Hypothesis: Clinical ethics is grounded in the belief that medicine is an inherently moral enterprise. Sick persons ask physicians to help them get better and physicians profess to be morally committed and technically competent to help the sick.

Data Sources: MEDLINE literature search and review of published works on medical ethics, and the references cited therein.

Study Selection: Critical studies containing supporting evidence were selected.

Data Synthesis: The central ethical aspects of modern medical practice are clinical competence, respect for patients and their health care decisions, and maintaining the primacy of patient’s need in the face of external pressure in a changing social, economic, and political climate. There is a need to teach both the cognitive and behavioral aspects of ethics. Development of these skills, in turn, depends on the character of the physician who will be applying these skills.

Conclusions: The outcome of patient care can be improved by efforts made to secure informed consent of the patient. This also helps avoid ethical conflicts, confusion, and misunderstanding between patients and physicians. Clinical ethics should be an integral part of medical education at all levels in medical school, in the residency, and in continuing education.


Attention to ethical issues in clinical medicine has increased in recent years as a result of profound changes both in medicine and society. Among the many factors causing the increased prominence of ethics in medicine are an unprecedented growth in scientific knowledge, expansion in the availability and efficacy of medical technologies, a more equal relationship between patients and physicians, new organizational arrangements in the provision of services, and increased pressure to contain spiraling costs.

Professions are as characteristic of the modern world as the crafts were of the ancient time and the professions have been studied for years by sociologists, the public, and professionals themselves. Professions are avocations subject to theoretical analysis, and the conclusions from the analysis modify the activities of the profession. This kind of analysis and its influence on the activities of the profession differentiates a profession from an avocation or occupation. Professions arise because of increasing specialization. Objective standards of competence such as licensing, certification, and the growth of service ethic are additional requirements of a profession. Ethical codes are the major characteristic that differentiates profession from occupation. Sustaining a code of ethics as the profession matures further distinguishes a profession.

Ethics is a branch of philosophy that examines rights and wrongs, what should or ought to be done. Dunstan et al defined clinical ethics as “the obligations of moral nature which govern the practice of medicine.”

Clinical ethics refers to application of the science and understanding of morality in the field of medicine and health sciences. The goal of clinical ethics is to improve the quality of patient care. Ethics is central to clinical medicine for 2 reasons: first, ethical considerations cannot be avoided when physicians and patients must choose what ought to be done from among the many things that can be done for a patient in a particular clinical situation, and, second, the concept of good clinical medicine implies that both technical and ethical considerations are taken into account.

The oldest (more than 2500 years old) medical code is Hippocratic Corpus, otherwise known as the Hippocratic oath, which contains several elements, emphasizing the commitment to the well-being of patients. The medical ethics that has developed over the centuries has been altered by religion, social change, and behavior of physicians and patients. An additional and newer influence on medical ethics is the human rights move-
ment. A fundamental concept of the human rights movement is that the decisions are made autonomously by informed patients. Human rights are a dominant force in the society and have substantial, positive implications for health care and medical ethics.

The American Medical Association (AMA) formulated an ethics code in 1847. The American Medical Association's code has undergone many revisions since that time, the most recent in 1998. A significant change in recent versions has been broadening the code beyond the Hippocratic commitment to exclusively benefit the patient. The recent versions include responsibility for the interest of the society, physician rights, and duties and benefits in addition to basic principles of standards of conduct for the "essentials of honorable behavior for the physician."

The founders of the American College of Surgeons, Chicago, Ill, strongly emphasized the fellowship pledge. It was suggested that technically able but unethical surgeons should not be admitted to membership. For several decades, the American College of Surgeon's central judiciary committee has diligently maintained oversight of standards and discipline. The Board of Regents has published several statements on positions deemed proper for the ethical practice of surgery. The fellowship pledge of the American College of Surgeons states "I pledge myself to pursue the practice of surgery with honesty and to place the welfare and rights of the patient above all else." Faithful adherence to such a pledge will do more to maintain the reputation of our profession than many pages of philosophical thought.

In 1997, the Senate of Surgery of Great Britain and Ireland published a short guide to medical ethics and law entitled The Surgeon's Duty of Care. The document has general and specific guidelines. As with most modern consensus statements on the ethics of medicine, it emphasizes patients' rights. Similarly, the Council of Medical Specialty Societies in the United States has recently developed a consensus statement on the ethics of medicine. This document addresses the dilemma all physicians are facing in balancing the primacy of the patient responsibility with constraints of managed care and community-based health care.

Clinical ethics is grounded in the belief that medicine is an inherently moral enterprise. Sick persons ask physicians to help them get better and physicians profess to be morally committed and technically competent to help the sick. This moral structure is revealed in the process of physician-patient accommodation, wherein a joint decision is reached that a patient places his or her care in the physician's hands and the physician affirms his or her ability to care for the patient.

There are several principles of ethics currently embraced by the medical profession. These include autonomy, beneficence, fidelity, justice, and utility. Autonomy refers to respect for a person's self-determination, allowing to a patient's wishes regarding treatment choice. Beneficence means doing good to patients. Fidelity emphasizes faithfulness to a physician's duties and obligations. Justice dictates that a physician's decision on patient treatment is made fairly and impartially. Utility implies that physician's actions should yield good results, achieving maximum benefits for the patients without wasting resources.

TEACHING OF CLINICAL ETHICS

The principal goal of teaching clinical ethics is to improve the quality of patient care in terms of both the process and outcome of care. The necessity for the teaching of clinical ethics rests in the fact that any serious decision making involves 2 components—a technical decision requiring the application of knowledge of basic and clinical sciences to the patient's present problems, and a moral component demanding that the technically correct decision is also morally defensible. The technical component tells us what can be done, the moral component, what ought to be done for the patient. The intermingling of the technical and moral dimensions in medical decisions puts emphasis on shared decision making; that is, on making decisions with, as well as for, the patient.

Because clinical ethics is so essential to medical practice, it should be an integral part of medical education at all levels in medical school, in the residency, and in continuing education. During the past 2 decades, clinical ethics teaching and research programs have developed. Most medical schools in North America offer preclinical courses in medical ethics, several have programs during clinical years, and some offer postgraduate training. Published reports of both analytical and clinical research in medical ethics are increasingly common.

In Tomorrow's Doctors, Britain's General Medical Council initiated a reform in medical education. One aspect of this reform is that medical ethics and law should constitute one of the core components of the medical curriculum. Thus, all medical students should acquire knowledge and understanding of "ethical and legal issues relevant to the practice of medicine" and an ability "to understand and analyze ethical problems so as to enable patients, their families, society, and the physician to have proper regard to such problems in reaching decisions." Teachers of medical ethics and law in medical schools throughout the United Kingdom have proposed a minimal core undergraduate program of work that they believe to be consistent with the stated objective of the General Medical Council. The consensus statement outlines a core list of topics under 12 themes: informed consent and refusal of treatment; the clinical relationship, meaning truthfulness, trust, and good communication; confidentiality and good clinical practice; medical research; human reproduction; the "new genetics"; children; mental disorders and disabilities; life, death, dying, and killing; vulnerabilities created by the duties of physicians and medical students; resource allocation; and rights.

The general requirements of The American Medical Association's Accreditation Council for Graduate Medical Education specifically require all residency programs to include education in medical ethics. However, most residencies in general surgery do not include ethics instruction as part of their ongoing, regular education schedule. It is clear that both cognitive and behavioral aspects of ethics have to be taught. These in turn depend on the character of the physician who will be applying these ethical skills. The cognitive aspects of teach-
COGNITIVE SKILLS

The necessary and teachable cognitive skills include recognition and definition of the ethical issue or problem; identification of the principles, duties, or obligations involved; clarification of real or potential conflicts among principles and ways of resolving such conflicts; and attainment of a moral choice. Also needed are the skills to identify the possible objections and the reasons for them and to formulate counterarguments and modify the decision on the basis of these considerations, if necessary. There is an orderly way to work up an ethical problem, just as there is an orderly way to make a differential diagnosis and select a method of management. The process of analysis of a clinical ethical dilemma is as orderly as the process of clinical evaluation and it can be readily taught. Students will need some familiarity with the research methodology in the emerging field of clinical ethics.

BEHAVIORAL SKILLS

To be effective in caring for patients, clinicians must have the behavioral skills that are necessary to put their knowledge to work. A physician who knows the legal and ethical requirements of writing an order not to attempt resuscitation would be expected to know how and when to approach patients and families in a thoughtful and sensitive way and initiate discussions about do not attempt to resuscitate status. Instruction in the behavioral skills of clinical ethics requires teaching and role modeling by experienced clinicians who can demonstrate the skills in practice. Students should have the opportunity to practice these skills under supervision of experienced clinicians. Surgeons are potent role models for junior health care professionals. Thus, it is important that the surgeons effectively model the behavioral skills of clinical ethics.

CHARACTER DEVELOPMENT

Ethics require that a physician be a person of character, one who can be expected habitually to act in a patient’s best interest when no one is watching. Trust is essential in the healing relationship. The values or principles physicians choose, the theory of ethics they espouse, and the way they interpret the relationship with the patient will shape the ethical decisions they make.

For medical students, residents, and fellows, clinical ethics can best be taught in the same way as clinical medicine—by supervised experience, increased responsibility, and discussion in rounds. Medical practitioners who had courses in medical ethics perceive themselves better prepared to deal with the ethical choices they need to make in their daily practice. They also appreciate the need to update themselves in medical ethics.

Many hospitals now have ethics committees. Ethics committees can serve several functions: they can educate staff, set institutional policy, provide a mechanism for the review and resolution of cases involving conflicts, and influence patient care decision making. Ethical committees could improve clinical-ethical decision making by educating the hospital staff and by developing rational and sensitive institutional policy on ethical matters, such as brain death, do not attempt to resuscitate orders, and organ transplantation. The committees could also provide real-life assistance to physicians in practice.

Sound ethical analysis in clinical settings relies on a foundation of trust between the patient and physician. Crucial components in the analysis of any ethical issue include an understanding by both parties of medical and scientific facts, the preferences, values, and goals of both the physician and the patient, and external constraints such as cost and limited resources. Defining medical indication is definitely the physician’s domain. The physician’s obligation based on training, experience, knowledge, and judgment is to suggest diagnostic procedures and treatment options as well as a preferred treatment choice. Patient preferences represent emphasis on free patient choice and the legal doctrine of informed consent. In the past, medical indications and patient preferences generally determined the outcome and the decision that was reached by the patient and the physician. In recent years, however, external factors are influencing the decisions.

Clinical Competence

Clinical practice has always been a unique blend of technical proficiency and ethical sensitivity, which together constitute the clinician’s art. The physician’s relationship to the patient is based on specific technical training and competency, which is used to cure or relieve patients’ illnesses or diseases and to help them in overcoming fear, pain, and suffering. The physician becomes involved in the patient’s problem. Physicians are personally accountable to their patients.

Respect for Patients’ Health Care Decisions

In recent decades, the relationship between patients and physicians have been evolving from one characterized by paternalism, in which physicians made decisions for patients according to their professional values, to a more equal relationship of shared decision making, in which physicians provide information that allows competent adult patients to make their own choices, referred to as “informed consent.” Informed consent has 4 key components: disclosure, competency, comprehension, and voluntaries.

Disclosure means the physician tells the patient about the diagnosis, prognosis, risks, and benefits associated with possible treatment options. Patients are entitled to enough information to enable them to ask reasonable questions about their options. Competency means that the patient is able to understand relevant information, appreciate his
or her needs and values, use information rationally, and make treatment choices. Comprehension refers to the requirement that patients understand the information that is given to them and that physicians make a reasonable effort to enable them to do so. Voluntaries means that the patient chooses freely without coercion.

Informed consent does not refer to a patient’s signature on a consent form. It is a process of continuous communication and dialogue between the physician and the patient. The outcome of care can be improved by efforts made to secure consent. Empowering patients to participate in decision making has been associated with beneficial outcomes in many chronic diseases. Compliance is improved by informing patients about their options and maintaining open and full communication with them. 30

Maintaining the Primary of Patients’ Needs

Escalating and uncontrollable health costs are enforcing health care reform. The goals of providing universal access to high-quality and cost-effective health care could be achieved by reducing administrative costs, using outcome data to rationalize services, and developing clinical guidelines. To reduce costs, it may be necessary to restrict services with marginal benefits; it may also require some restriction on both the patients' and physicians’ freedom of choice to make individual clinical decisions.

FUTURE TRENDS

There are now new ethical issues arising in different areas; eg, in the rapidly expanding area of palliative care, reproductive biology, gene therapy, genetic engineering, etc. The future direction of clinical ethics will be shaped by the sociocultural forces, medical technology revolution, growing concept of patient autonomy, and litigious spirit of the time. Areas in which clinical ethics will play an important role in the future include biomedical technology research, especially related to genetic engineering, reproductive biology, and gene therapy; development and maturation of the professional discipline; resource allocation for health policy planning, finances, and human resources; goals; priority setting; public education about patients’ rights and responsibility; concepts of biomedical ethics to avoid ethical conflicts, confusion, and misunderstanding between patients and physicians; and remodeling of the physician-patient relationships with a gradual shift from traditional paternalism to a patient-centered model.

Biomedical ethics has focused largely on the individual patient in an acute medical episode. In the future, it must also take the perspective of preventive and public health medicine. Strategies for public education must be developed. It must provide data and analyses on which public policy can be based, and provide mechanisms for public participation. Preventing ethical conflict, confusion, and misunderstanding is similar to preventing or containing chronic illnesses. Preventive ethics is less expensive, more effective, and less traumatic emotionally than litigation or misunderstanding between physicians, patients, and families. 37

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