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In Shortly about Medical and Health Ethics

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Research Article

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Abstract: Medical ethics deals with ethical reflection with considering to the field of medical activities within medical science and practice. It is a matter of professional ethics and interdisciplinary study of the ethical justification of certain medical procedures. Medical skill viewed from an ethical perspective emphasizes the need for proper action based on the basic ideas of philanthropy and action for the good of the person.

Keywords: *Ethics, Medicine, Health, Society, Patients*

Introduction

Medical practice, biotechnologies and scientific research all have a major impact on our lives, and whilst they can bring and have brought us great benefits, we do not have to look too far back into the past to recall atrocities that were committed in the name of medical and scientific advancement [1].

The criminal law enforces moral standards and, in so doing, exemplifies the wrongs society considers especially grievous. Medical practice, biotechnologies and scientific research can involve public wrongs – that is, wrongs that should be the concern of the criminal law because they contravene defining values that the state endeavours to safeguard to ensure the good of its citizens. Values that might be violated by medical practice and the development of biotechnologies include the sanctity of life and the protection of the vulnerable. Thus, arguably, the intervention of the criminal law is not only apposite, it is required and there is an inevitability about its intervention in any society that utilises the criminal law to reflect its basic values and punish those who culpably cause others harm or a risk of harm. Others might contend that resort to the criminal process in these areas constitutes morally supportable redress to what they see as a prior conspiracy of professions, whereby the law almost 'naturally' deferred to the perceived authority of those who practise in the rarefied environment of medicine.

Society

The relationship between science and society is at times an uneasy one [2]. On one hand, although the application of the modern scientific method is a relatively recent development, humans since the beginning of history have always sought to understand the world around us and to use that understanding to improve the human condition. Some might even argue that our curiosity and our desire to satisfy it through scientific inquiry are defining characteristics of what it means to be human. Certainly, science and its applications have provided tremendous benefits to humankind – for example, in terms of improvements to health and welfare. At the same time, however, science presents us with challenging social and ethical difficulties as the progress of technology opens up greater possibilities for changing and controlling our environment and even ourselves.

Keeping pace with fast-moving science and the ethical controversies to which such research may give rise has often presented a challenge to regulators. Public concerns over science must be allayed, whilst also ensuring scientists submit to standards of social acceptability, or at least ethical oversight. Yet the government must also consider the ideal of scientific freedom, which holds that the pure pursuit of knowledge, if it is to achieve its full potential, cannot be unduly influenced by social norms, nor fettered by constraints imposed by society. This dualistic, adversarial view of science and society as competing entities is not entirely apposite, given the mutuality of their natures: public trust, communication and engagement also play a vital role. In this complex environment, therefore, the question of how science is regulated has assumed an increasing importance as society seeks to realise the benefits of research, whilst keeping the goals and means of science aligned with ethically acceptable norms.

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Health Care

There are two fundamentally distinct views on the nature of health care: One sees health care as a right, the other construes it as a commodity [3]. This difference is not merely a matter of perspective: It has tremendous practical implications. For instance, a rights perspective tends to be associated with a socialized approach to health care. Further, according to this approach, the very structure of the health care delivery system must ultimately be justified in terms of ethical principles and economic measures can only be used as tools to effect a just and equitable distribution within the system. Finally, the function of a health care system that is constructed on a rights basis is not to generate revenue but to provide a socially mandated service.

On the other hand, a commodity perspective fosters a corporate view of health care. On this approach, health care is a commodity like any other that may be bought or sold in the market place. Accordingly, economic considerations determine the nature, range and availability of health care services, and ethical principles enter the decision-framework only as identifling the socially mandated limits within which all economic activities have to be conducted. Moreover—and this constitutes a crucial contrast to the rightsoriented perspective—the primary function of a commodity-oriented health care service approach is to generate revenue. It just so happens that the revenue-generating method that is adopted focuses in the delivery of health services. The fact that providing these services also meets a societal need is a serendipitous happenstance that may befall any economic enterprise. Moreover, while on a rights-based perspective the failure to deliver otherwise appropriate health care services to everyone on an equitable basis can be characterized as a failure of social duty, no such claim can be made from a commodity-based perspective. Here, the absence—or even maldistribution—of a particular service is merely a reflection of economic forces that render the provision of the relevant services unprofitable.

Public Health

In order to reduce disease and promote health, public health must be an agent of change—behavioral change among individuals and institutional change in societies [4]. Such change is never easy, even when unusual loss of life, injury, severe illness, and social disruption are threatened. Existing patterns of individual behavior and social institutions are embedded in structures of power and in social expectations and cultural norms. Behavioral and institutional change, no matter how seemingly urgent and reasonable, still requires ethical justification. This is because the principal goals of public health—security, safety, health, and well-being—must be balanced with other important values. Ethical justification is also required for emergency public health measures because, for the most part, public health and public safety authorities must rely on voluntary compliance by large numbers of people, and voluntary behavior change in turn depends on the fact that people see good reasons for their compliance, including good ethical reasons.

Ethical reasoning and sensitivity is always important in public health, but it is especially important in the sensitive and complex area of public health emergency preparedness. Indeed, the requirements of ethical justification in the context of emergency preparedness are quite demanding, and the ethical stakes are high because changes required are often disruptive and momentous, they may be financially costly, and they usually involve some form of state action. They involve the creation of legal sanctions and enforcement, the creation of administrative structures, the investment and allocation of resources, and the mobilization of popular support.

When considering ethics in emergency preparedness, decisionmaking with incomplete or imperfect knowledge and under pressure of time is one of the central concerns. Sound factual information is one foundation for ethically justified decision-making. Careful, thorough, and deliberate assessment of options is another. In the real world of emergency response, and even in the less pressured situation of prior emergency preparedness planning, both of these prerequisites of ethical decision-making may be compromised. But plans must be drawn, decisions and actions must be taken nonetheless.

Patients

Medical ethicists have been engaged in ongoing reflections on the nature and limits of patient rights [5]. Concern that patients are sometimes subjected to unwanted treatment, especially near the end of life, has led to an emphasis on the patient's right to refuse treatment. Concern that physicians are being forced to practice bad (futile) medicine has led to an effort to define the limits of the patient's right to demand specific treatment. Recognition of the diversity of cultural values in society has led to efforts to determine the accommodation that healthcare organizations should make to patients with different cultural values. Recognition of the importance of the non-dramatic ethical issues ("everyday ethics") has led to concern about the rights of patients in relationship to institutional practices and concerns. The growth of managed care has led to efforts to clarify the rights of patients as enrollees in healthcare plans. The growing interest in complementary and alternative medicine may well lead to additional refinements of the meaning of patient rights.

The right of informed competent individuals to refuse

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unwanted treatment is one of the most basic rights of patients in healthcare. Even when a patient consents to other medical treatment as recommended by the physician, his or her refusal of a particular intervention should be honored. Respect for individuals means that they will not be treated, something will not be done to or for them, without their permission. As a basic protection of human dignity, the right to refuse treatment continues to merit the emphasis that it has received in the last three decades in American medical ethics.

The hands of care providers are tied in cases like this only in one sense: they have no choice but to honor the patient's refusal of blood products. Beyond that, however, they need to exercise their professional responsibility as in any other case. If, as a result of the patient's refusal of specific interventions, the proposed treatment no longer meets criteria for safety or effectiveness, it should not be provided. The patient's decision may reduce options, but it does not change the essential relationship between clinician and patient. The patient's right to refuse unwanted treatment does not imply a "right" to get medically inappropriate treatment. The right to refuse what is medically indicated does not mean a "right" to demand (and get) what is not medically indicated. It is one thing to expect others not to treat without consent. It is something else entirely to expect others to practice medicine in ways contrary to professional standards.

Patients do have a legitimate expectation that reasonable efforts will be made to provide them with beneficial treatment at the same time that their refusal of specific treatment is honored. Patients should be able to expect that respect for their deeply held beliefs about healthcare will result in reasonable accommodation when alternative options exist. It should be noted, however, that while the criterion of reasonableness applies in these situations, it does not apply in the same way when the patient refuses unwanted treatment.

Competent patients have a legitimate expectation that others will respect their informed refusal of treatment even when these others judge the refusal unreasonable. The same patient has a legitimate expectation that others will provide an alternative option only when providers judge that option reasonable. Deciding whether to accept recommended treatment is different from deciding what treatment is medically appropriate. Patients do not have a right to have the treatment they want even if such treatment is at odds with the professional responsibility to practice only good medicine and to use resources wisely.

Clinical Medical Ethics

Clinical medical ethics is a new medical field, developed and named in the 1970s, that helps patients, families, physicians, and other health professionals reach good clinical decisions by taking into account both the specific clinical situation and the patient's values and preferences [6]. The field of clinical medical ethics is much broader and encompassing than its component of ethics consultations; it applies across the entire spectrum of routine, daily medical practice. For clinicians today, applying clinical medical ethics standards in patient care is not an elective matter but rather has become the standard of care in the United States and is mandated legally and professionally. For example, in caring for their patients, physicians must apply clinical ethics standards such as speaking truthfully to their patients, negotiating informed consent for clinical decisions, protecting patient confidentiality, assessing the patient's decisional capacity, and, when appropriate, working with surrogates or proxies to reach clinical decisions. In contrast to the 1970s, clinical medical ethics discussions have now become a part of everyday clinical discourse and are used to reach clinical decisions in outpatient and inpatient settings across the country. The goal of clinical medical ethics is to improve patient care and patient outcomes.

Biomedical Ethics

Bioethics is the application of ethical principles and processes to health, including, but not limited to, health services, systems, policies, and technologies [7]. In the latter half of the twentieth century, bioethics in the United States focused on clinical issues of the doctor-patient relationship, rather than issues of social justice or population health. During that period the role of the physician became less paternalistic than it had been, and bioethics emphasized the principle of patient autonomy, as expressed in concepts such as informed consent and the right to refuse treatment. In contrast, the recent trend in bioethics in the United States and many other countries is to move beyond the individual patient and the medical relationship and to address the broader issues of health disparities, public health, allocation of limited resources, and social determinants of health. This recent trend reflects a concern for social justice both within individual societies and from a global (or worldwide) perspective.

Biomedical ethics in our time largely derives from the patient-doctor relationship in light of the rapid advances in medicine and biomedical science [8]. In the past, paternalism (i.e., the doctor knows best), along with the physician's oath, "first, do no harm," seemed adequate. Scandals, litigation, and the fear that medical practice and research also have a dark side have led to scrutiny, regulation, and ethical analysis. The Nuremberg principles, the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979), and other documents are mainstays of modern biomedical ethics. Yet,

there are emerging issues that require new insights. Examples include cloning, abortion, enhanced fertility, genetic screening, genetic manipulation, stem cell applications, organ transplantation, euthanasia, privacy, and the soaring costs of health care.

Since bioethical issues are very often the subject of scientific discussions, bioethics needs to be considered in the current social context [9]. This would mean that the main source of most bioethical problems is the operation of systems that make up modern forms of technological sciences that include, among others, medicine, biotechnology, informatics, etc., and economics and politics. So, problems exist and need to be addressed systematically. Medical practice and biomedical research must be the foundation of the future development of bioethics.

Science

Two questions which ought to precede any properly informed discussion of how to teach ethics to scientists are 'Why should we teach this group ethics?' and 'What do we hope to achieve from their ethical education? [10]' Ethics teachers who are novices in the area might well be driven to ask these questions in despair as they confront resistance to their efforts on the part of both students and their colleagues in the science faculty. Nonetheless, how we respond to these questions is a serious matter and crucial to determining the shape of ethics courses.

A recent workshop on ethics education in science and engineering began by asking participants why they thought ethics education was important. Respondents talked about famous cases of research misconduct (presumably hoping they could be prevented in the future by ethics education) and how public trust in the integrity of science and research may be undermined by problematic practices. It was also noted that some students only appreciated the value of their ethics education in retrospect, after practising their discipline and being forced to confront real-life ethical issues. Interestingly, there was also a suggestion that talented students with high ideals might be lost if ethics education were ignored. Whilst all these factors can play a role in motivating ethics education for scientists, the central problem which surely underpins them all is that ethical issues constantly arise in science, and scientists need to learn how to deal with them. As researchers investigating ethics education in the life sciences have noted, the 'more influential science becomes, the more ethical issues become associated with scientific practice directly, and scientists are increasingly required to participate in the value questions born from new knowledge and new technologies'.

There are a number of ways in which the practice of science generates ethical issues. Regarding the methods adopted in research (for instance, we can ask 'Should we run placebo-controlled drug trials, or use animals in experimentation?') these include how knowledge is applied (for example, how do we respond to knowledge of aerosolisation being used to make more effective bioweapons?), as well as the very questions which drive scientific research in the first place (for example, should we do research into human reproductive cloning, or weapons of mass destruction?). In fact, the ethically charged nature of science is well exposed by the dual-use dilemma, since dual-use scenarios demonstrate that even the well-intentioned pursuit of scientific research can generate difficulties. Although a scientist may be pursuing admirable goals such as understanding how a particular disease spreads with a view to containing future outbreaks, this does not preclude this same research being used for harmful ends such as deploying the disease as a biological weapon.

Law

Law and bioethics are inherently different social and communicative systems [11]. Each constructs a social reality of its own, communicates distinctive norms, and fills a different social function. Each has different goals, methods, and epistemologies. Each identifies and uses expertise, presumptions, values, and burdens of proof in distinctive ways, yet they are deeply dependent on each other. One scholar has characterized them as "strange bedfellows."

The simultaneous separateness and mutual interdependence of law and bioethics raises important but difficult questions regarding their boundaries, relationships, and interface. Whenever nonlegal materials are borrowed for law's purposes—regardless of whether those materials are scientific, medical, social scientific, or bioethical—questions arise regarding how they interact with law, how closely law can rely on them, and how much openness or closure toward nonlegal material is desirable. Sociolegal systems theorists assert that, to function effectively in complex societies, law interacts with other systems in a variety of ways. These interactions are intricate formal and informal arrangements that link law with other systems. Law can, as a result, receive input from them; rely on them on an ongoing basis, even delegate some of its tasks to them; and thus evolve to meet its own needs and the needs of an increasingly complex society.

Some skepticism regarding drawing sharp distinctions between norms and other bioethics material is justified. However, when law confronts a system, such as bioethics, that has strongly normative features, some differentiation is critical, or law may be confused with religion or ethics. In the United States, limits are set on how open law can be toward

religions. The much-contested First Amendment, premised on the fact of religious and moral pluralism, has historically protected the freedom of individuals to follow their own religious norms, in part by preventing law from endorsing any specific religion. There is no ethics corollary to the First Amendment's religion clauses. Despite early attempts to portray bioethics as "philosophy for the people" and as an effort to "empower democracy," too much openness on the part of law to bioethics' normativity can be as troubling as too much openness to religion's normativity. Some observers of bioethics in the 1990s, drawing on First Amendment language, warned about an "establishment bioethics." One commentator, uneasy with the direction of the field, suggested this Constitutional amendment: "Congress shall make no law respecting an establishment of ethics, or prohibiting the free exercise thereof."…"If individuals are the arbiters of their own fate," he writes, "and are supposed to follow the dictates of conscience, then to have that conscience determined by a secular priesthood…is as offensive as having that conscience determined by a religious priesthood." Today, the probability is higher that law will fail to set boundaries differentiating itself from a religiously based ethics, and endorse, or open itself too completely, to fundamentalist Christian norms, but the issue of law's openness remains.

Knowledge of medical law, health law and bioethics can ultimately only mean one thing: providing quality health care [12]. That is the goal of every modern society. After formal education, all medical staff has to must go another form of education, and it is continuing training in their profession. Because medicine is an area where almost every day something new happens, with these new all medical stuff need to meet. New scientific findings certainly should be applied in practice as they are designed just for that. This will be achieved another goal and that a satisfied patient. If the patient is satisfied, satisfied with the doctor and others from medical staff. It's the only way that leads to a better tomorrow.

Conclusion

In the performance of his duties, the doctor must make decisions that may affect human freedom or life. He must solve problems that depend not only on his professional knowledge, but also on his belief and humanistic belief. Awareness of one's own limitations, respect for human dignity, the ability to put oneself in the position of a patient, will significantly contribute to medical care.

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