which preceded Islam, have kidnapped what was a much more egalitarian tradition in the original Islamic community. It is noteworthy here that Muhammad's first wife was an older business woman, and that she proposed to him and he worked for her. Muhammad's daughter Fatima was a public figure and an important early transmitter of the Hadith, and his young wife Aisha was also a significant public figure in the early community. Muhammad's great granddaughter is famous for insisting, in her marriage contract, on the fidelity and monogamy of her husband. These women provide clear examples from Muhammad's family that do not fit the model of seclusion and exclusion from the public sphere that have since come to characterize Islamic gender relations.

On these issues, see the following sources:

- Ahmed, Leila (1992). *Women and Gender in Islam: Historical Roots of a Modern Debate*. New Haven: Yale.
- Barlas, Asma (2002). "Believing Women" in *Islam: Unreading Patriarchal Interpretations of the Qur'an*. University of Texas: Austin.
- Haneef, Suzanne (1996). *What Everyone Should Know About Islam and Muslims*. Library of Islam: Chicago.
- Hassan, Riffat (1995). *The Development of Feminist Theology as a Means of Combating Injustice Toward Women in Muslim Communities/Culture*. *European Judaism* 28 (2).
- Hassan, Riffat. <http://www.religiousconsultation.org/hassan.htm>.
- Rahman, Fazlur (1968). *Islam*. Garden City, New York: Doubleday and Co.
- Ruthven, Malise (1997). *Islam: A Very Short Introduction*. Oxford: New York.
- Sechzer, Jeri Altneu (2004). "Islam and Woman: Where Tradition Meets Modernity": *History and Interpretations of Islamic Women's Status*. *Sex Roles* 51 (5-6).

Other non-Islamic practices that are now associated in the public mind with Islam include the immoral practices of "honor killings," which has tribal roots but which is soundly rejected by Sharia scholars, and female circumcision and genital mutilation.

and argues for the broadest possible freedom of action and of thought limited only by the principle that one limit one's action so as that one does not directly harm other people. This focus on the sovereignty of the individual is a distinctive and important feature of the western approach to ethics, and it has thoroughly permeated Western medical ethics with its focus on respect for autonomy, individual rights, and informed consent. In discussing Confucian ethics, we have already recognized both the limits and the strengths of an emphasis on individual rights (chapter III and section ?? above).

The Muslim patient also is likely to frame problems with more of a concern for relationships, family, and community, and physicians should recognize and honor this orientation. A family autonomy model is also common feature of many Islamic cultures. On the other hand, the values of compassion and non-malificence (that is, not harming) are common across cultures, and provide a shared basis for moral reflection. In addition, Islam recognizes the dignity of persons and the sanctity of human life, even if it does not base this sanctity on the autonomy of the will. There is thus much clear common ground for thinking about medical issues and problems. Indeed, a non-Muslim physician can respect the principles of informed consent, family autonomy, and shared decision-making, with a Muslim patient simply by better understanding the way in which the Quran and Islamic Sharia tradition shape and frame moral problems, and thus medical ethics (chapter II).

One last point is worth emphasizing. Although Islam emphasizes submission to God and also that God is the source of all that happens, of all life and all death, this is not taken to imply a fatalistic attitude towards life and death. Although disease may be a deserved, or even a scourge inflicted on man, in facing disease and hardship generally, we are to use *our best judgment and all of our skills and strength* in facing adversity. As Muhammad put it, "trust in God but tether your camel first." Trust in God does not mean that one neglects one's affairs or fails to take responsibility for one's action. On this matter, consider the following story making light of a fatalist attitude towards ethical action.

"al-Ash'ari tells of a man, Shu'ayb, who owed money to his friend Maymun.

However, when Maymun told him to pay up, Shu'ayb responded, "If God had willed it, then I could not have done otherwise!"³²

This example nicely captures the *fallacy of fatalism*: it robs humankind of responsibility for our own actions, makes every action God's will not man's, and thus contradicts the very idea of obedience to God which is the heart and soul of Islam. At the most basic level, Islam presupposes that *human responsibility is compatible with divine providence*. Similarly, that nothing is born or dies without God's consent does not mean that we should not act in ways that tend to preserve our lives. It also does not mean that we should avoid death at all costs, rather than facing death bravely if this is the right thing to do in some circumstance (see section 48). In each case, we must decide what seems right and reasonable in the circumstance and act accordingly. When it comes to medicine in particular, Muhammad tells us that *there is no illness for which there is no cure, except death itself*, and so for every disease we should seek a cure. So, at the most basic level, the Islamic ethic of medicine strives to cure all disease but also accepts the inescapable reality of death. This basic attitude has broad and widespread appeal to all of humanity.

³² Jonathan E. Brockopp "Taking and Saving Life: The Islamic Context" in *Islamic Ethics of Life* edited by Brockopp (University of South Carolina Press, 2003); p. 13.

Case Study:

Refusing Care, Shared Decision-making, and Family Consent

Mr. A, a 60 year-old-man with severe peripheral vascular disease, needs a jejunostomy feeding tube because of his inability to eat following a below-the-knee amputation. As a result of multiple cerebrovascular accidents, he has a right hemiparesis and an expressive aphasia. Because of difficulty swallowing, he has problems with chronic aspiration and has been hospitalized multiple times for treatment of pneumonia.

During the current hospital admission, he has refused medications and has “given up” trying to eat. He indicates with difficulty that he “only want to die.” He refuses to discuss treatment, beyond saying that he does not want surgery and wants to die.

Is he competent to refuse therapy?

Surrogate Decision-Making: Mr. A’s wife appears tearful and confused about the medical issues. She is unwilling to sign a consent form for the surgery, saying that she does not want to go “against” her husband’s wishes. His daughter, on the other hand, insists that surgery proceed and, at the request of the surgeon, has signed a consent form. The surgeon reports to you that he or she has obtained a valid consent for the procedure and demands that you proceed.

Consultation: You decide not to proceed until the issues are clarified, and you request a competency evaluation for the patient. The consultant returns the opinion that the patient is probably not competent, based on the presence of severe impairment from organic brain disease and both receptive and expressive aphasia.

The daughter insists that surgery proceed, and the wife still refuses to sign the consent. Both present conflicting perspective on “what the patient would want.” The surgeon wonders why you are holding up the surgery, since you now know the patient is probably incompetent and the surgeon has a signed consent from a surrogate.

What should you do?

Appendix A

Codes of Medical Ethics

Hippocratic Oath

American Medical Association Codes 1957, 1980, 2001

Singapore Medical Association

Japan Medical Association

Indian Medical Association

Hippocratic Oath

I swear by Apollo Physician, by Asclepius, by Health, by Heal-all, and by all the Gods and Goddesses, making them witnesses, that I will carry out, according to my ability and judgment, this oath and this indenture.

To regard my teacher in this art as equal to my parents; to make him partner

in my livelihood, and when he is in need of money to share mine with him, to consider his offspring equal to my brothers; to teach them this art; if they require to learn it, without fee or indenture; and to impart precept, oral instruction, and all the other learning, to my sons, to the sons of my teacher, and to pupils who have signed the indenture and sworn obedience to the physicians' Law, but to none other. *I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them.* I will not give poison to anyone though asked to do so, nor will I suggest such a plan. Similarly I will not give a pessary to a woman to cause abortion. But in purity and in holiness, I will guard my life and my art. I will not use the knife on sufferers from stone, but I will give place to such as are craftsmen therein.

Into whatsoever houses I enter, I will do so to help the sick, keeping myself free from all intentional wrong-doing and harm, especially from fornication with woman or man, bond or free.

Whatsoever in the course of practice I see or hear (or even outside my practice in social intercourse) that ought never to be published abroad, I will not divulge, but will consider such things to be holy secrets.

Now if I keep this oath and break it not, may I enjoy honor, in my life and art, among all men for all time; but if I transgress and forswear myself, may the opposite befall me.

The clauses in italics are the core of what is considered to be the Hippocratic tradition, and I will sum up these principles as the imperative “to help but above all not to harm one’s patients.” Obviously the prohibition on surgery is especially dated but some physicians still appeal to the prohibition on giving out poisons and on abortion. I am unaware of any general contemporary Hippocratic movement to teach medicine for free, or to share one’s money with one’s teachers when they are in need, and to treat one’s teacher as a father. These aspects of the Oath reflect the cult-like aspects of the Hippocratics.

American Medical Association (AMA) Codes

AMA Principles of Medical Ethics, 1957

Preamble These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1 The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2 Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3 A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4 The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5 A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his service only after giving adequate notice. He should not solicit patients.

Section 6 A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7 In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8 A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9 A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10 The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

AMA Principles of Medical Ethics, 1980

Preamble The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct that define the essentials of honorable behavior for the physician.

Principles of Medical Ethics

- I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

- II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
- III. A physician shall respect the law and recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
- V. A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talent of other health professionals when indicated.
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
- VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

AMA Principles of Medical Ethics, 2001

Preamble The Medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

Principles of Medical Ethics

- I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
- II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
- V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
- VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
- VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
- IX. A physician shall support access to medical care for all people.

Singapore Medical Association, Physician's Pledge

I solemnly pledge to:

- Dedicate my life to the service of humanity;
- Give due gratitude to my teachers;
- Practice my profession with conscience and dignity;
- Make the health of my patients my first consideration;
- Respect the secrets which are confided in me;
- Uphold the honor and noble traditions of the medical profession;
- Respect my colleagues as brothers and sisters;
- Not allow the considerations of race, religion, nationality or social standing to intervene between my duty and my patient;
- Maintain due respect for human life;
- Use medical knowledge in accordance with the laws of humanity;
- Comply with the provisions of the Ethical Code; and
- Constantly strive to add to my knowledge and skill.

I make these promises solemnly, freely and upon my honor.

Japan Medical Association, Principles of Medical Ethics, 2005

The mission of medical science and health care is to cure diseases, to maintain and promote the health of the people; and based on an awareness of the importance of this mission, the physician should serve society with a basic love for humanity.

- I. The physician should strive to achieve a lifelong dedication to continuing education, to keep abreast of medical knowledge and technology, and to support its progress and development.
- II. The physician should be aware of the dignity and responsibility of his/her occupation and strive to enhance his/her cultural refinement, education, and integrity.
- III. The physician should respect the individuality of his/her patients, treat them with compassion, provide full explanations of all medical treatment, and endeavor to earn the trust of the patient.
- IV. The physician should maintain respect for his/her fellow physician, cooperate with medical care personnel and serve the cause of medical care to the best of his/her abilities.

- V. The physician should respect the spirit of public service that characterizes health care, contribute to the development of society while abiding by legal standards and establishing legal order.
- VI. The physician will not engage in medical activities for profit-making motives.

Indian Medical Association (IMA), Physician's Oath

At the time of registration, each applicant shall be given a copy of the following declaration by the Registrar concerned and the applicant shall read and agree to abide by the same:

- I solemnly pledge myself to consecrate my life to service of humanity.
- Even under threat, I will not use my medical knowledge contrary to the laws of Humanity.
- I will maintain the utmost respect for human life from the time of conception.
- I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient.
- I will practice my profession with conscience and dignity.
- The health of my patient will be my first consideration.
- I will respect the secrets which are confined in me.
- I will give to my teachers the respect and gratitude which is their due.
- I will maintain by all means in my power, the honor and noble traditions of medical profession.
- I will treat my colleagues with all respect and dignity.
- I shall abide by the code of medical ethics as enunciated in the Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations 2002.
- I make these promises solemnly, freely and upon my honor.