Medical Ethics and Human Right

*** Dr. Mahaveer Prasad Mali**

Abstract

The sufficient food and adequate shelter cannot be enjoyed without a healthy body, and the development of medicine and surgery occurred therefore as early as the development of astronomy and the introduction of building materials for houses.

In recent years, there have been significant additions to the statutory control of the health care professions, including the Health Act 1999, the National Health Service Reform and Health Care Professions Act 2002, and the Health and Social Care Act 2001. One of the most remarkable aspects of this latest wave of statutory reform is that the government is now able to make changes to the regulation of the health care professions by issuing Orders in Council, as opposed to negotiating the, more public legislative processes inherent in the passage of Acts of Parliament. Human rights and medical ethics are parallel mechanisms, the former working at the socio-political level and the latter more at the level of the doctor–patient relationship. Human rights place a duty on the state and on healthcare providers to comply with minimum standards. Medical ethics place a duty on individual doctors to comply with parallel standards. Human rights and medical ethics are complementary, and use of the two together maximizes the protection available to the vulnerable patient

Thus, there are two fundamental differences between human rights and medical ethics. One is that the focus is on state-level action rather than a person-to-person relationship. The other is the issue of benevolence, which is important in the theory of biomedical ethics but has no place in human rights discourse. Rights do not depend on the empathy of other actors.

One conflict between human rights and medical ethics has been in court cases where the rule of law, an essential part of democratic society, requires medical confidentiality to be breached. Patients expect confidentiality to be absolute, otherwise they would not trust doctors with their intimate details, and medical ethics require that this information is protected as far as possible. Human rights, however, demand that justice takes priority and doctors know that, despite great reluctance, they may be obliged to disclose confidential information to a court.

Thus, issues of social justice-the punishments of those who have committed a serious crime-outweigh medical confidentiality. In psychiatry, many patients are considered to lack competence as a consequence of their medical condition. Thus, formal medical ethics falls back on beneficence to decide how patients should be treated. As society has increasingly rejected paternalism, a model based on human rights is replacing it which encourages patients to be involved in decisions about their care.

1. Medical Ethics and Human Right

In the concept of medical as a Profession, whereby physicians make a public promise that the interests of their patients are above their own interests. In recent times medical ethics has been greatly influenced by developments in human rights. In a pluralistic and multicultural world, with many different moral traditions, the major international human rights agreements can provide a foundation for medic ethics that is acceptable across national and Cultural boundaries. Moreover, physicians frequently have to deal with medical problems resulting from violations of human rights, such as forced migration and torture.

And they are greatly affected by the debate over whether healthcare is a human right, since the answer to this question in any particular country determines to a large extent that has access to medical care.

Medical ethics is also closely related to law. In most countries there are laws that specify how physicians are required to deal with ethical issues in patient care and research. In addition, the medical licensing and regulatory officials in each country can and do punish physicians for ethical violations. But ethics and law are not identical. Quite often ethics prescribes higher standards of behavior than does the law, and occasionally ethics requires that physicians disobey laws that demand unethical behavior.

Medical ethics is closely related, but not identical to, bioethics (biomedical ethics). Whereas medical ethics focuses primarily on issues arising out of the practice of medicine, bioethics is a very broad subject that is concerned with the moral issues raised by developments in the biological sciences more generally. As an academic discipline, medical ethics has developed its own specialized vocabulary, including many terms that have been borrowed from philosophy.

Increasingly throughout the world medical schools are realizing that they need to provide their students with adequate time and resources for learning ethics. They have received strong encouragement to move in this direction from organizations such as the World Medical Association and the World Federation for Medical Education. Ethical principles such as respect for persons, informed consent and confidentiality are basic to the physician-patient relationship. However, the application of these principles in specific situations is often problematic, since physicians, patients, their family members and other healthcare personal may disagree about what is the right way to act in situation.

2. Features of Medical Ethics

Throughout almost all of recorded history and in virtually every part of the world, being a physician has meant something special. People come to physicians for help with their most pressing needs—relief from pain and suffering and restoration of health and well-being. They allow physicians to see, touch and manipulate every part of their bodies, even the most intimate. They do this because they trust their physicians to act in their best interests.

The status of physicians differs from one country to another and even within countries. In general, though, it seems to be deteriorating. Many physicians feel that they are no longer as respected as they once were. In some countries, control of healthcare has moved steadily away from physicians to professional managers and bureaucrats, some of whom tend to see physicians as obstacles to rather than partners in healthcare reforms. Patients who used to accept physicians' orders unquestioningly sometimes ask physicians to defend their recommendations if these are different from advice obtained from other health practitioners or the Internet. Some procedures that formerly only physicians were capable of performing are now done by medical technicians, nurses or paramedics.

Despite these changes impinging on the status of physicians, medicine continues to be a profession that is highly valued by the sick people who need its services. It also continues to attract large numbers of the most gifted, hard-working and dedicated students. In order to meet the expectations of both patients and students, it is important that physicians know and exemplify the core values of medicine, especially compassion, competence and autonomy. These values, along with respect for fundamental human rights, serve as the foundation of medical ethics. Compassion, competence and autonomy are not exclusive to medicine. However, physicians are expected to exemplify them to a higher degree than other people, including members of many other professions. Compassion, defined as understanding and concern for another person's distress, is essential for the practice of medicine. In order to deal with the patient's problems, the physician must identify the symptoms that the patient is experiencing and their underlying causes and must want to help the patient achieve relief. Patients respond better to treatment if they perceive that the physician appreciates their concerns and is treating them rather than just their illness.

A very high degree of competence is both expected and required of physicians. A lack of competence can result in death or serious morbidity for patients. Physicians undergo a long training period to ensure competence, but considering the rapid advance of medical knowledge, it is a continual challenge for them to maintain their competence. Moreover, it is not just their scientific knowledge and technical skills that they have to maintain but their ethical knowledge, skills and attitudes as well, since new ethical issues arise with changes in medical practice and its social and political environment.

Autonomy, or self-determination, is the core value of medicine that has changed the most over the years. Individual physicians have traditionally enjoyed a high degree of clinical autonomy in deciding how to treat their patients. Physicians collectively (the medical profession) have been free to determine the standards of medical education and medical practice. Despite these challenges, physicians still value their clinical and professional autonomy and try to preserve it as much as possible. At the same time, there has been a widespread acceptance by physicians worldwide of patient autonomy, which means that patients should be the ultimate decision-makers in matters that affect themselves.

3. Role of World Health Organization

Ethics is pluralistic**.** Individuals disagree among themselves about what is right and what is wrong, and even when they agree, it can be for different reasons. In some societies, this disagreement is regarded as normal and there is a great deal of freedom to act however one wants, as long as it does not violate the rights of others. In more traditional societies, however, there is greater agreement on ethics and greater social pressure, sometimes backed by laws, to act in certain ways rather than others. In such societies culture and religion often play a dominant role in determining ethical behavior.

In liberal societies, individuals have a great deal of freedom to decide for themselves what is ethical, although they will likely be influenced by their families, friends, religion, the media and other external sources. In more traditional societies, family and clan elders, religious authorities and political leaders usually have a greater role than individuals in determining what is ethical. Despite these differences, it seems that most human beings can agree on some fundamental ethical principles, namely, the basic human rights proclaimed in the United Nations Universal Declaration of Human Rights and other widely accepted and officially endorsed documents. The human rights that are especially important for medical ethics include the right to life, to freedom from discrimination, torture and cruel, inhuman or degrading treatment, to freedom of opinion and expression, to equal access to public services in one's country, and to medical care. For physicians, the question, "who decides what is ethical?" has until recently had a somewhat different answer than for people in general. Over the centuries the medical profession has developed its own standards of behavior for its members, which are expressed in codes of ethics and related policy documents. At the global level, the WMA has set forth a broad range of ethical statements that specify the behavior required of physicians no matter where they live and practice. In many, if not most, countries medical associations have been responsible for developing and enforcing the applicable ethical standards. Depending on the country's approach to medical law, these standards may have legal status.

The medical profession's privilege of being able to determine its own ethical standards has never been absolute, however. For example:

Physicians have always been subject to the general laws of the land and have sometimes been punished for acting contrary to these laws. Some medical organizations are strongly influenced by religious teachings, which impose additional obligations on their members besides those applicable to all physicians.

In many countries the organizations that set the standards for physician behavior and monitor their compliance now have a significant non-physician membership. The ethical directives of medical associations are general in nature; they cannot deal with every situation that physicians might face in their medical practice. In most situations, physicians have to decide for themselves what is right way to act, but in making decisions, it is helpful to know what other physicians would do in similar situations. Medical codes of ethics and policy statements reflect a general consensus about the way physicians should act and they should be followed unless there are good reasons for acting otherwise.

Of course, many individuals now consider that they are their own primary health providers and that the role of physicians is to act as their consultants or instructors. Although this emphasis on self-care is far from universal, it does seem to be spreading and is symptomatic of a more general evolution in the patient-physician relationship that gives rise to different ethical obligations for physicians than previously.

4. Role of the Wma

As the only international organization that seeks to represent all physicians, regardless of nationality or specialty, the WMA has undertaken the role of establishing general standards in medical ethics that are applicable worldwide. From its beginning in 1947 it has worked to prevent any recurrence of the unethical conduct exhibited by physicians in Nazi Germany and elsewhere. The WMA's first task was to update the Hippocratic Oath for 20th century use; the result was the Declaration of Geneva, adopted at the WMA's 2nd General Assembly in 1948. It has been revised several times since, most recently in 1994. The second task was the development of an International Code of Medical Ethics, which was adopted at the 3rd General Assembly in 1949 and revised in 1968 and 1983. This code is currently undergoing further revision. The next task was to develop ethical guidelines for research on human subjects. This took much longer than the first two documents; it was not until 1964 that the guidelines were adopted as the Declaration of Helsinki. This document has also undergone periodic revision, most recently in 2000.

In addition to these foundational ethical statements, the WMA has adopted policy statements on more than 100 specific issues, the majority of which are ethical in nature while others deal with socio-medical topics, including medical education and health systems. Each year the WMA General Assembly revises some existing policies and/or adopts new ones.

Achieving international agreement on controversial ethical issues is not an easy task, even within a relatively cohesive group such as physicians. The WMA ensures that its ethical policy statements reflect a consensus by requiring a 75% vote in favor of any new or revised policy at its annual Assembly. A precondition for achieving this degree of agreement is widespread consultation on draft statements, careful consideration of the comments received by the WMA Medical Ethics Committee and sometimes by a specially appointed workgroup on the issue, redrafting of the statement and often further consultation. The process can be lengthy, depending on the complexity and/or the novelty of the issue. For example, the most recent revision of the Declaration of Helsinki was begun early in 1997 and completed only in October 2000 Even then, outstanding issues remained and these continued to be studied by the Medical Ethics Committee and successive workgroups.

A good process is essential to, but does not guarantee, a good outcome. In deciding what is ethical, the WMA draws upon a long tradition of medical ethics as reflected in its previous ethical statements. It also takes note of other positions on the topic under consideration, both of national and international organizations and of individuals with skill in ethics. On some issues, such as informed consent, the WMA finds itself in agreement with the majority view. On others, such as the confidentiality of personal medical information, the position of physicians may have to be promoted forcefully against those of governments, health system administrators and/ or commercial enterprises.

A defining feature of the WMA's approach to ethics is the priority that it assigns to the individual patient or research subject. In reciting the Declaration of Geneva, the physician promises, "The health of my patient will be my first consideration." And the Declaration of Helsinki states, "In medical research on human subjects, considerations related to the well-being of the human subject should take precedence over the interests of science and society."

5. Role of Individuals

For individual physicians and medical students, medical ethics does not consist simply in following the recommendations of the WMA or other medical organizations. These recommendations are usually general in nature and individuals need to determine whether or not they apply to the situation at hand. Moreover, many ethical issues arise in medical practice for which there is no guidance from medical Associations. Individuals are ultimately responsible for making their own ethical decisions and for implementing them.

There are different ways of approaching, ethical issues. These can be divided roughly into two categories: no rational and rational. It is important to note that non rational does not mean irrational but simply that it is to be distinguished from the systematic, reflective use of reason in decision-making.

Non-rational approaches

Obedience is a common way of making ethical decisions, especially by children and those who work within authoritarian structures (e.g., the military, police, some religious organizations, and many businesses). Morality consists in following the rules or instructions of those in authority, whether or not you agree with them.

Imitation is similar to obedience in that it subordinates one's judgment about right and wrong to that of another person, in this case, a role model. Morality consists in following the example of the role model. This has been perhaps the most common way of learning medical ethics by aspiring physicians, with the role models being the senior consultants and the mode' of moral learning being observation and assimilation of the values portrayed

Feeling or desire is a subjective approach to moral decision making and behavior. What is right is what feels right or satisfies one's desire; what is wrong is what feels wrong or frustrates one's desire. The measure of morality is to be found within each individual and, of course, can vary greatly from one individual to another and even within the same individual over time.

Intuition is an immediate perception of the right way to act in a situation. It is similar to desire in that it is entirely subjective; however, it differs because of its location in the mind rather than the will. To that extent it comes closer to the rational forms of ethical decision-making than do obedience, imitation, feeling and desire. However, it is neither systematic nor reflexive but directs moral decisions through a simple flash of insight. Like feeling and desire, it can vary greatly from one individual to another and even within the same individual over time.

Habit is a very efficient method of moral decision making since there is no need to repeat a systematic decision-making process each time a moral issue arises similar to one that has been dealt with previously. However, there are bad habits (e.g., lying) as well as good ones (e.g., truth telling); moreover, situations that appear similar may require significantly different decisions. As useful as habit is, therefore, one cannot place all one's confidence in it·

Rational approaches

As the study of morality, ethics recognizes the prevalence of these non-rational approaches to decision-making and behavior. However, it is primarily concerned with rational approaches. Four such approaches are deontology, consequentialism, principles and virtue ethics:

Deontology involves a search for well-founded rules that can serve as the basis for making moral decisions. An example of such a rule is, "Treat all people as equals." Its foundation may be religious (for example, the belief that all God's human creatures are. equal) or non-religious (for example, human beings share almost all of the same genes). Once the rules are established, they have to be applied in specific situations, and here there is often room for disagreement about what the rules require (for example, whether the rule against killing another human being would prohibit abortion or capital punishment).

Consequentialism bases ethical decision-making on an analysis of the likely consequences or outcomes of different choices and actions. The right action is the one that produces the best outcomes. Of course there can be disagreement about what counts as a good outcome. One of the best-known forms of consequentialism, namely utilitarianism, uses 'utility' as its measure and defines this as 'the greatest good for the greatest number'. Other outcome measures used in health care decision-making include cost effectiveness and quality of life as measured in quality-adjusted life-years or disability adjusted life,-years. Supporters of consequentialism generally do not have much use for principles; they me too difficult to identify, priorities and apply, and in any case they do not take into account what in their view really matters in moral decision-making, Le., the outcomes. However, this setting aside of principles leaves consequentialism open to the charge that it accepts that' the end justifies the means', for example, that individual human rights can be sacrificed to attain a social goal.

Idealism, as its name implies, uses ethical principles as the basis for making moral decisions. It applies these principles to particular cases or situations in order to determine what is the right thing to do, taking into account both rules and consequences. Principles have been extremely influential in recent ethical debates, especially in the USA. Four principles in particular, respect for autonomy, beneficence, non-malfeasance and justice, have been identified as the most important for ethical decision-making in medical practice. Principles do indeed play an important role in rational decision-making. However, the choice of these four principles, and especially the prioritization of respect for autonomy over the others, is a reflection of Western liberal culture and is not necessarily universal. Moreover, these four principles often clash in particular situations and there is need for some criteria or process for resolving such conflicts.

Virtue ethics focuses less on decision-making and more on the character of decision-makers as reflected in their behavior. A virtue is a type of moral excellence. As noted above, one virtue that is especially important for physicians is compassion. Others include honesty, prudence and dedication. Physicians who possess these virtues are more likely to make good decisions and to implement them in a good way. However, even virtuous individuals often are unsure how to act in particular situations and are not immune from making wrong decisions.

None of these four approaches, or others that have been proposed, has been able to win universal agent Individuals differ among themselves in their preference for a rational approach to ethical decision-making just as they do in their preference for a non-rational approach. This can be explained partly by the fact that each approach has both strengths and weaknesses. Perhaps a combination of all four approaches that includes the best features of each is the best way to make ethical decisions rationally. It would take serious account of rules and principles by identifying the ones most relevant to the situation or case at hand and by attempting to implement them to the greatest extent possible. It would also examine the likely consequences of alternative decisions and determine which consequences would be preferable. Finally, it would attempt to ensure that the behavior of the decision-maker both in coming to a decision and in implementing it is admirable. Such a process could comprise the following steps:

1. Determine whether the issue at hand is an ethical one.
2. Consult authoritative sources such as medical association codes of ethics and policies and respected colleagues to see how physicians generally deal with such issues.
3. Consider alternative solutions in light of the principles and values they uphold and their likely consequences.
4. Discuss your proposed solution with those whom it will affect.
5. Make your decision and act on it, with sensitivity to others affected.
6. Evaluate your decision and be prepared to act differently in future.

6. Physicians and Patients

The physician-patient relationship is the cornerstone of medical practice and therefore of medical ethics. Since many patients are either unable or unwilling to make decisions about their medical care, however, patient autonomy is often very problematic. Equally problematic are other aspects of the relationship, such as the physician's obligation to maintain patient confidentiality in an era of computerized medical records and managed care, and the duty to preserve life in the face of requests to hasten death.

Equal treatment

The belief that all human beings deserve respect and equal treatment is relatively recent. In most societies disrespectful and unequal treatment of individuals and groups was accepted as normal and natural. Slavery was one such practice that was not eradicated in the European colonies and the USA until the 19th century and still exists in some parts of the world. The end of institutional discrimination against non-whites in countries such as South Africa is much more recent. Women still experience lack of respect and unequal treatment in most countries. Discrimination on the basis of age, disability or sexual orientation is widespread. Clearly, there remains considerable resistance to the claim that all people should be treated as equals.

The gradual and still ongoing conversion of humanity to a belief in human equality began in the 17th and 18th centuries in Europe and North America. It was led by two opposed ideologies: a new interpretation of Christian faith and an anti-Christian rationalism. The former inspired the American Revolution and Bill of Rights; the latter, the French Revolution and related political developments. Under these two influences, democracy very gradually took hold and began to spread throughout the world. It was based on a belief in the political equality of all men (and, much later, women) and the consequent right to have a say in who should govern them.

In the 20th century there was considerable elaboration of the concept of human equality in terms of human rights. One of the first acts of the newly established United Nations was to develop the Universal Declaration of Human Rights (1948), which states in article 1, "All human beings are born free and equal in dignity and rights." Many other international and national bodies have produced statements of rights, either for all human beings, for all citizens in a specific country, or for certain groups of individuals. Numerous organizations have been formed to promote action on these statements. Unfortunately, though, human rights are still not respected in many countries.

The medical profession has had somewhat conflicting views on patient equality and rights over the years. On the one hand, physicians have been told not to "permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient" (Declaration of Geneva). At the same time physicians have claimed the right to refuse to accept a patient, except in an emergency. Although the legitimate grounds for such refusal include a full practice, (lack of) educational qualifications and specialization, if physicians do not have to give any reason for refusing a patient, they can easily practice discrimination without being held accountable. A physician's conscience, rather than the law or disciplinary authorities, may be the only means of preventing abuses of human rights in this regard.

Even if physicians do not offend against respect and human equality in their choice of patients, they can still do so in their attitudes towards and treatment of patients. Compassion is based on respect for the patient's dignity and values but goes further in acknowledging and responding to the patient's vulnerability in the face of illness and/ or disability. If patients sense the physician's compassion, they will be more likely to trust the physician to act in their best interests, and this trust can contribute to the healing process.

The trust that is essential to the physician-patient relationship has generally been interpreted to mean that physicians should not desert patients whose care they have undertaken. The WMA's International Code of Medical Ethics implies that the only reason for ending a physician patient relationship is if the patient requires another physician with different skills: "A physician shall owe his patients complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond the physician's capacity he should summon another physician who has the necessary ability." However, there are many other reasons for a physician wanting to terminate a relationship with a patient, for example, the physician's moving or stopping practice, the patient's refusal or inability to pay for the physician's services, dislike of the patient and the physician for each other, the patient's refusal to comply with the physician's recommendations, etc.

The reasons may be entirely legitimate, or they may be unethical. When considering such an action, physicians should consult their Code of Ethics and other relevant guidance documents and carefully examine their motives. They should be prepared to justify their decision, to themselves, to the patient and to a third party if appropriate. If the motive is legitimate, the physician should help the patient find another suitable physician or, if this is not possible, should give the patient adequate notice of withdrawal of services so that the patient can find alternative medical care. If the motive is not legitimate, for example, racial prejudice, the physician should take steps to deal with this defect.

Many physicians, especially those in the public sector, often have no choice of the patients they treat. Some patients are violent and pose a threat to the physician's safety. Others can only be described as obnoxious because of their antisocial attitudes and behavior. Have such patients forsaken their right to respect and equal treatment, or are physicians expected to make extra, perhaps even heroic, efforts to establish and maintain therapeutic relationships with them? With such patients, physicians must balance their responsibility for their own safety and well-being and that of their staff with their duty to promote the well-being of the patients. They should attempt to find ways to honor both of these obligations. If this is not possible, they should try to make alternative arrangements for the care of the patients.

Another challenge to the principle of respect and equal treatment for all patients arises in the care of infectious patients. The focus here is often on HIV I AIDS, not only because it is a life-threatening disease but also because it is often associated with social prejudices. However, there are many other serious infections including some that are more easily transmissible to healthcare workers than HN I AIDS. Some physicians hesitate to perform invasive procedures on patients with such conditions because of the possibility that they, the physicians, might become infected. However, medical codes of ethics make no exception for infectious patients with regard to the physician's duty to treat all patients equally. The WMA's Statement on the Professional Responsibility of Physicians in Treating AIDS Patients puts it this way:

AIDS patients are entitled to competent medical care with compassion and respect for human dignity. A physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence, solely because the patient is seropositive. Medical ethics do not permit categorical discrimination against a patient based solely on his or her zero positivity. A person who is afflicted with AIDS needs competent compassionate treatment. A physician who is not able to provide the care and services required by persons with AIDS should make an appropriate referral to those physicians' or facilities that are equipped to provide such services. Until the referral can be accomplished, the physician must care for the patient to the best of his or her ability.

The intimate nature of the physician-patient relationship can give rise to sexual attraction. A fundamental rule of traditional medical ethics is that such attraction must be resisted. In recent years. Many medical associations have restated this prohibition of sexual relations between physicians and their patients. The reasons for this are as valid today as they were in Hippocrates' time, 2500 years ago. Patients are vulnerable and put their trust in physicians to treat them well. They may feel unable to resist sexual advances of physicians for fear that their treatment will be jeopardized. Moreover, the clinical judgment of a physician can be adversely affected by emotional involvement with a patient.

This latter reason applies as well to physicians treating their family members, which is strongly discouraged in many medical codes of ethics. However, as with some other statements in codes of ethics, its application can vary according to circumstances. For example, solo practitioners working in remote areas may have to provide medical care for their family members, especially in emergency situations.

Communication and Consent

Informed consent is one of the central concepts of present day medical ethics. The right of patients to make decisions about their healthcare has been enshrined in legal and ethical statements throughout the world. The WMA Declaration on the Rights of the Patient states: The patient has the right to self-determination, to make free decisions regarding him/her. The physician will inform the patient of the consequences of his/her decisions. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions. The patient should understand clearly the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.

A necessary condition for informed consent is good communication between physician and patient. When medical paternalism was normal, communication was relatively simple; it consisted of the physician's orders to the patient to comply with such and such a treatment. Nowadays communication requires much more of physicians. They must provide patients with all the information they need to make their decisions. This involves explaining complex medical diagnoses, prognoses and treatment regimes in simple language, ensuring that patients understand the treatment options, including the advantages and disadvantages of each, answering any questions they may have, and understanding whatever decision the patient has reached and, if possible, the reasons for it.

Two major obstacles to good physician-patient communication are differences of language and culture. If the physician and the patient do not speak the same language, an interpreter will be required. Unfortunately, in many settings there are no qualified interpreters and the physician must seek out the best available person for the task. Culture, which includes but is much broader than language, raises additional communication issues. Because of different cultural understandings of the nature and causes of illness, patients may not understand the diagnosis and treatment options provided by their physician. In such circumstances physicians should make every reasonable effort to probe their patients' understanding of health and healing and communicate their recommendations to the patients as best they can.

Evidence of consent can be explicit or implicit. Explicit consent is given orally or in writing. Consent is implied when the patient indicates a willingness to undergo a certain procedure or treatment by his or her behavior. For example, consent for vein puncture is implied by the action of presenting one's arm. For treatments that entail risk or involve more than mild discomfort, it is preferable to obtain explicit rather than implied consent.

There are two exceptions to the requirement for informed consent by competent patients: Situations where patients voluntarily give over their decision-making authority to the physician or to a third party. Because of the complexity of the matter or because the patient has complete confidence in the physician's judgment, the patient may tell the physician, "Do what you think is best." Physicians should not be eager to act on such requests but should provide patients with basic information about the treatment options and encourage them to make their own decisions. However, if after such encouragement the patient still wants the physician to decide, the physician should do so according to the best interests of the patient.

Instances where the disclosure of information would cause harm to the patient. The traditional concept of 'therapeutic privilege' is invoked in such cases; it allows physicians to withhold medical information if disclosure would be likely to result in serious physical, psychological or emotional harm to the patient, for example, if the patient would be likely to commit suicide if the diagnosis indicates a terminal illness. This privilege is open to great abuse, and physicians should make use of it only in extreme circumstances. They should start with the expectation that all patients are able to cope with the facts and reserve nondisclosure for cases in which they are convinced that more harm will result from telling the truth than from not telling it.

In some cultures, it is widely held that the physician's obligation to provide information to the patient does not apply when the diagnosis is a terminal illness. It is felt that such information would cause the patient to despair and would make the remaining days of life much more miserable than if there were hope of recovery. Throughout the world it is not uncommon for family members of patients to plead with physicians not to tell the patients that they are dying. Physicians do have to be sensitive to cultural as well as personal factors when communicating bad news, especially of impending death. Nevertheless, the patient's right to informed consent is becoming more and more widely accepted, and the physician has a primary duty to help patients exercise this right.

In keeping with the growing trend towards considering healthcare as a consumer product and patients as consumers, patients and their families not infrequently demand access to medical services that, in the considered opinion of physicians, are not appropriate. Examples of such services range from antibiotics for viral conditions to intensive care for brain-dead patients to promising but unproven drugs or surgical procedures. Some patients claim a 'right' to any medical service that they feel can benefit them, and often physicians are only too willing to oblige, even when they are convinced that the service can offer no medic')l benefit for the patient's condition. This problem is especially serious in situations where resources are limited and providing 'futile' or 'non-beneficial' treatments to some patients means that other patients are left untreated.

Futile and no beneficial can be understood as follows. In some situations a physician can determine that a treatment is 'medically' futile or no beneficial because it offers no reasonable hope of recovery or improvement or because the patient is permanently unable to experience any benefit. In other cases the utility and benefit of a treatment can only be determined with reference to the patient's subjective judgment about his or her overall well-being. As a general rule a patient should be involved in determining futility in his or her case. In exceptional circumstances such discussions may not be in the patient's best interests. The physician has no obligation to offer a patient futile or no beneficial treatment.

The principle of informed consent incorporates the patient's right to choose from among the options presented by the physician. To what extent patients and their families have a right to services not recommended by physicians is becoming a major topic of controversy in ethics, law and public policy. Until this matter is decided by governments, medical insurance providers and! or professional organizations, individual physicians will have to decide for themselves whether they should accede to requests for inappropriate treatments. They should refuse such requests if they are convinced that the treatment would produce more harm than benefit. They should also feel free to refuse if the treatment is unlikely to be beneficial, even if it is not harmful, although the possibility of a placebo effect should not be discounted. If limited resources are an issue, they should bring this to the attention of whoever is responsible for allocating resources.

As with patients, though, there are legitimate grounds for refusing to enter or for terminating a relationship with another healthcare provider. These include lack of confidence in the ability or integrity of the other person and serious personality clashes. Distinguishing these from less worthy motives can require considerable ethical sensitivity on the physician's part.

Although physicians can experience many different types of conflicts with other physicians and healthcare providers, for example, over office procedures or remuneration, the focus here will be on conflicts about patient care. Ideally, healthcare decisions will reflect agreement among the patient, physicians and all others involved in the patient's care. However, uncertainty and diverse viewpoints can give rise to disagreement about the goals of care or the means of achieving those goals. Limited healthcare resources and organizational policies may also make it difficult to achieve consensus.

Disagreements among healthcare providers about the goals of care and treatment or the means of achieving those goals should be clarified and resolved by the members of the healthcare team so as not to compromise their relationships with the patient. Disagreements between healthcare providers and administrators with regard to the allocation of resources should be resolved within the facility or agency.

*** Lecturer**
Vinayak Law College
Chomu (Jaipur)