MEDICAL ETHICS: PAST, PRESENT AND FUTURE

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EXECUTIVE SUMMARY

Purpose
From antiquity to the present, all societies have faced health challenges that prompted the formation of groups of healers and the development of codes of ethics to govern the treatments that they offered. Medical oaths and codes of ethics blend the moral precepts, normative behaviour and social duties of the civilization in which they are used, and they change as new medical therapies and social issues arise. The purpose of this primer is to show how each society from Mesopotamia to the present has grappled with defining a code of ethics for its medical students and clinicians, and to show why this is a never-ending task.

Studying the history of the development and use of oaths and codes of ethics provides us with a means of understanding how other societies grappled with ethical issues. But to do so requires an appreciation of the social, cultural, attitudinal, economic and political difference between the 21st and all preceding centuries. This primer therefore is divided into three sections: “Laying the Foundations,” which examines early societies and their attempts to define medical training and practice; “Medical Professionalization and Ethics Codes,” which discusses the process of professionalization and how British and American codes of ethics affected Canadian doctors and their association; and “Modern Medicine and Ethical Issues,” which looks at the rise of bioethics, the secularization of society, the role of government, and the transformation of medical practice as a result of new technology, scientific innovation, multiculturalism and renewed public interest in self-help and non-traditional medicine. Like healers throughout the ages, it is vital that you examine your own beliefs, read the current Canadian Medical Association Code of Ethics (www.cma.ca) and discuss with colleagues, friends and patients the key role that ethics play in medical training and practice.

Laying the Foundations
In Mesopotamia, ancient Egypt, Hellenic Greece, India, China, the early Ottoman Empire and pre-Renaissance Europe, each society defined its expectations of physician behaviour based on existing religious/spiritual beliefs, medical knowledge and healing practices. But it was the Greeks who most clearly articulated the ethical principles on which the western medical tradition was founded: beneficence, confidentiality and admonitions against actions that would harm the patient. The Hippocratic Oath, however, said nothing about payment for services rendered because Greek society revered personal honour more than wealth. This produced the “paradoxical duality of the conflict between altruism and self-interest” that medical ethicists such as Albert Jonsen see at the heart of western codes of ethics.

The source of this conflict was the separation of church and state during the Middle Ages. At this time, the ability to purchase medical assistance was usually confined to royalty, the aristocracy or the wealthy upper classes, while middle class merchants, urban workers, farm labourers, peasants, serfs and the poor had to rely on home remedies, astrologers, bone-setters, barber-surgeons and the charity of academically trained practitioners. Although religious orders provided charity care starting in the early Christian era, this model of altruism contrasted with the medieval guilds, which provided care for a set fee. Was medicine therefore a trade like goldsmithing? What ethical foundation now existed, and who would define it? Was it simply understood that Christian principles of benevolence and charity would prevail, or was a specific code of ethics required?

Medical Professionalization and Ethics Codes
As a result of scientific advances in medical knowledge during the Renaissance and Enlightenment, medical training and practice gradually began to professionalize and claim the right to self-regulation based on expertise. With the shift from apprentice-training to formal courses in universities or proprietary medical schools in the 18th and 19th centuries, medical leaders recognized the need to identify core values for practitioners and students. This led to the creation of the first formal codes of ethics by John Gregory (1725–1773) and Thomas Percival (1740–1804). Their works provided many American and Canadian doctors who studied in Edinburgh and London with the intellectual foundation from which to formulate codes of ethics when the American and Canadian medical associations were formed in 1847 and 1867, respectively. Building on the belief that medicine was an altruistic calling, these codes emphasized the concept of fiduciary duty and shared responsibilities by doctors, patients and society. Their purpose was to define practitioners’ behaviour and to create a cohesive group identity.

Many commentators, however, saw and still see these codes as paternalistic (and frequently misogynistic) expressions of self-
interest designed primarily to protect doctors from external competition and oversight by lay people and governments. Others have argued that the principal aspects of these codes hark back to the emphasis on good character, scientific knowledge, technical expertise and compassion found in the Hippocratic Oath. The conflict between these two views was evident during the late 19th century, when both the American Medical Association and the Canadian Medical Association (CMA) endeavoured to eliminate sectarian practitioners and to refine professional training and behaviour. As medical training became focused in universities and research provided preventive measures, antibiotics and vaccines, new surgical techniques, and diagnostic technology, medicine acquired the status and prestige that it had long sought by the middle of the 20th century. All of these changes and the horrifying revelations of the Nazi death camps and Japanese experiments on captive populations, however, prompted revisions to the codes of ethics that reflected contemporary concerns and the impact of new therapies and technological innovations.

Modern Medicine and Ethical Issues
The very success of medical science, however, led western European nations and Canada to move medical practice from the commercial realm to public policy through the creation of government-funded hospital, medical and diagnostic services in the 1950s and 1960s. Only the United States has failed to create a universal health program for its citizens. By making medical services a “public good,” Canadian and European governments were creating a social contract with their citizens and the medical profession. But many doctors continued to believe that their ethical code required them to defend the sanctity of the doctor-patient relationship against third party intrusion, and this led to strikes and work stoppages that raised ethical questions and prompted further revisions to the “CMA Code of Ethics” through the 1960s and 1970s.

Canada’s ethnic composition also changed between 1960 and the present, which affected not only medical education but also physician-patient relationships as the code of ethics began to stress informed consent, effective communication and respect for the viewpoints of team members, patients and their families. As bioethics became an important aspect of medical education and clinical practice in response to public and professional concern about issues such as reproductive health, end-stage renal disease, transplantation, allocation of CAT and PET scans, terminal care, pain control, human organ sales, euthanasia, and physicians’ relations with the pharmaceutical industry, both the CMA and the Royal College of Physicians and Surgeons of Canada worked to integrate ethical questions into medical training and practice. This primer reflects the belief that understanding the historical roots of contemporary ethical codes will enable students and fellows to comprehend their place in history and to recognize that the definition of what constitutes ethical standards changes as social mores are modified and new scientific discoveries extend or limit our capacity to preventive, cure or palliate disease.

Medicine has always stood at the intersection between science and society, practised as both an art and a craft. Ethical considerations must be debated and discussed during training and throughout one’s career because they are the foundation of both the art of dealing with patients and the effective practice of the craft. The written codes of ethics are based on modern terms for many of the issues raised in ancient Greece. They also represent an effort to codify the essence of “the clinical encounter between physician and patient” while emphasizing the importance of compassion, beneficence, non-maleficence, respect for persons and accountability.