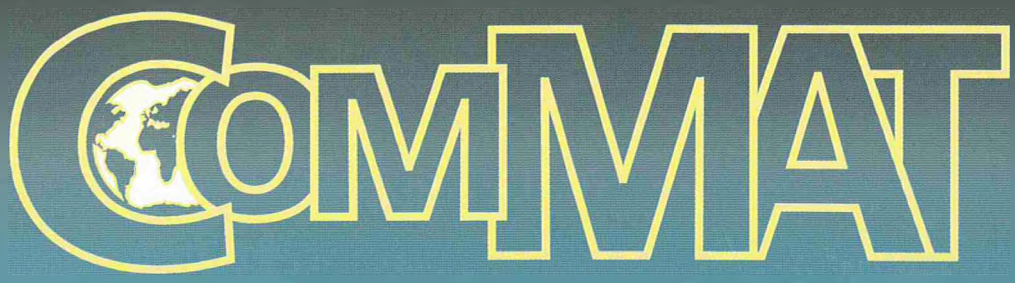


Commonwealth Medical Association Trust

# Training Manual on Ethical and Human Rights Standards for Health Care Professionals

# COMMONWEALTH MEDICAL ASSOCIATION TRUST

# TRAINING MANUAL
# on
# ETHICAL AND HUMAN RIGHTS STANDARDS
# for
# HEALTH CARE PROFESSIONALS


Marianne Haslegrave (Director)
John Havard (Secretary)
Commonwealth Medical Association Trust
BMA House, Tavistock Square
London WC1H 9JP
United Kingdom

Tel: 44 171 383 6095
Fax: 44 171 383 6195
E-mail: com_med_assn@compuserve.com
website: http://www.cma.co.za

Published May 1999.
Printed by the British Medical Association

*[Governments should] ensure that all health services and workers conform to human rights and to ethical, professional and gender-sensitive standards in the delivery of women's health services aimed at ensuring responsible, voluntary and informed consent [and] encourage the development, implementation and dissemination of codes of ethics guided by existing international codes of medical ethics as well as ethical principles that govern other health professionals.*

*United Nations Fourth World Conference on Women, Beijing 1995*

*Platform for Action, para 106(g)*

*...a young woman's right to privacy, confidentiality, respect and informed consent is often not considered.*

*Ibid, para 93*

This manual attempts to address the ethical concerns likely to arise during everyday medical practice in developing countries. It does not attempt to be comprehensive, and issues with lesser everyday impact, such as the new reproductive health technologies, cloning, genetic engineering, euthanasia etc have not been discussed.

# A TRAINING MANUAL OF ETHICAL AND HUMAN RIGHTS STANDARDS FOR HEALTH CARE PROFESSIONALS

## CONTENTS

# PREFACE

Medical ethics has been of concern to medical practitioners for many centuries. Ethical standards have been propagated within the profession largely through ethical codes, exhortation and professional example. Since the 1960s medical ethics has become an attractive field of academic endeavour for philosophers and scholars from a wide range of disciplines. Their work, and in particular the application of moral reasoning by philosophers to the public debate, has provided a new dimension with important social implications.

Concern for human rights also has a long history. Since the 1940s when the *Nuremberg Code* and the *Universal Declaration of Human Rights* were promulgated there has been a shift from mere exhortation towards academic interest by scholars from many disciplines, and the development of protective legal instruments.

Renewed interest in teaching medical ethics has been stimulated by unethical research practices and concerns that patients should have more decision-making power in ethical dilemmas, particularly where their own vital interests are at stake. Human rights abuses in many countries, which have received a high profile in recent decades, have been a stimulus to the human rights movement. Because health care professionals are often the first to become aware of such abuses, for example torture in prisons, child or wife abuse in the family and abuse of patients in mental institutions, there has been a growing trend towards linking education and exhortation about medical ethics with action to protect human rights.

The Commonwealth Medical Association (CMA)[1], assuming that the low level of observances of ethical standards and human rights by many health professionals is due to inadequate and often inappropriate instruction on the ethical and human rights aspects of professional practice, has been in the forefront of the move to link education in medical ethics to education about human rights.

Four modules, each comprising three hours of work, have been designed to educate health care professionals through case discussions and role playing, particularly in those countries where some human rights abuses may be most prevalent. The objective is that all health professionals participate in one module each year as part of the requirements for renewal of the licence to practice. These carefully designed modules have been tested and found acceptable in the field context in the Fiji Islands, Pakistan, Tanzania and Zimbabwe.

While it will be generally accepted that guidelines and workshops can improve knowledge, it is justifiable to ask whether they can also improve practice, ie does knowing what is right and good translate into doing what is right and good? The answer is that while knowledge does not always translate into action, doing the right thing is to a major extent dependent on knowing what is considered to be right. How can one do good if one does not know what is right? It is also important, if one wishes to influence others, to be able to provide reasons for why one course of action is preferred over another. Hence, the value of moral reasoning and an understanding of ethical knowledge needed to inform moral reasoning over moral exhortation.

It is necessary to appreciate that respecting human rights requires more than passive non-interference with the rights of others. Unless responsibility is taken to ensure that rights are protected, aspirations to achieve the goals of human rights will be frustrated. While it is appropriate and necessary to stimulate health care professionals to take responsibility for protecting human rights, it should be acknowledged that this is not sufficient. Without national responsibility at social, economic and political levels human rights abuses will continue.

Finally, it is necessary to understand the arduous context of impoverishment and oppression within which many health professionals work in some countries. Because these conditions are almost unimaginable for many working in privileged environments, there is the danger that higher ethical standards may be expected from those in poor countries that the more privileged are themselves willing to live up to. Such imperialistic attitudes are unethical and also need to be addressed.

These modules should therefore not be seen as a panacea. However, if used sensibly they have the potential to sensitise health care workers to ethical and human rights issues and to contribute to improvements in professional standards of practice. They should be widely used, carefully evaluated and further developed.

S R Benatar
Department of Medicine and Bioethics Centre
University of Cape Town

## Endnote

1 At its triennial meeting in Mauritius in 1995, the CMA Council agreed to form the Commonwealth Medical Association Trust (ComMAT) which assumed responsibility for the CMA's charitable activities in 1997.

# Part I

## Contents

# 1 INTRODUCTION

The generally low levels of compliance by health workers with ethical and human rights standards has attracted much adverse comment in the past decade, especially during the recent series of UN inter-governmental conferences. The consequences are particularly serious for the health of vulnerable and disadvantaged groups in developing countries. This manual has been prepared to help redress the inadequate, often inappropriate, and sometimes non-existent instruction received on medical ethics and human rights by health professionals in developing countries during their basic training. Its aim is to provide them with the necessary guidance as part of their continuing education.

The institutions and agencies that determine the distribution of health information and services and impose the conditions and restrictions under which they are provided should, of course, accept their share of the blame for the commission of health-related violations of ethics and human rights in developing countries as, of course, should the licensing bodies that have been given statutory powers to regulate and enforce standards of education and conduct for medical and other health professionals, and the training schools (particularly medical schools), that are entrusted with their basic professional education.

## Guiding Principles on Medical Ethics and Human Rights

The principles contained in this manual have been field tested at workshops in a number of developing countries, and have since been adopted by some of their medical associations as the national code of medical ethics. They are unique among international codes of medical ethics in that they take account of conditions of practise in developing countries; they deal with the obligations of health professionals towards vulnerable and disadvantaged groups (which in many such countries includes the majority of their women and adolescent girls); and they are extensively annotated with references to the corresponding human rights instruments.

The guidance contained in the manual should be regarded as 'best practice'. It has to be accepted that the unsatisfactory conditions under which health professionals have to work in many developing countries (eg severe shortage of resources, inadequate facilities, restrictions and conditions imposed on services by health authorities, institutions and agencies or by structural adjustment programmes etc) may make it difficult to follow the guidance to the letter. However health professionals who choose, for whatever reason, not to follow the guidance should carefully examine their reasons for doing so and be prepared to justify them.

Traditional and cultural factors exert a more powerful influence on human behaviour in developing countries. Where such behaviour results in violation of human rights that is damaging to health the objective should be to encourage the community to recognise the fact. The global dialogue on medical ethics has so far been concentrated on issues arising in 'western' countries . Little attention has been paid to the situation in developing countries with the result that the ethical implications of the extended family, son preference, polygamy, widow inheritance, structural adjustment programmes etc have been largely ignored. Medical associations of developing countries in the Commonwealth have had little opportunity to participate in the dialogue, and their views have not been heard. It follows that unqualified introduction of 'western' standards of ethics could easily be seen as an imposition by the former colonial power. For this reason the manual has been field-tested at workshops held jointly with the national medical and other health professional associations of the countries concerned.

## Health professionals

These workshops have confirmed that there is an urgent need for health professionals in developing countries to become better informed and more aware of the adverse consequences to health by failure to respect ethical and human rights standards, particularly to the health of vulnerable and disadvantaged groups.

*For the purposes of this manual, health workers are recognized as health professionals if they have undertaken to comply with recognised standards of professional conduct, training and competence, for which they are accountable to an independent licensing body with powers to enforce them. This applies irrespective of the nature of their practice or employment ie whether employed, full or part-time, self-employed, or whether in government or private practice. In most developing countries this will include physicians, dentists, nurses, midwives, pharmacists, and members of comparable health professions. The distinction is one of accountability, and should not, of course be taken as reflecting adversely on the standards of conduct, training and competence of those health workers who are not accountable to an independent regulatory body.*

## Training modules

Arrangements for the continuing education of established health professionals in medical ethics and human rights must take account of the fact that they are usually able to afford only short periods of absence away from their work. Accordingly the Guiding Principles have been clustered into four training modules, each of which should occupy about three hours, depending on the number of case studies that are discussed. The modules can be presented singly or collectively as part of an established continuing education programme, or in association with other events at which health professionals are likely to collect together, eg medical conferences and other meetings organized by health professional associations and academic bodies.

Each module includes four Guiding Principles, and each Principle is followed by a commentary and illustrative case studies (a technique with which most health professionals are familiar). The ultimate objective is that every year practising health professionals, as a condition of renewal of the annual licence to practise, should be required to have attended at least one session at which instruction has been given based on one or more of the modules. Meanwhile a short guide is being prepared for trainers.

## Acknowledgements

The preparation of this manual was made possible by grants from the United Kingdom Department for International Development (DfID) and the United Nations Population Fund (UNFPA). The Guiding Principles upon which it is based were developed with the aid of a grant from the Canadian International Development Agency (CIDA) and The Ford Foundation.

# 2 ETHICAL AND HUMAN RIGHTS STANDARDS FOR THE HEALTH CARE OF VULNERABLE AND DISADVANTAGED GROUPS IN DEVELOPING COUNTRIES

The principles of medical ethics were introduced to protect members of the community who were desperate to obtain relief from their pain and suffering, or a cure for their illness or disability, from exploitation by physicians. The term ethics implies relationships, and the principles of medical ethics were concerned with the doctor/patient relationship which, until recently, was on a one to one basis. It was unusual for any other health workers to be involved in that relationship.

As the practice of Medicine became transformed from a humanity into a science, other health workers such as nurses, midwives, pharmacists, opticians etc undertook training that equipped them to carry out medical procedures of varying complexity and to assume important responsibilities for the care of patients. Licencing bodies, usually similar to, but not necessarily separate from, those for physicians were formed to establish and to monitor their standards of professional education and ethical conduct. Those who are licenced by such bodies and, therefore, required to meet those standards, are known as health professionals.

Meanwhile institutional bodies, beginning in Britain during the 19th century with the Friendly Societies, were formed to administer and to manage health services for various population groups, such as the general practitioner services that were introduced for employed persons under the British National Health Insurance Act of 1912 and the free comprehensive health service for all, including hospital and specialist services, that was introduced as the British National Health Service Act in 1948. The conditions imposed by these and other institutions that provide health services have an important impact on the relationships of physicians and other health professionals with their patients, which is why health service authorities and managers should respect both the human rights of patients and principles of medical ethics, although they have not always done so.

## Principles of medical ethics

What are the principles of medical ethics? The most important and, in a sense, that from which all the others are derived, is respect for the patient which must be observed without discrimination, in particular, respect for the dignity and privacy of women and young girls. Health professionals should avoid the patronizing, critical and judgmental attitudes that were often adopted in the past when the doctor/patient relationship was characterized by power and privilege on the part of the physician and trust and dependence on the part of the patient.

Why should lack of respect for the patient be regarded as unethical? Because the primary ethical concern of health professionals must always be the interests of the health of their patients. Those interests, particularly in the case of women and adolescent girls, are at risk whenever they are discouraged by the way health professionals treat them from seeking medical help, or from disclosing sensitive information. that is essential for safe and effective diagnosis and treatment.

One of the adverse consequences of the introduction of modern management techniques into health care, such as the market model of medicine, has been a marked diminution in the importance traditionally attached to compassion and even to altruism in the management by health professionals of their patients. This is evidenced by the increasing tendency to replace the term 'patient' by 'client'; 'consumer'; or, worse still, 'customer'. Health professionals should bear in mind that the poor health status of vulnerable and disadvantaged groups in developing countries is rooted in their exceptional exposure to poverty; discrimination; malnutrition; functional illiteracy; unemployment and violence, compounded by inadequate access to the health information and services that they need.

Failure to provide women with information enabling them to exercise full, free and informed consent to medical interventions is common in developing countries. Their consent is often not sought or is given for them by their husbands or male partners. Failure by health professionals to respect their confidentiality, particularly in the case of adolescents, is a major reason for their not

seeking medical advice or treatment and for the withholding of information essential for providing them with safe and effective treatment, a previous history of past pregnancies, abortions, STDs etc.

Failure by health professionals or health authorities to comply with ethical obligations towards women, adolescent girls, and other vulnerable and disadvantaged groups in the community, amounts to an invasion of their integrity and often involves a violation of their human rights. As such, society should demand an explanation for such conduct and a justifiable excuse for its continuation. But there are usually no excuses apart from those based on traditional practices, and most of these are rooted in gender discrimination.

The report of the United Nations Expert Group on *Women and Health - Main streaming the Gender Perspective into the Health Sector,* which met in Tunis from 28 September to 2 October 1998, has pointed out that medical textbooks still retain the male as the norm or reference point and regard women as exceptions to the male. The report cites as an example the fact that instruction of medical students in the correct procedure for carrying out breast and pelvic examinations in the female, while correctly based on the need to detect abnormalities, usually omits the technique for carrying them out painlessly and with the minimum of discomfort.

This is, of course, an issue of ethical principle as it discourages women from seeking medical help or encourages them to postpone it until it is too late. The expert group recognised that integrating a gender perspective into the medical curriculum will involve drastic ideological changes. It also noted that medical students do not, or cannot, conceptualize what they are learning if they have not been taught to do so, and medical teachers have not been taught how to teach.

## Human rights

Although principles of medical ethics governing the conduct of physicians with their patients, such as the possibly apocryphal Hippocratic Oath, have been circulating throughout the 'civilized' world since antiquity, it was not until 1945 that a commitment was entered into by governments, through the *United Nations Charter,* to take joint and seperate action in cooperation with the United Nations to promote respect for human rights. The *Universal Declaration of Human Rights* followed in 1948 and today, some 50 years later, its standards are applicable in every State, whether or not they are recognized by national legislation.

The Declaration has since been supplemented by a number of internationally recognised human rights instruments. The most important are the following six covenants and conventions that are legally enforceable in States that have ratified or acceded to them:

- *International Covenant on Economic; Social and Cultural Rights*
- *International Covenant on Civil and Political Rights*
- *International Convention on the Elimination of All Forms of Racial Discrimination*
- *Convention on the Rights of the Child (Children's Convention)*
- *Convention on the Elimination of All Forms of Discrimination against Women (Women's Convention)*
- *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (Torture Convention)*

All of the above have an impact, to a greater or lesser extent, on health professional practice, as do many other human rights instruments, and the ethical principles contained in this manual are extensively referenced to them.

## Education of medical and other health professionals in ethics and human rights

Much of the responsibility for the present unsatisfactory levels of compliance by health professionals with ethical and human rights standards in the health care of vulnerable and disadvantaged groups in some developing countries has resulted from inadequate or even non-existent instruction on ethics and human rights given in their training schools.

It is hardly surprising that the World Conference on Human Rights in 1993 should have identified the health professions as a group in special need of instruction in human rights and humanitarian law. The following year the International Conference on Population and Development urged governments *'to secure conformity to human rights and to ethical standards in the delivery of family planning and related reproductive health services aimed at ensuring responsible, voluntary and informed consent and also regarding service provision'*. In 1995 the Fourth World Conference on Women said very much the same thing. It urged governments to 'encourage the development, implementation and dissemination of ethics guided by existing international codes of medical ethics as well as ethical principles that govern other health professionals', adding with concern that respect, informed consent and confidentiality were not often accorded to women.

## Enforcement of ethical principles and human rights

Violations by health professionals of human rights are often not recognized as such by their licensing bodies unless they amount to what is often described as 'serious professional misconduct'.This usually amounts to conduct involving sexual contact with patients (whether or not consensual); obtaining unfair advantage over colleagues by unacceptable advertising of services etc. It is difficult to escape the conclusion that licensing bodies, in deciding whether conduct by a physician involved in a violation of human rights amounts to serious professional misconduct, are more concerned with whether the conduct in question has brought the profession into disrepute than with any adverse consequences to the health of patients.

Hence violations by physicians of the Torture Convention which invariably attract unwelcome publicity for the medical profession will be treated extremely seriously whereas violations of the Women's Convention may be ignored altogether. We may take as an example the following scenario: A physician deliberately submits a woman, without adequate justification, to a medical procedure or course of treatment that is known to carry an unacceptably high risk of damage to women's health. This is, of course not only negligence in law, but is instantly recognizable as unethical and serious professional misconduct and will be dealt with very firmly by the licensing body.

Now compare this with the case of a senior and experienced physician with management responsibilities for health services who takes a highly discriminatory administrative or planning decision that results in the grossly inadequate and discriminatory provision of services for medical conditions from which only women suffer, eg cervical cancer, vesico-vaginal fistula etc or from which women suffer more severely than men, such as breast cancer, and that as a result many women suffer permanent or fatal damage to their health.

This is a form of gender discrimination that amounts to violation of human rights, specifically of the Women's Convention. But a medical licensing body or national medical association would be most unlikely to consider such conduct unethical, or amounting to serious professional misconduct, still less so if the physician had only supported or concurred in the decision. Needless to say, if such a damaging degree of discrimination came to the attention of the monitoring committee of the Women's Convention, ie the Committee on the Elimination of Discrimination against Women (CEDAW), the government concerned would be closely questioned as to the reasons for it.

It must, of course, be added in the context of gender discrimination that the same would apply to a decision which resulted in the grossly inadequate provision of services for medical conditions from which only men suffer, but this is a less likely scenario as most planning decisions in the health sector of developing countries are taken by men.

The example does, however, illustrate the curious anomaly that in adopting and enforcing ethical principles for health professionals, national licensing bodies and professional associations can and do ignore legally enforceable obligations contained in human rights instruments, notwithstanding the fact that they may have been ratified without reservation by their own governments.

The failure of training schools for health professionals to provide adequate instruction in internationally recognised human rights, together with the reluctance of licensing bodies to enforce

them effectively are a serious obstacle to the prevention of human rights violations that have an adverse effect on health. Health professionals are in a particularly advantageous position to recognize such violations as they are often among the first to be involved in situations where they take place. However their inadequate knowledge of human rights means that they are often unaware of them, or may only become aware when it is too late, by which time they may have personally become implicated

## Enforcement of human rights through the UN procedure

The procedure for the enforcement of internationally recognised human rights through the UN system should be understood by health professionals and their national associations so that they can take effective action in the event of health-related violations coming to their attention. The purpose of the procedure is to monitor the progress made by governments in meeting the obligations they enter into when they ratify a Convention. The procedure is broadly similar for each of the six legally enforceable covenants and conventions and we can take the Women's Convention as an example.

Governments (known as States parties) are required to submit a report to CEDAW at the end of the first year following ratification and every four years thereafter. They can enter reservations to various articles of the Convention when ratifying it but they will be closely questioned by CEDAW on the reasons for any reservations and invited to explain why they cannot be withdrawn. CEDAW issues advice to governments on what should be included in their reports, and has produced a number of general recommendations dealing with particular articles of the Convention, many of which deal directly or indirectly with discrimination affecting the health of women.

It is impossible to attempt a comprehensive review of operation of this important Convention in the space available. However it should be noted that there remains some doubt about the extent of the remit of the CEDAW to investigate discriminatory practices affecting health under the terms of the Convention. These will, it is hoped, be resolved by the general recommendation of the Committee on Article 12 of the Convention, which deals specifically with *Women and health*.

CEDAW's activities in investigating health related discrimination against women are hampered by the inadequacy of gender specific health indices and the technical nature of much of the health information that it has to consider. The 23 members of CEDAW are appointed in their own individual capacities (and not as representatives of their governments) as experts in the field of women's human rights from different parts of the world, cultures and legal systems. It follows that there is no guarantee that they will include experts in health, and particularly in medical conditions affecting women. The Commonwealth Medical Association Trust (ComMAT) has been active in assisting CEDAW with the various problems it has been facing in investigating health-related discrimination against women and adolescent girls.

Discrimination affecting the health of vulnerable and disadvantaged groups is also dealt with under other human rights instruments including those listed above, notably the Children's Convention, which applies to adolescent girls up to the age of 18, unless they reach the age of majority earlier. The following categories of violation have been identified by the Science and Human Rights Programme of the American Association for the Advancement of Science (AAAS):

- those resulting from direct government action, coercive sterilization programmes such as making abortion services conditional upon women's agreement to sterilization;
- those related to a State's failure to fulfil the minimum obligations of human rights, eg neglecting to undertake measures to prevent and reduce maternal mortality;
- those related to patterns of discrimination, eg policies and/or budget allocations that cumulatively disadvantage the reproductive health status of particular groups such as adolescents, or of particular groups, eg rural women.

## Conclusion

Compliance by health professionals and by health institutions with medical ethics and human rights has an important role to play in improving the adverse health status of vulnerable and disadvantaged groups in developing countries, especially of their women and adolescent girls.

The existing low levels of compliance are the result of inadequate or non-existent training of their health professionals and health authorities in medical ethics and in the health-related components of human rights, and of low levels of enforcement.

Those interested in ascertaining the position in their own countries should seek answers to the following questions:

- What advice is issued by licensing bodies and/or health professional associations to health professionals about compliance with ethical principles and human rights, in providing health services for vulnerable and disadvantaged groups in the community?
- To which articles of the Women's Convention that deal directly or indirectly with women's health issues has the government entered reservations on ratification and what are the reasons for them?
- Are health-concerned NGOs, including national health professional associations, involved by the government in the preparation of its periodical reports to CEDAW and to the Committee on the Rights of the Child as far as health issues are concerned?
- Are they allowed to see both the final version of the reports before they are submitted, and the committee's concluding comments after they have examined the report?
- What independent (non-governmental) steps are being taken to monitor ethical or human rights violations in the health sector, eg by national human rights institutions?

# Part II
# Training modules

Contents

# MODULE 1

## 1.1 Respect for persons

**Guiding Principle: Health professionals should show respect at all times and in all circumstances to persons that they are attending.**[1]

This principle applies irrespective of the race, colour, gender, age, sexual orientation, lifestyle, religion, or political affinities of persons they are attending; as well as of their status, eg whether they be indigenous, refugees, schoolchildren, prisoners or visitors; and of the diseases or disabilities from which they may be suffering.[2] It is not limited to attendances upon sick or disabled persons, but extends to all attendances in a professional capacity, eg for purposes of pre-employment, pre-school or insurance examinations, or for inoculations. Special care needs to be taken to avoid discrimination against persons suffering from sexually transmitted diseases (STDs), especially HIV/AIDS infection, and against those of whose lifestyles a health professional may personally disapprove, eg unmarried mothers, commercial sex workers, drug abusers, homosexuals, lesbians etc.

Care should always be taken to respect personal integrity, which includes respect for dignity and privacy, particularly in the case of women and young girls who are likely to be especially sensitive, eg chaperones should be available whenever pelvic examinations are carried out. The conscientious, moral or religious beliefs of persons attending health professionals should never be ignored, even if such beliefs can clearly be seen to be damaging to the health of the person concerned or of others for whom they may be responsible, eg children and adolescents. However the interests of the health of persons they are attending should remain their main concern and they should never allow their own personal beliefs to have a detrimental influence on the services they provide, particularly in the field of sexual and reproductive health. They should not discriminate against patients who have been attending practitioners of traditional or alternative medicine, or who have decided to go overseas for treatment. Finally they should not associate themselves with unacceptable discriminatory medical procedures such as pre-natal sex selection, unless the intended outcome is to prevent the transmission of genetic disease, for which purpose the procedure should be only used selectively.

Respect does not imply that health professionals must seek to gratify the patient's every wish. Patients should be seen as members of both their families and of the broader community. Their autonomy and rights should be viewed in the context of their environment, especially where resources are limited. In some cases this may give rise to conflicts of interest, eg when certain kinds of expensive treatments are given preferentially to those who are expected to derive lasting benefit from them, as against those who are expected to derive only transitory benefits, eg coronary by-pass operations on intractable chain smokers, or very expensive drugs for patients suffering from advanced clinical AIDS.

**Case studies:** These should illustrate the consequences of health professionals failing to show respect to various patients, particularly if they are women and adolescents. Decisions on the use of scarce resources for patients with a poor prognosis should be discussed. Examples should be given of health-related violations of relevant human rights instruments, especially the Women's and the Children's Conventions.

## 1.2 Health care of vulnerable and disadvantaged groups

**Guiding Principle: Health professionals should take account of the special health needs of disadvantaged and vulnerable groups in the community.**

All sick or disabled persons are vulnerable and disadvantaged insofar as they are likely to be unduly susceptible to suggestions which offer them relief from pain and suffering and a cure of their condition. Health professionals should constantly bear this in mind[3] and be careful not to take advantage of it. They should be aware, and take account, of those who are deprived of adequate access to health care or who have difficulty in making their requirements known. They should bear in mind that such groups are exposed to risk of exploitation, violence and abuse. They should also take account of the special health needs of such groups as well as ascertaining the causes of their ill health. The risks are greatest for the following groups:

**Children:** Health professionals should constantly bear in mind that violence suffered by children is by no means always accidental[4] and that sexual abuse of children can remain undetected for long periods of time. Whenever they suspect violence to children, from whatever source, they should enlist the aid of the social or other supporting services to deal with the problem. The recognition and assessment of signs of violence in children, particularly sexual abuse, requires special skills. Health professionals requested by the police to examine such cases should not attempt to do so if more experienced colleagues are available.

In developing countries girl children are likely to be undernourished as a result of the prevailing discrimination in favour of male children in the family. This may result in delayed physical development and difficulties with future childbearing. The girl child is also less likely to receive adequate schooling and may often be required to carry out an unfair share of heavy physical work in the family home which can further damage her health. Child labour, eg in the fields, is a common hazard to the health of children in such countries[5] even though it is usually proscribed by law.

Other hazards to the health of the girl child include traditional practices such as genital mutilation.[6] Health professionals should endeavour to expose the dangers of such practices with the aim of changing the beliefs and attitudes which support them. Increasing numbers of children will lose their parents, and become orphans as a result of the HIV / AIDS pandemic in developing countries.

**Adolescents (aged 10-19 years, according to the WHO definition):** Adolescent girls are exposed to special health risks in developing countries as a result of gender (sex) discrimination and of being forced into marriage at too young an age.[7] Where additional earning power is needed for the family, or where their parents become sick, eg from clinical AIDS, the girls in the family, rather than boys, will be the first to be taken away from school.

Girls in developing countries may frequently be expelled from school if they become pregnant following which they will have to earn money from available sources, which may be limited to commercial sex, drug peddling or other occupations hazardous to their health. Too often their only recourse is to unsafe abortion. Health professionals should try to help girls to avoid these adverse consequences to their health by providing them with family planning counselling and services whenever necessary,[8] and with safe termination of pregnancy whenever it is appropriate and permitted by law.

Health professionals should take account of the fact that it may take some time for adolescents to come to the point during a consultation, and that they may withhold essential information for fear that their confidences may not be respected. The critical and judgmental attitudes adopted by many health professionals towards adolescents, particularly where their sexual and reproductive health is concerned, discourages them from seeking professional help at a time when they most need it. Adolescents should, therefore, be given assurances that the consultation will be treated as strictly confidential, especially as far as sexual or reproductive health problems are concerned.

**Women:** Women in developing countries may suffer disproportionately from ill health including many illnesses that are life-threatening. Violence is usually identified by women as the health issue about which they are most concerned. Women who have been assaulted by their partners will often

claim that their injuries are the result of an accident. In deciding whether or not to report such cases to the police health professionals should weigh the consequences to the woman and her children of her partner being imprisoned against the risk of her being subjected to more serious attacks if no action is taken.

Women are often denied access to means of controlling their fertility[9]. Reliable information about the prevention of disease may never reach them because of the high prevalence of female functional illiteracy in developing countries. The high maternal mortality and morbidity rates in such countries are largely avoidable. The morbidity associated with pregnancy may include conditions such as vesico-vaginal fistula (VVF), the social consequences of which often lead to the affected woman being evicted from her home and left with no means of support. Health professionals should do all they can to advocate services that can help women avoid such consequences, whilst taking care not to expose them to non-essential invasive procedures.

**The elderly:** The dependence of the elderly on others for their care renders them susceptible to exploitation. The capacity of the extended family to care for the elderly, which has already been reduced by social factors such as migration to cities, has been further compromised in many developing countries by the effects of the HIV/AIDS pandemic, which has reduced the number of family members available to look after them. Health professionals should be alert to the signs of violence and neglect in the elderly and do all that is possible to provide them with the support necessary to protect their health.

**Other high risk groups:** Health professionals should be aware of the special needs of refugees, asylum seekers, minority ethnic groups,[10] indigenous peoples,[11] immigrants,[12] persons under compulsory detention etc and should recognise that their access to health care is often limited. Refugee status is not conducive to health and refugee women are often subjected to sexual abuse.

Persons suffering from severe physical or mental incapacity[13] are often at risk of abuse, maltreatment or neglect by their families or by the institutions in which they have been placed. Health professionals attending these vulnerable and disadvantaged groups should be vigilant in detecting any suspicious signs of violence or neglect, and should be sure to alert the appropriate authorities promptly.

**Case studies:** Examples should be given of the ethical and human rights implications of providing adolescents with sexual reproductive health information and services. The management of cases of violence to women should be illustrated.

## 1.3 Confidentiality

### Guiding Principle: Information obtained about patients in the course of a professional relationship should be treated as strictly confidential.

Respect for the confidentiality of medical information is essential to the relationship of trust that should exist between health professionals and their patients. Unless confidentiality is assured patients are unlikely to make full disclosure of aspects of their medical history that might attract social stigma in the local community, eg extra-marital pregnancies, abortions, STDs etc with the result that an incorrect diagnosis may be made or inappropriate treatment provided. Health professionals need to be aware of all relevant aspects of the patient's personal and family medical history in order to arrive at a reliable diagnosis and to give safe and effective treatment.

Uncertainty about confidentiality is the main reason given by adolescents in developing countries for their reluctance to consult health professionals about their sexual and reproductive health needs. While health professionals should always attempt to persuade adolescents to allow parents or guardians to be involved in such cases, adolescents are entitled to confidentiality which should always be respected unless there are the most clear and compelling reasons to the contrary.

When seeking consent to disclosure of confidential medical information, health professionals should ensure that patients understand the reasons for it and of any consequences of disclosure of which they should be made aware. Apart from situations where disclosure is required by law such

as the notification of infectious diseases, there must always be the most compelling reasons before a health professional discloses confidential information without the consent of the patient,[14] and in such cases health professionals should always inform patients that they intend to disclose the information.

Where failure by a health professional to disclose such information could result in an immediate and serious threat to the life or health of a patient or of others in the vicinity of the patient, much will depend upon the counselling skills of the health professional in persuading the patient to agree to disclosure, eg where patients refuse to inform sexual partners of their HIV positive status, or insist on driving a motor vehicle or operating potentially dangerous machinery, when unfit to do so.

Health professionals should restrict access to medical records by their own staff and other health workers to medical information that they need to know in order to provide services for the patient concerned, and should ensure that they understand the need for strict confidentiality, and undertake to observe it.

**Case studies:** Examples should include cases where patients refuse to allow their HIV status to be disclosed to their spouses; the consequences of failure to ensure that staff with access to records maintain confidentiality; situations where patients who are unfit to drive refuse to notify the licensing authorities; the position where the male head of an extended family insists upon being given detailed medical information about members of his family.

## 1.4 Requests by third parties

### Guiding Principle: Care should be taken not to compromise the interests of patients when supplying information about them at the request of a third party.

Health professionals should observe the ethical guidance set out in this manual, especially that concerned with consent and confidentiality, whenever medical examinations or reports are requested by third parties. Confidential medical information should not be passed to a third party without the full free and informed consent of the person concerned, and care should be taken to avoid divulging such information inadvertently. Pre-employment medical reports should be limited as far as possible to a simple statement of fitness or unfitness for the job or position concerned.

Where a report containing detailed or specific medical information is required by a third party it is important to ensure that the person to whom it relates understands the possible consequences before consenting to disclosure, or agreeing to submit to any medical examination or test upon which the report would need to be based, eg a HIV test. Advance warning must always be given to the patient if it is impossible to guarantee confidentiality of the information concerned. The same considerations apply to medical examinations and reports carried out for life insurance, health insurance, or for any other purposes requested by third parties.

Court orders to disclose confidential medical information must always be given the most careful attention. A subpoena (court order) compels a health professional to attend court with or without the complete medical records of the patient(s) concerned. However, objection should be taken by health professionals to any direction by the court to disclose confidential information that is irrelevant to the litigation, eg medical details of other family members of parties to the action that are included in the records. In such cases a health professional should raise objection before being sworn to give evidence and request that the judge hears that objection *in camera*, ie with only judge and counsel present, before proceeding to hear the case. Health professionals requested by a lawyer to hand over complete medical records of patients should not do so until they have satisfied themselves on this point and/or have removed the documents concerned.

The above guidance is based on the procedure in English courts much of which has been retained or adopted by other Commonwealth countries since they gained their independence. On the other hand most of them, unlike England, now protect certain kinds of medical information by granting it 'special privilege' from disclosure in court.

Case studies: The consequences of including unnecessarily detailed medical information, and/or information about other persons should be discussed. Examples should include requests from insurance companies seeking to avoid payment arising out of the illness or death of a patient. Failure to warn patients of the consequences of disclosing information to third parties, eg HIV status should also be discussed.

## Endnotes

1 Universal Declaration of Human Rights (UDHR) (1948) Art 1

2 ibid Art 2; International Covenant on Civil and Political Rights (ICCPR) (1966) Art 26

3 See eg Hippocratic Oath, the Kind code Caraquet Samita (1st century AD) and the Islamic Declaration of Kuwait

4 International Covenant on Economic, Social and Cultural Rights (ICESCR) Art 10(3); Convention *on the Rights of the Child (Children's Convention) (1989) Arts 3(2), 9 & 32-37*

5 *Children's Convention Art 32*

6 *ibid Art 24(3); Convention on the Elimination of All Forms of Discrimination against Women (Women's Convention) (1979) Art 5(a)*

7 *Women's Convention Art 16(2)*

8 *Women's Convention Art 16(1)(e)*

9 *Women's Convention Arts 12, 14(2)(b) & 16(1)(e)*

10 *Declaration on the rights of persons belonging to national or ethnic, religious and linguistic minorities (UN General Assembly resolution 47/135 of 18 December 1992)*

11 *International Labour Office (ILO) Convention No 169 (concerning indigenous and tribal peoples in independent countries) Art 25*

12 *Children's Convention Art 22(1); International Convention on the Protection of Rights of all Migrant Workers and members of their Families (1990) Art 28*

13 *UN principles for the protection of persons with mental illness and for the improvement of mental health care (UN General Assembly resolution 47/135 of 17 December 1991)*

14 *UDHR Art 16(3); ICCPR Art 23(1); ICESCR Art 10(1)*

## MODULE 2

## 2.1 Patient's right to information

**Guiding Principle: Patients have a right to receive information about their own medical condition and its management.**

Patients have a right to request and to receive relevant information about their own medical condition in a form that they are able to understand. Refusal to impart such information diminishes the trust that is fundamental to the relationship that should exist between health professionals and their patients. In exceptional cases, where a health professional has good reason to believe that receipt of the information that is requested would be detrimental to the health of the patient, it may be withheld. But the development of good communication and rapport with patients requires that it should be withheld only on a temporary basis until a suitable time can be found to provide a full explanation of the facts.

There are, of course, many instances in which patients should be given certain information whether or not they request it. They should, for example, always be given sufficient information to make a valid choice about treatment (see next section on 2.2 Consent to medical interventions) and to follow correctly any treatment or regime that is prescribed for them such as warnings about any significant adverse effects of proposed medical interventions including the main or side effects of prescribed drugs and adverse interactions with other drugs (including alcohol). This is, of course, particularly important where the treatment may impair skills requiring divided (as opposed to concentrated) attention, eg driving a motor vehicle or operating dangerous machinery.

Patients who demand information about all the possible adverse effects are entitled to be told about them. They should always be warned about the possibility of any significant financial or social consequences of investigations or treatment such as those resulting from HIV tests, removal of ovaries etc. Health professionals should always inform patients of any significant errors or mishaps that may have occurred in the course of investigation or treatment.

**Case studies:** These should include the consequences of failure to inform patients of possible adverse consequences of medical interventions, eg removal of ovaries and HIV testing as well as the consequences of refusing on conscientious grounds to assist underage sexually active adolescents seeking advice as to how to protect themselves from unwanted pregnancy or STDs.

## 2.2 Consent to medical interventions

**Guiding Principle: Treatment and other forms of medical intervention should not be undertaken without the full, free and informed consent of the patient.**

Sufficient information should always be given to enable the patient to decide whether or not to consent to the proposed treatment or diagnostic procedures[1] and to exercise a choice between such alternative and practicable options as may be available (which should be discussed with, and offered to, the patient, as appropriate). The patient should be told about relevant risks as well as the expected benefits of the proposed treatment.[2] The amount of information that can usefully be given will, of course, depend upon the ability of the patient to understand it, which the health professional should assess. A change of mind by the patient at any stage during treatment should always be respected.[3]

Health professionals should be careful not to exert undue pressure on patients to accept treatment[4], and they should bear in mind that influences may be exerted on patients by other persons, eg in societies where polygamous marriages are accepted it is not uncommon for an older wife who has not yet produced a son to exert pressure on younger wives to practise contraception, or to seek an abortion. It is particularly important that health professionals should refuse to participate in unacceptably coercive health policies such as those that have been reported as having been introduced for population control in some developing countries.

In some situations it is customary for the male head of an extended family to take decisions about medical treatment on behalf of other members of the family. In such cases patients should be encouraged to make their own choices about medical treatment, even if they are unaccustomed to do so and are content that others should express an opinion and take the final decision for them. This is particularly important in societies where it is usual for marriages to occur at an early age, when it is in the interests of the health of the young wife and her children that she should have unrestricted access to services such as family planning. Conflict situations may arise where contraception, abortion or sterilization is indicated in the best interests of the health of a woman, but where the law requires spousal consent, which may not be forthcoming.

Health professionals should be aware that the reluctance of patients to consent to treatment, especially if it involves hospital admission, may often result from anxiety, particularly in women, about the consequences for other members of their family,[5] and they should do what they can to alleviate such anxiety, eg by allowing members of the family to stay in hospital with the patient, by arranging early discharge, or by offering alternative arrangements or procedures.[6].

Where patients are regarded, for whatever reason, as incapable of making a decision for themselves to consent to treatment, the test must always be whether the patient has the capacity to understand the nature of the treatment and its likely consequences. Subject to the law relating to the age of consent to treatment the wishes of minors who have that capacity should always be respected regardless of their age or of any other factors which might be regarded as affecting their right to consent.[7]

However conflict situations may arise where parents or guardians refuse on religious or other conscientious grounds to allow life saving procedures to be carried out on children who have not yet reached the legal age of consent to medical treatment, eg Jehovah's witnesses. In some countries provision is made for application to a court of law in order to protect children in need of medical treatment.

The extent to which health professionals can meet the sexual and reproductive health needs of adolescents who have not yet reached the legal age of consent to treatment, without notifying and obtaining the agreement of their parents or guardians, is regarded as controversial in many societies. Wherever possible health professionals should try and persuade the adolescent to agree to a parent or guardian being involved. However, subject to the law of the country concerned, adolescents who are capable of understanding the required treatment and its consequences, but who refuse to allow their parents to be involved, should be given the necessary advice or treatment, eg contraception, or even abortion, if it is clearly in the best interests of their health to do so.

The Children's Convention (which applies up to the age of 18, unless the age of majority is reached earlier) states that the interests of the child must always be the primary consideration, and that in exercising their rights over the child parents must take into account the child's evolving capacity.[8] In cases where the adolescent is insufficiently mature to understand the nature of the treatment and its consequences health professionals should not give any treatment without the consent of the parent or guardian. However the confidentiality of the consultation should be respected and health professionals should not inform the parent or guardian without the consent of the adolescent unless there are the most clear and compelling reasons to the contrary.

Where an adult patient does not have the capacity to understand the nature of proposed medical treatment and its consequences, the decision whether to proceed should be taken in the best interests of the health of the patient, and should not be unduly influenced by others, such as those caring for the patient, as they may have financial or other interests in the management of the case. However in cases where the proposed treatment infringes human rights, such as reproductive rights, an application to a court of law may be necessary before certain procedures can be carried out, eg sterilization of mentally subnormal women.

It is always preferable that the health professional carrying out an intervention is satisfied that the patient understands what is to be done. In cases where this is delegated to a professional colleague, there is an obligation to ensure that the colleague has taken the necessary steps to obtain valid consent. (See also module 3.2)

**Case studies:** Examples should be given of conflicts between the ethical principles involved, legal constraints, implications for human rights, cultural or religious factors in the country concerned, eg the requirement of spousal consent for abortion, contraception, vasectomy or tubal ligation; the need for parental consent before sexually active underage adolescents can be given contraceptive advice and treatment; refusal by the parents to allow life saving treatment to be administered to their child etc.

## 2.3 Medical emergencies

### Guiding Principle: Health professionals should do all they can to assist at medical emergencies.

Health professionals should acknowledge that their primary obligation is to save life and to relieve pain and suffering, Conscientious objection to procedures such as contraception, termination of pregnancy, sterilization etc[9] does not absolve them from taking immediate steps in an emergency to ensure that the necessary treatment is given without delay and before any avoidable and permanent damage has been caused to the health of the patient.[10]

Health professionals should be alert to situations where their ability to provide emergency treatment could be compromised, eg employment in hospitals which place unreasonable restrictions on emergency admissions, such as delaying or refusing treatment until it has been established that the patient is able to pay. They should not participate in industrial action unless adequate arrangements have been made to ensure that patients already under their active clinical care will continue to be cared for and that emergency treatment will continue to be available.

## 2.4 Medical attendance upon persons held in detention

### Guiding Principle: Attendance by health professionals on persons held in detention should always be conducted in the best interests of their health.[11]

Prison conditions in many countries are damaging to both the physical and mental health of detainees as a result of inadequate nutrition, bad sanitation, prolonged detention, abuse of various kinds and the many other disadvantages of having to live in a dehumanising environment. Health professionals working in prisons should draw the attention of the prison authorities in writing to unhealthy conditions that are capable of being remedied and keep a copy of their report. All possible steps should be taken to preserve the personal dignity and integrity of detainees whilst they are being attended by health professionals, eg by insisting wherever possible that medical examinations are carried out in private, that the ethical requirements of consent and confidentiality are respected, and that treatment is carried out in a humane manner.

**Body searches:** When prison authorities decide that it is necessary to carry out an intimate body search on a detained person, eg where there is reason to believe that dangerous substances may be concealed in body cavities, the health professional who is asked to carry out the search should be satisfied that it is really necessary, and, having explained the reason for the search, obtain the detainee's consent. If this is refused, it should be explained that the search may have to be carried out by an unqualified lay person, eg a prison officer. This should be communicated not as threat, but as respecting the right of the detainee to be told the consequences of refusal.

**Signs of violence:** Health professionals should be vigilant to detect signs of violence in detainees, particularly those resulting from torture or other degrading and inhuman practices, and must report them immediately. They must not acquiesce in any concealment of signs of violence discovered at post-mortem examinations of prisoners, nor falsify their reports at the request of prison authorities. Drugs or medicaments (including psychoactive drugs) should never be prescribed or administered to prisoners by health professionals for purposes other than *bona fide* medical treatment

**Hunger strikes:** Health professionals requested to attend hunger strikers must first determine whether the detainee is capable of forming the necessary intent to refuse food and/or whether there has been any coercion exerted by others. Detainees should be informed of the injurious effects on health if food is refused beyond a certain point. Those who fully understand the implications of their choice should not be forcibly fed. Health professionals should insist that only they, and not the prison authorities, are in a position to decide whether compulsory feeding is appropriate, eg in cases where a detainee's demands have already been met but he or she no longer has the mental capacity to take a decision.

**Participation in judicial punishments:** It is a legal requirement in some countries that corporal and/or capital punishment be overseen by a health professional, usually a physician. The participation of health professionals in such punishments (which can range from a flogging chosen by the convicted prisoner in lieu of a prison sentence to life-long mutilation and disability following judicially authorised amputations) lends a spurious respectability to practices which are contrary to the widely accepted goals of medical practice. On the other hand the mandated presence of a health professional may result in humane intervention, eg if the flogging is excessively harsh. It may also result in less pain, mutilation and disability if judicial amputations are carried out by a health professional rather than a prison officer with a butcher's cleaver — an outcome that is often desired by victims faced with the inevitability of the sentence being carried out.

Health professionals who refuse to co-operate in such punishments may be found guilty of civil disobedience and be punished themselves, while the detainee may be subjected to greater pain, suffering and disability than if a health professional had been present. However, if health professionals do participate, even under protest, they may be identified with, and help to perpetuate, an oppressive and inhuman practice. Neither option is satisfactory. Health professionals opposed to such activities should be supported and encouraged, and those who participate in them should be sensitized to the implications of their participation in the international quest for the elimination of degrading punishments and coercive forms of control, as defined in the Torture Convention.[12]

## Endnotes

1 *UDHR Art 19*

2 *ibid*

3 *ibid Art 18; ICCPR Art 18*

4 *UDHR Art 3*

5 *Women's Convention Art 12 & 14(2)(b)*

6 *UDHR Art 16(3); ICCPR Art 23(1); ICESCR Art 10(1)*

7 *UDHR Art 3; ICCPR Art 6*

8 *Children's Convention Art 12(1)*

9 *UDHR Art 18*

10 *ibid Art 3*

11 *UN Economic and Social Council (ECOSOC) Resolution 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977 (Standard minimum rules for the treatment of prisoners); Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, inhuman or degrading treatment or punishment (UN General Assembly Resolution 37/194 of 18 December 1982); Basic principles for the treatment of prisoners (UN General Assembly Resolution 45/111 of 14 December 1990);*

*Body of principles for the protection of all persons under any form of detention or imprisonment (UN General Assembly Resolution 43/173 of 9 December 1988);*

*UN rules for the protection of juveniles deprived of their liberty (UN General Assembly Resolution 45/113 of 14 December 1990)*

12 *UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (General Assembly Resolution 39/46 of 10 December 1984);*

*ECOSOC Resolution 1984/50 of 25 May 1984 (safeguards guaranteeing protection of the rights of those facing the death penalty)*

## MODULE 3

## 3.1 Competence to practise

**Guiding Principle: Health professionals should maintain their competence to practise at all times and should never expose patients to avoidable risks.**

Health professionals must take steps to ensure that they keep up-to-date with relevant developments in their fields of practice[1], and remain competent to provide their patients with reliable advice about measures they should take to promote their good health. Patients should not be subjected to risk of avoidable harm from unnecessary or outdated procedures, nor should they be placed at risk as a result of a health professional's own health status[3], eg dependence on alcohol or other drugs, HIV infection, hepatitis etc.

Health professionals should be aware of the limitations of their own professional skills and abilities and only in exceptional circumstances, eg immediate risk of death where no appropriately qualified colleague is available, should they attempt clinical procedures or treatment that they are not fully qualified and experienced to carry out. Health professionals should always be willing to refer patients to suitably qualified and experienced colleagues and should readily acquiesce in requests by patients for a second opinion.

Every hospital or healthcare facility should have in place effective procedures for the prompt investigation of medical or surgical accidents and of any unusually high incidence of complications or mistakes, and should institute risk management procedures to deal with them. The health professionals involved should be ready and willing to participate fully in such procedures.

**Case studies:** Examples should include the adverse consequences of outdated or inappropriate procedures; excessive use of Caesarean sections; wrongful use of blood transfusions; inexperience in using new procedures, eg 'keyhole' surgery etc

## 3.2 Relationships with health professional colleagues

**Guiding Principle: Health professionals should co-operate fully with their colleagues in the interests of providing the best possible health care for their patients and the community.**

Health professionals should act responsibly in delegating to their colleagues the care of patients who are under their active clinical care. They should not leave such patients in the charge of less experienced colleagues unless they themselves or a suitably qualified colleague is available to provide effective cover, including emergency care.

Shared health care between health professionals is becoming increasingly common. It is in the best interests of patients that health professionals should co-operate fully with each other and avoid undermining the reputation of their colleagues by criticising them unfairly. On the other hand, where it is apparent that patients are in danger as a result of incompetence or deterioration in the professional skills of a colleague, eg as a result of mental illness or substance abuse, the matter should be reported without delay to the appropriate authority, eg hospital manager, licensing or registration body, using whatever special procedures exist for the purpose. Wherever practicable it is advisable to discuss the matter with a colleague, preferably a senior colleague, before such action is taken, and it must always be taken in good faith. (See also module 2.2 Consent to medical interventions)

**Case studies:** Examples should be given of the consequences to patients of inappropriate delegation, and of cases in which health professionals have made inadequate on-call arrangements. Illustrations should be given of the procedure to be followed whenever a health professional becomes aware that deterioration in the skills of a colleague is having an adverse effect on patient care.

## 3.3 Relationships with other health workers

**Guiding Principle: Health professionals should recognise their own limitations and respect and collaborate with non-professional health workers.**

It is in the best interests of patients that the expertise of non-professional health workers should be acknowledged by health professionals, who should reinforce the contribution they can make to health care, by giving them clear directions about any procedures they require them to carry out. In all such cases health professionals should retain responsibility for patients who are under their active clinical care.

Health professionals should ensure that the conduct of non-professional health workers towards patients is appropriate, eg that informed consent is obtained to any procedures they carry out at their request and that their access to confidential medical information is restricted in accordance with the guidance set out in module 2.1 Patient's right to information.

**Case studies:** Illustrations should be given of cases where health professionals have failed to instruct non-professional health workers adequately on the importance of observing confidentiality. Examples should be given of inappropriate delegation of procedures.

## 3.4 Relationships with traditional healers

**Guiding Principle: Health professionals should encourage traditional healers and birth attendants to adopt safe practices.**

In many societies the majority of people rely partly or wholly on traditional healers for their health care, and it is common for them to consult orthodox practitioners and traditional healers at the same time. While health professionals should always warn patients whenever they have good reason to believe that the traditional treatment they are receiving is dangerous,[3] they should be careful not to exaggerate the proven benefits of orthodox medicine, and should help their patients to make an informed choice. Wherever possible health professionals should encourage traditional healers and birth attendants to adopt safe hygienic and infection control measures.

Many specific remedies used by traditional healers such as herbal treatment have proved effective in the treatment of infertility, malaria etc and also as contraceptives. Traditional healers such as experienced herbalists, and those who have undertaken courses in structured systems such as Traditional Chinese Medicine should be distinguished from those claiming to cure diseases by the exercise of supernatural powers.

Traditional birth attendants who have undergone training are often competent to carry out procedures such as uncomplicated deliveries.

**Case studies:** Examples should be given of the circumstances in which patients should be warned about continuing to attend unqualified practitioners and about the claims they make for curing diseases. Illustrations should be given about unsafe traditional procedures.

## Endnotes

1 *ICESCR Art 12(d) and 15(1)(b)*

2 *UDHR Art 29*

3 *Children's Convention Art 24(3)*

# MODULE 4

## 4.1 Responsibility to the community

**Guiding Principle: Health professionals should be vigilant in calling attention to unsuspected hazards to the health of the community.[1]**

The populations of many developing countries are exposed to a wide and increasing range of hazards to health. Health professionals, as a result of their training in public health and their status in the community, are in an exceptionally favourable position to call attention to such hazards, whether they be industrial, domestic or therapeutic. Examples include water pollution, bad sanitation, toxic emissions, the improper disposal of toxic waste, and drug dumping by international companies.

**Case studies:** Examples should be given of hazards which have remained unrecognized for some time. The range of drugs and medicaments available without the need for a prescription should be reviewed.

## 4.2 Health promotion and preventive medicine

**Guiding Principle: Health professionals should take every opportunity to promote healthy lifestyles in the community and to educate their patients in disease prevention.[2]**

Health promotion and preventive medicine are especially important in developing countries where avoidable diseases and disabilities are the main causes of ill health. Accordingly health professionals should, whenever practicable, promote healthy life styles and educate their patients in the avoidance of ill health, eg smoking, unprotected sexual promiscuity, teenage pregnancy etc.[3] Convalescent patients should be given the information they need to help them avoid a recurrence of their illness.

Health professionals should call attention to the adverse consequences of traditional practices (such as female genital mutilation) which are harmful to health, particularly those that are based on a denial of equality of the sexes and amount to violations of the Women's Convention. They should seek to modify adverse social and cultural patterns of behaviour with a view to eliminating prejudicial and stereotyped roles for the sexes, as these have a deleterious effect on women's health, in particular their sexual and reproductive health.

Case studies: Examples should be given on the role health professionals can play in discouraging unhealthy lifestyles, eg smoking, substance abuse etc. The problems associated with female genital mutilation (FGM) should be discussed in countries where it is practised. Attention should be drawn to other potentially damaging practices that may take place in the country concerned, eg son preference; polygamy and widow inheritance.

## 4.3 Transplantation

**Guiding Principle: Interests of potential donors and recipients must be safeguarded by observing internationally accepted rules and procedures for transplantation.**

Health professionals involved in transplantation have an obligation to explain fully to potential donors the health risks associated with removal of their organs or tissues, and should ensure that the decision to donate has been entirely voluntary, ie that it has not been influenced by coercion, financial inducement, or undue pressure from other sources, such as by the family of a potential recipient. The selection of recipients for available organs should be made on the basis of their medical suitability for the procedure.

Financial inducements or other forms of coercion to donate organs are regarded as unethical and health professionals should be careful not to become involved in such transactions. In developing countries donors are usually close blood relatives of the recipient and it may be difficult or even

unwise to enquire too closely into how the family made the selection. Financial inducements to get donors from developing countries to travel to industrialized countries to donate their organs are also regarded as unethical.

Few developing countries have legislation in place to control transplantation and reports have been received of clinics being set up in developing countries as part of 'medical tourism' taking advantage of the absence of controlling legislation by offering financial inducements to the local populace to donate organs for transplantation into foreign recipients. Health professionals should be careful not to get involved in such arrangements.

Where the organs are removed after death for transplantation, the fact that death has occurred must be confirmed by a physician who has no professional connection with the team carrying out the transplant procedure, and wherever possible by the physician who was responsible for treatment of the donor's terminal condition. There are serious objections to the use of cadaveric organs from executed prisoners as judicial decisions and the timings of executions could be influenced by the most convenient time for the transplant to take place. The *Guiding Principles on Human Organ Transplantation* adopted by WHO should be observed. (Annexe 1).

**Case studies:** Examples should be given of cases where the health of donors has been compromised by the failure of health professionals to observe the WHO guidelines and where improper inducements have been offered to donors. Illustrations should be given of the conflict of interest that may occur where transplantation may offer the only chance of saving life, eg in countries where there is no dialysis available for patients with end-stage renal disease.

## 4.4 Medical research

**Guiding Principle: Health professionals should not participate in medical research unless it conforms with internationally accepted guidelines.**

Research subjects are at risk in developing countries where internationally accepted guidelines are not always enforced. The free and informed consent of research subjects to participate should always be obtained, and those who are unable, for whatever reason, to consent to participation should not be included in the projects unless the protocol has been endorsed by a properly constituted ethical review committee. The provisions of the World Medical Association's *Declaration of Helsinki* should be observed. (Annexe 2)

The use of placebos in control groups should be given very careful consideration. It is a widely held view that the control group should be given the most effective treatment for the medical condition concerned. In developing countries it may happen that the most effective treatment is not available, eg very expensive combinations of drugs for HIV / AIDS. However, the most effective treatment for the condition should not be withheld from the control group if it would otherwise be available to them.

Fees paid to health professionals for participating in research projects should be related to the amount of work involved and should not be so large as to constitute an inducement. Offers of sponsorship to attend medical conferences overseas in return for participation in a research project should be regarded with suspicion.

Case studies: Examples should be given of research projects with which health professionals should not become involved, and of the consequences of failing to ensure that the research subjects have fully consented to participating in the trial.

## Endnotes

1 *ICESCR Art 12*

2 *ibid*

3 *ICESCR Art 10(3); Children's Convention Art 3(2), 9 & 32-37*

# Part III
# Case studies

Contents

# INTRODUCTION

The case studies that follow were collected at workshops held in developing countries where the training modules were field tested, and are based in each case on events that have actually taken place in the countries concerned. The extent to which they are used to illustrate the principles contained in the training modules is entirely at the discretion of trainers. However, before using any of the case studies trainers will need to study them carefully and to make such amendments or substitutions as may be necessary to take account of the situation in the country where the modules are being used eg a case study based on female genital mutilation would be unsuitable for inclusion in a country where the practice does not take place. Wherever appropriate names, titles, medical procedures etc should be amended or substituted to conform with the situation in the country concerned so as to make the case studies appear as realistic as possible.

Throughout these case studies it is important to bear in mind that ethical principles are guidelines and that in developing countries cultural and traditional factors are especially likely to affect the extent to which the guidance given in this manual is followed in particular cases. However they are intended to apply generally and health professionals who do not follow them should always be prepared to justify their actions. Similarly human rights are intended to be of general application, particularly where the government of a country has ratified the covenant or convention concerned without reservation. However cultural and traditional factors may affect their implementation.

In many cases case studies may involve more than one ethical principle, and attention should always be drawn to this wherever it occurs.

# MODULE 1

## 1.1 Respect for patients

**Guiding Principle: Health professionals should pay respect at all times and in all circumstances to persons they are attending.**

### Case study A

A 25 year old man from a drug rehabilitation centre was brought to hospital with abdominal pain. The junior doctor/nurse, who was very busy at the time with other admissions, decided to leave him for a short while and attend to the other patients. When the junior doctor/nurse finally completed her assessment, she found the patient had severe lower right quadrant abdominal pain and was nauseated. No analgesic was given for pain. The on-call surgeon ordered a course of antibiotics and a HIV test in accordance with hospital policy. The young man was not informed of the test and consent was not given. He was then referred to the medical unit. The man's pain worsened and a surgeon was requested to review the patient. A diagnosis of perforated appendicitis was made and emergency surgery was performed. Just prior to surgery the man was informed by the surgeon that he was HIV positive within the hearing of other patients in the ward.

#### Questions for discussion

1 What is the most important fact that the junior doctor/nurse should have taken into account in deciding to delay dealing with this case?

2 To what extent should the junior doctor/nurse have been influenced by the fact that the patient had been referred from a drug rehabilitation unit?

3 Was it ethically acceptable for the surgeon to order a HIV test without (a) informing the man and (b) obtaining his consent?

4 Was it ethically acceptable for the nurse to take a blood sample knowing that the man had not been told the reason and had not consented?

5 To what extent, if at all, should account be taken of the high prevalence rate of HIV in an area (eg one in four of the population in parts of Africa) in deciding whether to obtain consent?

6 Was it ethically acceptable for the surgeon to inform the man of the result of the test within the hearing of other patients?

7 Was it ethically acceptable for the surgeon to refer the man to a medical unit in the presence of signs of an acute abdomen?

## 1.2 Health care of vulnerable and disadvantaged groups

**Guiding Principle: Health professionals should take account of the special health needs of disadvantaged and vulnerable groups in the community.**

### Case study A

Jane, a 15 year old girl student, accompanied by a school friend from her class, arrives at the local hospital outpatient clinic at 8.30 am and asks the nurse if she can see Dr Idji, the gynaecologist. She tells the nurse that she has been feeling very weak and has been vomiting for the last few weeks. The nurse tells her to join a long line of patients waiting to see Dr Idji and several hours pass before Jane and her friend are shown into her office.

Dr Idji shows Jane and her friend a bench for them to sit on and asks them why they have come to see her. They look at each other and Jane's friend explains the problem while Jane keeps her eyes fixed on the floor. Dr Idji immediately asks Jane when she had last had her menstrual period. When she says she can't remember, she rebukes her and asks her what kind of student she thinks she is if she can't even remember when she had her last period. She asks her no further questions and tells her to undress and lie down on the examination couch.

While Jane slowly removes her blouse Dr Idji tells her to hurry up as other patients are waiting, at which point she begins to cry. She palpates her abdomen quickly without saying a word and then tells her to get off the couch and get dressed. She then walks back to her desk, completes a request form for a pregnancy test and haemoglobin estimation. She asks the nurse to direct the girls to the laboratory, and to tell them to return the following morning. She says nothing to either of the girls.

Jane returns the next day, this time with her mother, and Dr Idji tells them that Jane is pregnant. Jane's mother, who was unaware of the real reason why Jane had gone to see Dr Idji, immediately castigates her and tells her how disappointed she is with her. Dr Idji, who has conscientious objections to termination of pregnancy tells them that Jane must attend the antenatal clinic and come back in two months' time. Jane's mother attempts to ask Dr Idji whether the pregnancy should be terminated in view of her age and the effect on her studies but she refuses to listen to her.

Five days later, while doing a gynaecological ward round, Dr Idji discovers that Jane had been admitted to the ward during the night as an emergency. She is severely anaemic and jaundiced and has already been given three units of blood as well as receiving treatment with antibiotics. No member of her family is with her.

A nurse tells Dr Idji that a friend had advised Jane to insert a local herb in her vagina before consulting a local abortionist, and that several hours after leaving the abortionist Jane had experienced severe abdominal pains and had begun to bleed profusely, passing clots and pieces of tissue. Jane had been rushed to hospital by her friend who was terrified that she might bleed to death. After two weeks in hospital Jane was well enough to go home and is discharged from hospital without seeing Dr Idji again.

### Questions for discussion

1 Did Dr Idji, as specialist in obstetrics and gynaecology, fulfil her obligation to respect the sensitivities and special needs of an adolescent girl?

2 Should health professionals, and the places in which they work, develop special procedures for dealing with adolescents, eg a specially trained nurse take a history and carry out a preliminary assessment before the young person sees a doctor?

3 What is the ethical obligation of a doctor who has conscientious objection to abortion when consulted by a woman seeking termination of her pregnancy?

4 Should the possibility of rape, sexual abuse etc, have been taken into consideration in this case, and if so by whom and when?

5 Should Jane have been counselled before being discharged from hospital?

## Case study B

Tobias, a five year old boy, was brought to the casualty department by his mother, who said that he had been having convulsions after he had fallen out of bed that morning and banged his head. She said that shortly afterwards he had begun to foam at the mouth, that his limbs had stiffened and that his eyes had turned up. He was still having fits when he arrived at the casualty department. His mother confirmed that he had no recent history of fever nor headaches and that he had eaten his supper the previous evening following which he had slept well.

Tobias had been living with his mother and his 11 year old sister. His father, a truck driver, worked away from home most of the time, and had a history of epilepsy in childhood. Tobias had achieved his childhood milestones in good time and had been fully immunised. But he had been admitted twice before with convulsions, remaining in hospital for only a day on each occasion, and had been discharged each time without medication. He had also attended outpatients six months previously with a fractured humerus.

The doctor found that Tobias was unconscious with a Glasgow Coma Score of 3. Clinical signs included spastic posturing; dilated fixed pupils; a boggy swelling of the left side of the scalp; and bruises on his forehead and lips. His fundi were clear with no haemorrhages. He had multiple linear raised lesions over his chest, back and trunk and his scrotum and penis were swollen and bruised. Clinically he was moribund. A diagnosis was made of non-accidental injury.

Tobias died before any treatment could be instituted. However the consultant took photographs of his injuries and the Ward sister was asked to talk to his mother and his sister in order to try and ascertain the cause of the injuries. Tobias's sister said that the bruises had more than likely been caused while he was playing. But she then changed her mind, saying that his injuries resulted from a fall while he was at school, and that her mother had not been worried about it.

### Questions for discussion

1 What action should be taken by the health professionals concerned with this case?

2 Should any action have been taken when Tobias attended with a broken humerus, having regard to his previous admissions to hospital?

3 Should hospitals develop policies for dealing with non-accidental injuries to vulnerable patients such as children?

4 Who is responsible for documenting the sequence of events when children are seen repeatedly in hospital with injuries suspected that could be non-accidental?

5 Should the health professional staff be concerned about risks to the health of anyone else in the circumstances of this case?

6 Do national health professional associations have any role to play in such cases eg by advocating that agreed procedures are established for reporting such cases to the police or to social services departments?

## 1.3 Confidentiality

**Guiding Principle: Information obtained about patients in the course of a professional relationship must be regarded as strictly confidential.**

### Case study A

A young Indian man aged 28 is aware of his HIV positive status as a result of a test that had been carried out with his consent several weeks ago by his doctor. His orthodox Hindu parents, who have not been told, are pressing him to get married. The young man believes that his parents would not be able to cope with the knowledge that he is HIV positive. He has been seen for the past several weeks by a community health nurse who is teaching him about the changes to his lifestyle that accompany his diagnosis, his health needs, and his ability to deal with HIV. The nurse and the young man have discussed his difficulty in telling his parents about his HIV positive status.

#### Questions for discussion

1 Should the doctor or nurse tell the parents that their son is HIV positive?

2 Should the nurse help the young man to share his test result with his family?

3 What are the effects of the HIV positive status outside of the immediate family?

4 What other ethical principles should be considered in this case?

### Case study B

A married man had been given a HIV test by his doctor and is found to be HIV positive. During post-test counselling his doctor tells him that he should tell his wife, who is in good health. But he refuses to do so. Both husband and wife are his patients.

#### Questions for discussion

1 How should the doctor handle this situation so as to prevent the wife becoming infected?

2 Should the doctor tell the wife without the husband's consent?

3 If the wife becomes pregnant, how should the pregnancy be managed?

4 Should the fact of the pregnancy have any influence on the decision whether or not to inform her about her husband's HIV status?

5 What duty does the doctor owe to (1) the husband (2) the wife and (3) the unborn child?

### Case study C

A man offered to donate blood for an acutely ill relative. When his consent was sought for a routine screening HIV test he specified that he did not wish to know the result and his wishes are recorded on his file. The test revealed that he was HIV positive.

#### Questions for discussion

1 What policy should be adopted in such a case?

2 Should the doctor or nurse concerned inform any other members of the donor's family who are at risk of infection?

3 What are the implications of this dilemma for the community and for the donor's family?

4 Are there any other ethical principles that need to be considered in this case?

## 1.4 Requests by third parties

**Guiding Principle: Care must be taken not to compromise the interests of patients when supplying information about them at the request of a third party.**

### Case study A

A security guard, who had been employed at a mining company for 20 years, developed cor pulmonale secondary to emphysema. Although it was the policy of the company to offer its employees an annual medical check-up by its medical officer and regular monitoring by the occupational health nurse on a voluntary basis, the employee had not attended for any check-up during the year before his condition was diagnosed.

Protective clothing is worn by miners employed by the company to reduce the risk of exposure to atmospheric pollutants, but the security guard had never worked in the vicinity of the mine and had not been exposed to them. He decided to sue both the company and its medical officer for negligence, claiming that inadequate precautions had been taken to protect him from prolonged exposure to pollutants and that if the damage to his lungs had been detected earlier it could have been alleviated by removing him further away from the affected area and by instituting earlier treatment.

The company's medical officer and the nurse received a request from the employee's lawyer to inspect his client's work medical records. Although reluctant to comply with the request they agreed when so directed by the mining company. The lawyer commenced an action against the company, but the employee died before the case could be heard. After a lengthy delay, the employee's relatives attempted to renew the action, but the court held the action to be barred by the Statute of Limitations because of lapse of time.

#### Questions for discussion

1 Has a company medical officer or occupational health nurse a duty to explain the health risks when examining a potential employee for a particular job?

2 Should a company doctor reveal detailed diagnostic findings when reporting to the employer on the fitness of an applicant for a particular post?

3 When is it ethical for details of an employee's occupational health record to be disclosed to (a) the company lawyer; (b) a lawyer acting for an employee?

### Case study B

An occupational health doctor/nurse working for a company, received a request from the company's human resources department for a health report on an employee who had a bad record of absences from work. The doctor/nurse had been in previous contact with the employee.

The doctor/nurse provided the human resources department with a detailed history and report which included a reference to a urethral stricture that the employee had suffered in the past following an attack of gonorrhoea. It was not company policy to disclose this information, but since the manager of the human resources department requested the information, the doctor/nurse decided that it was alright to forward the information. No consent was obtained from the employee.

A couple of weeks later, the doctor/nurse received a letter from a lawyer representing the employee threatening to sue for breach of confidence.

### Questions for discussion

1 Should the doctor/nurse have revealed detailed medical information to a person's employer without the employee's consent?

2 Should any information obtained in a doctor/nurse - patient relationship be disclosed to a third party without the consent of the employee?

3 In what circumstances would it be ethically acceptable for a doctor/nurse to disclose health information about an identifiable person without their consent?

4 What does the principle of informed consent mean in terms of sharing health data relating to identifiable patients?

## Case study C

Anto and Aisha, who are engaged to be married, consult their priest about their wedding plans. The priest tells them that they will have to undergo medical tests to prove that they are fit for marriage, and gives them the necessary forms for the tests to be carried out, telling them that the forms must be signed by the doctor concerned who must then return them to him.

Blood samples are taken from the couple at a clinic after pre-test counselling has been carried out, and they return two days later for the results of the tests and for any post-test counselling that might be necessary. They are devastated to be told that Anto is HIV positive, and when they take the results back to the priest they are told that he will not marry them. The wedding is due to take place in four weeks time and the local community is surprised and anxious to know why the wedding has suddenly had to be postponed.

### Questions for discussion

1 What ethical principles should the doctor have taken into account when presented with the form sent by the priest?

2 Should the doctor have returned the form containing the result of the test to the priest before seeing Anto again for post-test counselling?

3 What are the doctor's ethical obligations to (a) Aisha; and to (b) the community in such a case?

4 Would any useful purpose be served by the health professional association seeking a meeting with religious leaders to discuss the issues raised in this case?

## Case study D

A patient fails to regain consciousness after a relatively simple and uncomplicated surgical operation carried out under a general anaesthetic and is found to have clinical signs of brain anoxia consistent with a vegetative state. The patient remains comatose for several weeks. His employers, who are paying his hospital bills, demand a medical report from the doctor in charge of the case, including an assessment of the likelihood of his responding to treatment, as a condition of their continuing to pay the bills.

### Questions for discussion

1 Has the doctor fulfilled his ethical obligations to (a) the patient and (b) the employers by submitting a report which contains no reference to the cause of the anoxia?

2 What other ethical principles are relevant in this case?

# MODULE 2

## 2.1 Patient's right to information

### Guiding Principle: Patients have a right to receive relevant information about their own medical condition and its management

### Case study A

A business woman was admitted to the teaching hospital with a high grade fever and profuse bleeding from the vagina. The fever persisted for about a week during which the cause for the bleeding was not discovered. A decision was made to screen her for HIV infection after failure to establish the cause of the fever. She was not told that the test was being carried out on one of her blood samples and she was not told of the result of the test, which was positive.

The woman's only close relative in the city was her cousin, a fourth year medical student, who was not a member of the clinical team looking after her. However, the ward nurse decided to inform him that she was HIVpositive. The young medical student did not tell his cousin the result of the test. As it was generally believed at that time that HIV positive persons had little time left to live he immediately contacted the woman's brother, who lived in the family village in a distant part of the country and was looking after her son. He told the brother that his sister was about to die and urged him to come as soon as possible to the hospital and take her home to die. However, when her brother arrived a week later she had improved so much that she had been discharged from hospital. The medical student gave the woman's brother the HIV test results and they both tried to persuade the woman to return to the family village. She was still unaware of her test result and refused to leave the city.

A few months later, and still unaware of the test result, the woman went back to her family village for a holiday intending to take her son back to live with her in the city. When she was about to leave the village, her brother took her son away and hid him in another village where she would be unable to find the child. After a quarrel both brother and sister were arrested and taken to the village court of law where the brother produced his sister's positive HIV test result, claiming that he was justified in preventing the boy being taken back to the city because the boy would be left alone and unsupported in a distant city after his sister's death from AIDS. The woman was devastated to hear for the first time that she had been tested HIV positive and outraged that it should have been disclosed in open court before the whole of the village.

### Questions for discussion

1 What steps should be taken before carrying out a HIV test?

2 Whose responsibility was it to decide the steps to be taken upon receiving the result of the HIV test?

3 Which principles of medical ethics did the ward nurse fail to observe when she informed a family member (the medical student) of the positive test result?

4 What is the ethical obligation of a medical student in respect of medical information concerning patients in his hospital?

5 To what extent, if at all, does the family relationship excuse the behaviour of the medical student?

6 How could the medical student cousin have obtained advice and support in handling the unwelcome news of his cousin's HIV test result?

7 How might the ethical obligation of respect for the patient have been more effectively observed in this case?

8 In what other respects was there failure to observe ethical standards in this case?

9 How could the city hospital develop an agreed policy on protecting identifiable patient information?

## Case study B

A company doctor/nurse was asked to undertake pre-employment medical examination of a new employee. The company's policy was to include a pregnancy diagnosis test as part of a battery of blood and urine tests for all new female applicants of child-bearing age. No information was given to the woman as to what tests would be carried out on the samples that were taken. When the pregnancy test was reported as positive, the doctor informed the company of the result and that, as a result, she had failed the medical examination.

### Questions for discussion

**Note:** The questions apply equally to health professionals other than doctors (eg nurses) retained by companies to carry out pre-employment medical examinations.

1 Is pregnancy testing without informed consent ethically acceptable as part of a pre-employment medical examination?

2 Does the company doctor/nurse have a duty to inform the applicant of the positive pregnancy test?

3 Which ethical principle was broken when the company was informed of the applicant's test result?

4 Is the primary ethical obligation of a doctor or nurse in this situation to (a) the applicant; or to (b) the company?

5 What is the professional responsibility of a company doctor or nurse to an applicant for employment if the findings indicate that the applicant is in need of medical advice or treatment?

6 What is the professional responsibility of a company doctor or nurse in advising the company's management on their pre-employment medical testing policy?

7 What is the role of the national medical/nursing association in advising their members on the ethical principles associated with pre-employment examinations?

## 2.2 Consent to medical procedures

**Guiding Principle: Treatment and other forms of intervention should not be undertaken without the full, free and informed consent of the patient.**

### Case study A

Alice is 38 years old, the successful owner of a catering business and has been happily married for 11 years. Her only, but major, grief is her inability to conceive. She and her husband have undergone the stress and expense of fertility treatment, which was unsuccessful, probably because she has endometriosis, a condition which was also causing her increasingly and disabling pelvic pain. Eventually they accept her specialist's advice that she will not be able to have any children and that she should have a hysterectomy to relieve the pain and bleeding caused by endometriosis and allow her to get on with her life. She consults a local gynaecologist and is admitted for a hysterectomy three months later. Alice's consent to a hysterectomy was obtained by a house surgeon (intern). During the operation, endometriosis is confirmed. However, and quite unexpectedly, it is also found that the uterus is enlarged. No pregnancy test had been carried out before the operation and the gynaecologist had not examined her since she attended Out Patients some three months earlier. The gynaecologist, who does not know her well, has seen from her notes that she had at one time been treated for depression. This, he considered, justified continuing with the planned hysterectomy, as, even if she was pregnant the history of depression made it unlikely she could cope with bringing up a child. Pathological examination of the surgically removed uterus reveals a 12 week pregnancy. Alice sues the gynaecologist who is later summoned to appear before his licencing body and charged with serious professional misconduct.

#### Questions for discussion

1 What precautions were omitted before it was decided to operate?

2 Was Alice's consent to hysterectomy, obtained by the house surgeon, ethically valid?

3 What ethical principles did the surgeon ignore when he found during the operation that the uterus was enlarged and went on to remove it?

4 What was the ethical duty of health professionals in the team assisting at the operation when the uterus was discovered to be enlarged and that Alice could possibly be pregnant?

5 Was the gynaecologist ethically justified in continuing on grounds that the notes mentioned that Alice had received previous treatment for depression and might not, therefore, be able to cope with a child?

6 Who could have prevented this tragedy if they had been consulted?

### Case study B

A five year old girl with sickle cell anaemia was admitted to hospital with severe malaria, haemolytic anaemia and impending heart failure. The junior doctor/nurse on duty cross-matched her blood for an urgent blood transfusion. The girl's mother, a Jehovah's witness, refused to consent to blood being transfused. She explained "I will pray to Jehovah to spare her, He is a giving God".

The junior doctor/nurse contacted the consultant on duty who said, "This illiterate village woman does not grasp the consequences of her beliefs..... don't allow the girl to die because of the mother's strange religious ideas." The mother was told to go home and shortly afterwards the girl was transfused without her mother's knowledge.

The mother returned several hours later, with a group of fellow believers to pray for the girl, they were delighted to find the child awake and feeling much better. Three days later the girl was discharged from hospital. The mother was happy that Jehovah had answered her prayers.

### Questions for discussion

1 What should have been taken into account in deciding whether a transfusion should take place against the wishes of the mother?

2 Should the consent of anyone have been sought for the blood transfusion to be given?

3 What ethical obligations did the doctors and nurses involved in this case owe to the girl?

4 Did they show sufficient respect for the mother's religious beliefs?

5 What human rights might have been violated in this case if the transfusion had been withheld and the child had died as a result?

6 What other procedures should be available when parents or guardians refuse to allow life-saving measures to be carried out when a child is under the legal age of consent?

## Case study C

A 32 year old nurse midwife employed in a hospital on a small island consulted a private gynaecologist complaining of menorrhagia with dysmenorrhoea. She was planning to get married and wanted to know her chances of having a baby. She had been living with her fiancé for the last four years without using any contraception but had been unable to conceive. No fibroids could be found on examination, but the gynaecologist decided that fibroids were the most likely cause of her dysmenorrhoea and menorrhagia, and probably of her primary infertility as well.

After a lengthy discussion with the gynaecologist she agreed to be admitted to the private hospital where she worked in order to have a myomectomy, for which purpose the gynaecologist proposed to use his newly imported laparoscope. She would be one of his first patients on which laparoscopy had been used, but there had so far been no experience on the use of the technique on the island. The nurse, who had worked with the surgeon, had serious doubts about his competence to use the new technique, and refused to sign a consent form for laparoscopic surgery. Instead she left in writing a note stating her insistence on not having a laparotoscopy and repeated it even as she was being anaesthetized.

The gynaecologist ignored her request and went ahead with laparoscopic surgery. It proved to be a long and difficult procedure complicated by massive bleeding. The gynaecologist had to resort to a laparotomy in the course of which he failed to notice that the sigmoid colon had been perforated by the laparoscope. The woman had to be given four units of blood and developed abdominal distension with severe pain and fever two days later. A diagnosis of paralytic ileus with bowel perforation was made.

She demanded to be transferred to the government hospital for the further surgical operation that would now be necessary on her perforated bowel. Subsequent laparotomy by another surgeon revealed perforations of the sigmoid colon as a result of which and she had to have a colostomy. She considered suing the gynaecologist for negligence, but her relatives discouraged her as they believed that it was just a case of bad luck.

### Questions for discussion

1 Which ethical principles must a health professional consider before subjecting a patient to a technique with which he/she is unfamiliar?

2 Are there any situations in which a doctor can proceed with a specific intervention against the express wishes of a patient?

3 How much information should be given to the patient about the possible risks and outcomes of any treatment that is proposed?

## Case study D

Zainabu was seen by a male doctor in the medical unit in Juma, her husband's company medical unit. While her history was being taken the doctor observed that Juma gave a lengthy story about Zainabu's illness and replied to all the questions he asked. His attempts to get more details of the illness from Zainabu failed.

When finally the doctor wanted to examine Zainabu, Juma objected and insisted that the history was adequate therefore there was no need for physical examination. All this time Zainabu had remained quiet and raised no objection to anything said or suggested by her husband. The doctor finally prescribed some medication to Zainabu and she and her husband together thanked the doctor and walked away.

### Questions for discussion

1 Were attempts by the doctor to get more information from Zainabu justified?

2 Did Juma have the right to decide what medical procedures should be carried out on Zainabu?

3 Were the rights of Zainabu to consent to medical procedures observed?

## Case study E

After listening attentively to a talk on AIDS which had been organized by her school on the occasion of World AIDS day, Sharon, a 15 year old schoolgirl became increasingly preoccupied by the possibility of her having become infected with HIV. Her family doctor was also a family friend and she was too shy to ask to seek advice from him. In the end she decided to attend the Government Health Centre situated in a nearby village and to request that she be tested for HIV.

The attending doctor wanted her to explain why she wanted this test done, but Sharon blushed and declined to answer. When the doctor insisted, she relented and admitted that four months earlier she had met a visiting student from another country , who was two years older and with whom she had had unprotected sexual intercourse on a couple of occasions. The student had since returned to his home country and it was only after the talk on AIDS that Sharon began to worry about the possibility of HIV infection as a result of her sexual experience.

The doctor asked whether Sharon had confided in her mother about what had happened. "Of course not!" replied Sharon, "My Mum would kill me if she ever got to know about it!" The doctor doubted whether the girl could validly consent to have such a test and sought the advice of a colleague in an adjoining consulting room. He returned a few minutes later and explained to Sharon what the test was all about and what were the implications. He then took a blood sample from her for HIV testing, having previously made her sign a consent form. Sharon was asked to report back the two weeks later for the result. Much to her great relief, the test was subsequently reported negative. Sharon was given no further appointment to attend the Health Centre.

### Questions for discussion

1 Was the doctor at the Health Centre ethically correct in testing Sharon for HIV without first obtaining her parents' consent?

2 What are the doctor's ethical obligations with regard to HIV testing of patients?

3 What further advice should Sharon have been given after she was informed of the result of the HIV test?

## 2.3 Medical emergencies

**Guiding Principle: Health professionals must do all they can to assist at medical emergencies.**

### Case study A

Rosa, a 32 year old pregnant woman, was admitted to the labour ward of a hospital in a small island state. It was her second pregnancy and had so far been uneventful. Her previous pregnancy had gone well and there were no abnormal signs on admission. However she developed an ante-partum haemorrhage soon after admission which the obstetrician on call decided required an immediate Caesarean section.

The resident medical officer (RMO) on call phoned the consultant anaesthetist who gave him instructions over the phone about the way he should anaesthetize Rosa. Rosa was taken to theatre with an IV line running and the blood on its way from the blood bank. Rosa was anaesthetized by the RMO and a section was carried out with the safe delivery of a baby who cried immediately.

After closure of the abdomen, the patient was given drugs for reversal, at which stage she went into bronchospasm and shortly afterwards developed ventricular fibrillation. The heart was shocked twice but she failed to revert and sustained a cardiac arrest from which she failed to recover in spite of vigorous attempts at resuscitation.

An investigation was held that revealed (1) that the resident medical officer had only two months experience in an anaesthetic post and had only recently started to take night calls; (2) that the post operative procedure carried out by the RMO was inappropriate; and (3) that the anaesthetic consultant was on call for all three hospitals on the island. When contacted by the medical officer about Rosa he was dealing with a surgical emergency case in another hospital which he had been unable to leave.

As a result of the investigation the Ministry of Health decided that each of the three hospitals on the island should have its own consultants on call for major specialities including anaesthesia. This measure has since been introduced.

### Questions for discussion

1 What actions should health professionals take if they become aware that patients are being put at risk by inadequate or badly organized emergency cover?

2 Whose responsibility is it to arrange adequate and appropriate service cover (including emergencies)?

3 Is thorough and careful investigation of untoward occurrences (a) an exercise to apportion blame; (b) a learning experience; (c ) a whitewash to maintain the good name of the hospital; or (d) an ethical imperative?

4 If hospital management fails to respond to recommendations made as a result of such an investigation, what action can concerned health professionals take?

5 What can national health professional associations do in such cases where hospital management refuses to introduce adequate emergency cover arrangements? eg advise members not to apply for posts at the hospital?

6 What is the ethical obligation of a health professional when confronted with an emergency?

7 Having regard to the circumstances, what should the resident medical officer have taken into consideration before carrying out the specialist's instructions?

## 2.4 Medical attendance upon persons held in detention

**Guiding Principle: Attendance by health professionals on persons held in detention must always be conducted in the best interests of their health.**

### Case study A

Samuel, who has a part-time contract as a prison medical officer, is asked during his daily prison visit to certify that a prisoner is medically fit to be punished by caning. He is expected to be present when such punishments are administered. Having been to a recent workshop on medical ethics and human rights, Samuel is very unhappy about his involvement in a brutal, degrading and inhuman judicial punishment.

He knows that his predecessor had been summarily sacked by the prison governor for having protested at the lack of medical care for prisoners following the death of a woman prisoner from antepartum haemorrhage. Prison warders had refused to contact his predecessor when the woman sought medical help. Samuel is well aware that his prison contract provides about a third of his current income, and his wife is putting pressure on him not to risk losing it.

#### Questions for discussion

1 What action should Samuel take when faced with this request?

2 Should the national health professional associations have a policy on the involvement of their members working in prisons in brutal, inhuman and degrading judicial punishments?

3 Which other organisations could Samuel contact for support?

# MODULE 3

## 3.1 Competence to practise

**Guiding Principle: Health professionals should maintain their competence to practise at all times and should never expose patients to avoidable risks.**

### Case study A

Dr Xhosa, who is a successful general surgeon in a busy, but remote district hospital, has found out that Katrina, his former lover, has developed clinical AIDS as a result of which he fears that he may be HIV positive. He knows that if he is HIV positive the risk of his passing the infection on to his patients when he operates is statistically very remote indeed. He also knows that if he gave up surgery it would be very difficult to attract expert surgeons away from the capital to replace him. He himself has developed the surgical service for the past seven years.

Accordingly he decides not to have an HIV test as he judges that even if he is HIV positive the risk of his passing on the infection to his patients would be insignificant, certainly when compared with the risks they take during their own sexual relationships.

#### Questions for discussion

1 To what extent does a health professional have an ethical obligation to ensure that patients are not put at risk as a result of his own health status?

2 Who should Dr Xhosa consult for advice and support in making his decision about HIV testing?

3 What should Dr Xhosa do, and which ethical principles should he consider?

4 If Dr Xhosa confides in a friendly colleague, after a few drinks at a party, what action, if any, should the friend take?

5 In which medical careers/specialities should doctors be allowed to practise whilst suffering from a blood-borne infection without the risk of harming patients?

### Case study B

A new modern private hospital, organised by a foreign health care development company, has been established in the capital city of a developing country. An important feature of the hospital is the unit for minimal access (keyhole) surgery – which was not previously available in the country. The intention behind the unit was to avoid very expensive hospital trips abroad having to be taken by business men, politicians etc and to provide additional revenue.

After one year, during which bed occupancy dropped, an investigation reveals that there has been a high incidence of complications and some unexpected deaths in the unit. The European surgeon, on a two year contract at the hospital, has been associated with a high proportion of these adverse outcomes. Careful re-examination of his qualifications revealed that he had grossly overstated his experience in this type of surgery, and that he had left his last job in the UK 'under a cloud'. No proper check had been made of his curriculum vitae nor of his references from previous employers when he was appointed by the foreign health care company.

#### Questions for discussion

1 What is the ethical responsibility of the medical director for the quality of care in a hospital and the standards of competence of its staff?

2 Does a health professional have any ethical obligation to ensure that he is sufficiently qualified and experienced to carry out his work, and to take steps to correct any deficiencies that could have an adverse effect on the care of his patients?

3 Is audit of the outcomes of medical interventions an ethical imperative?

4 What actions should have been taken by other health professionals involved in the care of the patients concerned?

5 What ethical principles should be considered by health professionals before using a new form of treatment?

## 3.2 Relationships with health professional colleagues

**Guiding Principle: Health professionals should co-operate fully with their colleagues in the interests of providing the best possible health care for their patients and the community.**

### Case study A

A junior trainee surgeon was pleased when the senior surgeon allowed him to carry out major surgery. However he became concerned when the senior surgeon appeared on several occasions to have no recollection the following morning of telephone calls he had made to him the previous night asking for advice on dealing with difficult cases.

On return from leave, the trainee noticed that the senior surgeon's documentation of operations was very erratic and on one occasion, when he called the surgeon for help in dealing with some seriously injured road accident victims, the surgeon was clearly drunk when he finally arrived. The trainee decided to seek another post, but realised that he had a duty to the local community and to future patients. He was also unhappy at abandoning his boss in a situation where a disaster could not long be avoided.

#### Questions for discussion

1 What would be an effective and ethical way for the trainee surgeon to deal with the situation?

2 When is 'whistle-blowing' on a professional colleague ethical?

3 What precautions should the junior bear in mind before taking any action?

4 Are there any circumstances when public criticism by a health professional of a colleague's professional abilities is justified?

5 Would disclosure of his alcohol problem necessarily end the surgeon's career?

6 Can you think of any situations in your own professional experience when you would have been be prepared to risk 'whistle-blowing' on one of your own colleagues?

7 Would you feel aggrieved or grateful at being reported if you were the senior surgeon in this case?

8 What ethical considerations do you hope you would have borne in mind?

### Case study B

A woman was admitted in labour with her fourth pregnancy. The junior doctor who examined her suspected there was disproportion and an obstructed labour. As the woman had been in labour at home for more than six hours, the duty obstetrician was called. By then it was about 2 am and the obstetrician had just returned home from an alcoholic party. When he got to the hospital and examined the woman he found she was fully dilated with a large baby presenting in the occipito-posterior position.

Against the advice of the senior nurse in charge of the maternity department the obstetrician, who was smelling strongly of alcohol, prescribed oxytocin and went home to sleep it off. The following morning when he came in to the hospital for his round, he was informed that the patient had died undelivered one hour after he had left.

The woman's husband was successful in an action he brought in negligence against the obstetrician for the loss of his wife and baby. As the disaster occurred in a state hospital the damages awarded by the court were paid by the government and the medical officer was transferred to an office job in the Ministry of Health where he is still working.

### Questions for discussion

1 Did the senior nurse have a responsibility to inform the hospital Director that the obstetrician had been under the influence of alcohol when he examined the woman?

2 What course of action could the junior doctor or the senior nurse have taken to protect the woman and her child?

3 Are there any circumstances when loyalty to a colleague should take precedence over the duty to protect the interests of the health of a patient?

4 What should the obstetrician have done when he was called in view of the fact that he had been drinking for several hours?

5 Does a doctor have a duty to take account of the views of other experienced health professionals who disagree with him over the management of a case?

## Case study C

Late on Saturday night Dr Mboti, a surgeon on emergency duty at the hospital over the weekend, admitted Mrs Onola, who was the wife of a hospital colleague, with a severe laceration of her hand and possible tendon damage. She explained that she had accidentally put her hand through a glass door. On examination she was found to have a bruised and swollen face, a fracture of her right wrist and a clean but deep laceration of her hand which, on exploration, was found to need tendon suture. There was evidence of old bruising on her upper arms, her back, and her legs. She was uncommunicative, silent, and her eyes were swollen from crying. She was unable to give a coherent account of how the accident had happened. She did not appear to have been drinking.

### Questions for discussion

1 What further action should Dr Mboti take?

2 If he decides to report the case to the police, what steps should he take before doing so?

3 What importance should be attached to the following consequences of reporting or not reporting the matter to the police?

(a) his colleague might be imprisoned and a seriously short-staffed hospital deprived of his services;

(b) his colleague might make further and possibly life threatening assaults on his wife.

4 What other persons or organizations would be in a position to deal with the situation if Dr Mboti decides not to report the case to the police?

## 3.3 Relationships with other health workers

**Guiding Principle: Health professionals should recognise their own limitations and respect and collaborate with non-professional health workers.**

### Case study A

Because of an acute shortage of trained nursing staff at a district hospital, untrained nursing assistants are being used to assist the anaesthetists. When asked during a hectic operating list to hand the anaesthetist a syringe containing a muscle relaxant antagonist for injection into the IV line, the untrained nurse who was assisting inadvertently handed the anaesthetist the wrong syringe which contained more of the relaxant instead of the antagonist. The nurse concerned had also been heard in the hospital canteen to discuss operation cases at which she had assisted. The theatre superintendent asked to see the nurse the next morning.

#### Questions for discussion

1 What are the ethical issues that the superintendent should consider?

2 What is the superintendent's responsibility in this case?

3 What are the ethical responsibilities of an anaesthetist working with untrained staff?

4 What precautions should be taken when untrained staff are working as part of a clinical team?

### Case study B

Anna, a 39 year old woman, was referred from a district hospital with a diagnosis of carcinoma of the cervix. On examination the admitting doctor noticed a laparotomy scar. The patient could not recall why she had a laparotomy, but she remembered that she had symptoms suggestive of fibroids at the time. She added that she had been back to see the surgeon after the operation to enquire why she was no longer menstruating. He had replied by asking her whether she wanted to live or have menses.

The admitting doctor confirmed the diagnosis of carcinoma of the cervix and, as he was unable to feel a uterus, he concluded that the patient must have had a sub-total hysterectomy and bilateral salpingo-ophorectomy.

#### Questions for discussion

1 Which ethical principle did the surgeon who carried out the first operation fail to observe before he operated on Anna?

2 Which ethical principles did he ignore when she asked him why she was no longer having any periods?

### Case study C

Jeremy, when he was a second year resident hospital doctor, had been asked by his friend Yan to carry out a HIV test. Yan, who was married at the time with two children (twins), had been offered a scholarship to a European university which had insisted on the test being carried out before he could take up the scholarship. He had travelled a long distance in order to visit Jeremy because he felt that Jeremy was the only doctor he could trust in such a sensitive matter. Yan had left his wife at home up-country, and Jeremy did not enquire whether she had been told that her husband would be having a HIV test.

Jeremy agreed to take Yan's blood to the laboratory personally and the result was reported 'strong HIV positive' Jeremy wondered whether he should tell Yan the truth? How might he react? Suppose he killed himself whilst at Jeremy's home. Yan came to see Jeremy again on the day that the results were expected. He was anxious and sweating and Jeremy could not summon up the

courage to tell his friend the result. He told him instead that the results would not be ready until the following day. He then went back to the laboratory, wrote out a new request form, and asked the technician to write HIV negative on it and sign it.

Yan, who was relieved to receive the result, took up the scholarship and completed his university course during which he was not required to take a further test. He went home to a good job and built his own house. At present he is still living with his wife and children, and both he and his wife insist that they do not want to have another child. By now they could be aware of Yan's HIV status, but Yan has never requested Jeremy to repeat the test and Jeremy has never suggested that it should be repeated.

### Questions for discussion

1 How should the laboratory technician, who must have suspected the reason for Jeremy's request, have dealt with it?

2 How did Jeremy's request affect his professional relationship with the technician?

3 Did Jeremy have ethical obligations to anyone other than Yan (whose career prospects he was trying to protect)?

4 Should Jeremy's personal friendship with Yan have been allowed to influence his ethical responsibility to act in the best interests of the health of Yan and Yan's family?

## Case study D

A couple, Mr and Mrs John Matanmi, had been married for ten years without producing a child. John had been blaming his wife for their childlessness. They both decided to visit a gynaecologist Dr Grace Adedare who carried out investigations into the causes of their infertility. Dr Adedare discovered that the husband was azoospermia, while his wife, Elizabeth, showed no abnormality. She called the couple together and informed them that: 'The results of Elizabeth's investigations show that there are no abnormalities. I do need to refer John to the urologist for further tests.'

Dr Adedare gave the couple a four-week appointment to allow the husband to see the urologist. She then handed over the case notes to the medical record officer.

Elizabeth went to see a member of the medical record officer's staff, whom she knew, at a later date and prevailed on her to allow her to photocopy her husband's investigation results. Armed with these results, she pac ked her things and telephoned Dr Adedare before the appointment date to say that she was leaving her husband as she had found out the truth as to why they could not produce children.

### Questions for discussion

1 Was Dr Grace Adedare ethically correct in disclosing the results to both the husband and the wife at the same time?

2 Did Dr Adedare give adequate information about the nature of their problem?

3 What precautions should the doctor have taken when handing over the case notes to the medical record officer?

## Case study E

Mrs D X was admitted to the hospital for repair of vesico-vaginal fistula (VVF) which resulted in an abdominal hysterectomy being performed on her by the gynaecologist a couple of months earlier. Instructions were left by the gynaecologist to cross-match two pints of blood and other pre-op investigations. The junior doctor had signed all the request forms on the previous night so that the blood samples could be taken be the nursing staff early in the morning on the day of the operation, as was the practice in the hospital.

A junior nurse was delegated by her superior to take the blood sample from Mrs D X. She took the blood instead from Mrs M X, as the surname was the same. Mrs M X was Mrs D X's mother-in-law, and was in hospital for investigations for a medical problem.

Mrs D X's operation was performed by the gynaecologist in the afternoon who called the urologist to help. In the meantime Mrs M X was discharged from the ward.

The anaesthetist asked for a pint of blood for transfusion as the patient was bleeding heavily and the blood pressure (BP) was coming down. The blood was run rapidly and the second pint was started. After a few minutes the anaesthetist noticed a cutaneous rash over the patient's body and stopped the blood transfusion. The BP was still low. He suspected something was wrong and blood from the patient was immediately sent for grouping and was found to be a different group from the two pints already transfused. He then realised the problem of mis-matched blood transfusion. He ordered the appropriate blood group and took the necessary measures to counteract the problem of severe shock and renal shut-down. The VVF was repaired and Mrs D X was sent to the ICU for strict monitoring and care.

Mrs D X's BP became normal and she passed some urine. At midnight, however, the urologist was telephoned as her condition had deteriorated as her BP was coming down and her abdomen was distended. The urologist gave instructions by phone and saw the patient next morning when he came on duty, and cautioned conservative treatment. Mrs D X died the following day.

**Questions for discussion**

1 What were the ethical responsibilities of the senior medical officer?

2 Did the urologist fulfill his obligations towards the patient?

3 Who was to blame for the catastrophe?

## 3.4 Relationships with traditional healers

**Guiding Principle: Health professionals should encourage traditional healers and birth attendants to adopt safe practices.**

### Case study A

Sannala, aged 22, came back to the family village from a working holiday in Mwanza. She was horrified to find her youngest sister Maria, aged seven desperately ill with dehydration and sepsis, as a result of having been subjected to female genital mutilation (FGM) by their Grandmother while she was away. Sannala thought she had persuaded her parents to shield their youngest child from this practice, (of which she personally had a horrific experience) as being both outdated and old-fashioned.

However, while the parents were away visiting another village, the grandmother carried out the operation, assisted by her friends, as she believed that the child would be unacceptable as an adult woman in her own society if it was not done. Sannala took the child to the nearest hospital, where Maria died in spite of intensive resuscitation with IV fluids, blood transfusion and antibiotics.

The hospital doctor who treated Maria knows that if he contacts the police, they will charge the grandmother with causing Maria's death. The resultant publicity could also result in delays in similar cases being brought to hospital, if at all, in the future.

#### Questions for discussion

1 What is the hospital doctor's ethical duty in this case?

2 How can the hospital doctor discourage female circumcision in his district?

3 Should the hospital set up a monitoring system to record the incidence and complications of FGM?

4 Which international human rights instrument were violated in this case?

5 What are the public health implications of this case?

### Case study B

Mrs Chacha was delivered of twin boys at home under the care of a traditional birth attendant who had also assisted her during her previous pregnancies. Her husband's friend, Mr Mwita, called in to see the twins. As he was well known for his expertise in ritual circumcision, he offered to circumcise them. Having obtained the consent of the parents he went ahead with the operation, leaving the house as soon as he had finished.

Both twins developed retention of urine and were admitted to the district hospital the next morning. After some delay a urologist was called in, by which time both of them had developed severe local infection requiring amputation of the glans penis in the case of one of the twins. Mr. Chacha decided to sue Mr Mwita.

#### Questions for discussion

1 Has the urologist any obligation to give evidence in support of Mr. Chacha's action?

2 What steps can the urologist take to reduce the risks of operations carried out by traditional practitioners?

3 What ethical principles are relevant in this case?

## Case study C

A child of three months was brought to a dental Clinic by her mother, Seema, who claimed that the child had 'nylon teeth' and that they were the cause of the child's sporadic fevers and diarrhoea. At the Dental Clinic Seema was told by the dentist that so called 'nylon teeth' do not exist and was advised to seek medical treatment for the fever and diarrhoea. Back at home, Seema's grandmother insisted that the child's illness was caused by 'nylon teeth' and that such conditions cannot be treated successfully in hospitals.

The following morning the child was taken to the local traditional healer who agreed with the grandmother and proceeded to excavate the germinating deciduous tooth buds of the canine teeth. The child began to bleed heavily and the local doctor was called in. But he could not control the bleeding, and sent the child to the nearest hospital.

On arrival at the outpatient department the child was found to be dead from cardiac failure resulting from severe loss of blood. It was well known at the hospital that several cases are admitted each month of children treated in this way by traditional healers for 'nylon teeth'.

### Questions for discussion

1 Does the health professional staff at the hospital have a responsibility to help local traditional healers to avoid such deaths - if so, how?

2 Does the staff have any responsibility to expose the myth of 'nylon teeth'?

# MODULE 4

## 4.1 Responsibility to the community

**Guiding Principle: Health professionals should be vigilant in calling attention to unsuspected hazards to the health of the community.**

### Case study A

Martin is a physician at a district general hospital. He has seen a succession of employees of large commercial flower farms in the Emergency Department presenting with extreme weakness and often with mental confusion. Sometimes they complain of abdominal cramps, vomiting, sweating and excessive salivation. One of them became comatose and died. He has also seen them with acute paralysis, which resolves to leave a diverse, persistent and frequently disabling neuropathy. Many of them admit to having had previous instances of extreme fatigue and depression, and they claim that many of their fellow workers are suffering from similar symptoms.

The flower farms are foreign owned and supply the country's most lucrative export market. However Martin has discovered that they use powerful insecticides and that their employees seem to have been given no information on the risks; little training; and no protective clothing, eg they work in bare feet shortly after the ground has been sprayed with insecticide.

Martin is anxious to be quite certain that he has very sound evidence on the toxicity of these insecticide before he considers raising the issue with the employers' medical advisers. But he is uncertain what his next step should be as last year workers on the farm who complained about the conditions were sacked and some were badly beaten up by unknown assailants (no arrests were made).

#### Questions for discussion

1 What steps should be taken by health professionals who become aware of unrecognized public health hazards?

2 Should Martin contact a newspaper about his concerns? (He has a friend who is a journalist).

3 Which other groups in the community, apart from agricultural workers, could be at risk from insecticide sprays?

4 Which other agencies should Martin alert?

5 Have the national health professional associations any responsibility to act in such a case and what could they do?

6 Does Martin have an ethical responsibility to keep a record of cases of suspected insecticide toxicity in the hospital?

7 What other hazards to the health of the community might first be noticed by an observant and informed health professional?

### Case study B

A company doctor was asked to undertake pre-employment testing of a new recruit. The company's policy was to undertake HIV testing of all new employees. No specific counselling was provided and the doctor took a blood sample as part of a battery of other tests, without informing the new recruit that it included an HIV test. When the test was reported as positive, the doctor informed the company that the new recruit was unfit to be employed because he was HIV positive.

### Questions for discussion

1 When is routine HIV testing ethically acceptable as part of pre-employment medical examination?

2 To whom does a doctor carrying out a pre-employment examination owe a duty of care — the new recruit; the company or both?

3 Should the doctor have informed (a) the recruit or (b) the company of the result of the HIV test?

4 How much information should be given by the doctor to the company as a result of his examination and the tests he carried out?

5 What action should the doctor take if he becomes aware of unethical practices requested by employers?

## Case study C

Madalitsu, a nine year old boy with a two-day history of diarrhoea mixed with blood and mucus, and weighing only 18 Kg was brought to hospital by his aunt. There was no complaint of abdominal pain and no history of vomiting nor of worms. His aunt reported that he had been ill for three months with a dry cough, fever and night sweats. She said that his mother was suffering from 'pneumonia' and so had been unable to seek treatment for the child.

Madalitsu, the eldest of four children, had only had one previous illness, malaria, from which he had made a good recovery after treatment in hospital with quinine and fansidar. His father, a business man, and the other children in the family were all said to be well. But his mother had suffered from a chronic cough before developing 'pneumonia'. There was no family history of tuberculosis (TB).

On examination the hospital doctor found the child to be wasted, mildly dehydrated, and lying passively on his aunt's lap. He looked ill, with a raised respiratory and pulse rate and was mildly febrile. His fingers were clubbed, but there were no signs of jaundice, cyanosis, oedema, or lymphadenopathy. The only significant abnormal signs found on auscultation were bilateral coarse crepitations in the upper and lower zones of the lungs. The air entry was good with equal expansion.

A provisional diagnosis of pneumonia and dysentery was made with a differential diagnosis of Pulmonary TB. Sputum was sent for culture of acid fast bacilli and treatment was instituted with antibiotics and intravenous fluids. Chest X-ray revealed hilar adenopathy and bilateral infiltrations of the lung fields consistent with pulmonary TB. Accordingly treatment was started with Isoniazid, Rifampicin and Pyrazinamide.

### Questions for discussion

1 Is there any social stigma attached to the diagnosis of TB?

2 Is there any need for tests to be carried out on other members of the family, and if so what tests and to whom?

3 What action should the doctor take if the mother proves to be suffering from TB or is HIV positive?

## Case study D

Dr Chan has been providing healthcare for the employees of a company for the past two years.

In an effort to ensure the company's survival following the East Asian economic turmoil in 1997 and 1998, the management budgeted for a marked reduction in expenditure. The staff in the human resource department, who had been administering the employees' health benefits, were retrenched. Their function was contracted to a subsidiary of a United States based, for-profit managed care organization (MCO) which had promised efficiency and a reduction of the employees' healthcare expenditure.

Dr Chan was informed of the new arrangements and that the MCO would now be reimbursing his practice for healthcare services rendered to the company's employees. It was not long before Dr Chan received a communication from the MCO requesting the details of the medical histories of all the company's employees.

### Questions for discussion

1 How should Dr Chan respond?

2 What ethical principles should Dr Chan consider in deciding on his response?

3 What role should national medical associations play in addressing such cases?

## Case study E

A young man of 19 years of age was brought to the emergency room of the teaching hospital in a state of shock with severe abdominal pain and vomiting. He was examined and admitted by the surgical unit and was operated in the emergency theatre.

After the successful operation he was recovering satisfactorily, was moving around and was on a normal diet. His stitches were removed and he was about to be discharged from the hospital when the consultant in charge noticed that he was coughing. An examination showed pulmonary congestion. The consultant prescribed an injection of Mucosolva for him. As this injection was not available in the hospital, so the house officer wrote 2 Amp of this injection and asked one of the patient's relatives to go to get it from the pharmacy near the hospital. The relative went to the pharmacy, which was full of people. He was given the injection by an assistant, which he took back to the hospital and handed it over to a nurse, who injected the patient.

After receiving the injection, the patient's condition started deteriorating. He became pale and was in a state of shock. His relatives ran to call the nurse, who in turn called the house officer. He saw the patient and called the medical officer, who had gone to lunch. In the absence of the medical officer, the house officer, thinking that the patient had a drug reaction, gave him an injection of Antihistamine and an injection of Solucortif. The patient died after a few minutes.

The incident was reported in the press the next day and an inquiry was ordered by the health minister. During the inquiry it was revealed that the injection that had been given to the patient Muscolin, a drug used by anaesthetists when giving anaesthesia as a strong muscle relaxant of respiratory muscles.

It was also revealed that the assistant in the pharmacy was in a great hurry and had had no training. He had therefore given the wrong injection to the patient's relative. The nurse had given the injection without reading the name. The house officer or the medical officer, moreover, could have managed the case which really needed an endotracheal tube and not the Antihistamine which caused further deterioration, or could have called the anaesthetist on call, who was available round the clock.

### Questions for discussion

Who was responsible for this tragedy:

1 The hospital management – for not making it possible that all the necessary medications were available in the hospital?

2 The nurse – for not bothering to read the name of the injection or getting it confirmed by a doctor?

3 The house officer – who had insufficient training or experience to be able to deal and manage such emergencies?

4 The pharmacist – who was employing untrained assistants who sold the wrong injection?

## Case study F

An 82 year old retired accountant was admitted to hospital because of haematemesis and malaria. Evaluation was unremarkable save for a past history of ulcer-type dyspepsia, recent impairment of short-term memory and difficulty in performing simple calculations. Upper GI endoscopy revealed an actively bleeding posterior duodenal ulcer; attempts at endoscopic therapy proved unsuccessful. The patient repeatedly said he did not want surgery and refused to sign the consent form. His children unanimously disagreed with this, expressed concerns about his senility and signed on his behalf.

While the patient was being prepared for surgery, the consultant physician overheard him say: "So when you're old and ill, you don't have rights any more?" The consultant immediately asked for a psychiatric evaluation. The psychiatrist thought that the patient did indeed have some cognitive impairment but was readily able to make his wants to needs known, recognize those dependent on his bounty, and appreciated the probable consequences of his refusal to have surgery. After further discussions with the patient, the family (who continued to disagree) and the surgical team, it was decided not to proceed with the operation. The patient died a few hours later despite transfusion.

### Questions for discussion

1 Was the consultant correct in accepting the opinion of the psychiatrist?

2 Should the consultant have over-ruled the decision of the family?

3 Should the medical attendants have persisted with the transfusion?

4 Might the consultant's decision have been different if the psychiatrist had diagnosed 'depression'?

## 4.2 Health promotion and preventive medicine

**Guiding Principle: Health professionals should take every opportunity to promote healthy lifestyles and to educate their patients and the community in disease prevention.**

### Case study A

Dr Jonathan, a public health doctor working in the Ministry of Health, is asked by the Minister to devise a simple health promotion programme module on adolescent health for teachers in teacher training colleges. It is to be called the *Protect Your Future* campaign and will focus on sexual and reproductive health, smoking and alcohol abuse. When he sends the programme to the Ministry for final approval he finds that there has been a change of political heart and he is told to remove all references to smoking as it will be dealt with 'at a later stage'.

Tobacco is grown in one of the provinces and there had apparently been heavy pressure put on the Government by the tobacco growers who have an important economic role in that province and wield considerable political power.

Dr Jonathan is committed to the programme but he is also politically ambitious, and has hopes of establishing himself in the eyes of the ruling party as a potential future Minister of Health. He is also very much aware that many youngsters, particularly in the shanty towns surrounding the capital, see smoking as 'cool' and a badge of adulthood. Hundreds of people make a living selling single cigarettes to children. He can see that this will result in huge demands being made in the future on the health services of a country that is hard pressed to provide its people even with the most basic health services. He is torn between his professional and his political ambitions.

#### Questions for discussion

1 What are the ethical principles that Dr Jonathan needs to bear in mind as he decides how to deal with this situation?

2 Who should Dr Jonathan approach for ethical and practical advice on how best to proceed in order to protect the future health of his country's young people ?

3 To what extent, if at all, should Dr Jonathan allow his political ambitions to influence his responsibilities to the community?

4 How could he mobilise the country's medical opinion to support the introduction of health education in schools?

5 To what extent does an individual clinician have any obligation to promote healthy lifestyles in the community?

## 4.3 Transplantation

**Guiding Principle: The interests of potential donors and recipients must be safeguarded by observing internationally accepted rules and procedures for transplantation.**

### Case study A

Matthew Nyanza is a successful entrepreneur with a thriving export business based in Dar-es-Salaam. He has had an American college education and is well respected in Tanzania's business community. His one grief is that his only son Adam has nephrotic syndrome and incipient renal failure. Renal dialysis is not a long-term option and there is no transplantation service available. He has sought advice abroad, but no matching cadaveric kidneys have been available during his extended visits to Europe.

Tissue-typing of his relations has revealed that his 14 year old sister Elena would be a compatible donor. She is very frightened of the operation, but she loves her brother. She is unable to tell her parents that she feels she is merely being used to enable the adored and only son to inherit the family business. She hates herself for feeling this way, but is tormented with nightmares about the operation and is becoming increasingly anorexic.

The whole family is about to travel to Spain where the transplant operation is due to be carried out. But Mrs Nyanza, who is troubled about the risks posed by Elena's loss of weight decides to consult the family doctor.

### Questions for discussion

1 Is it ethically acceptable for Elena's parents to give consent for her to donate a kidney to her brother?

2 How does the principle of informed consent apply in this case?

3 When transplanting a cadaveric kidney, what code of ethical practice should be adopted?

4 What would be the effect of Elena's informed consent to donate her kidney if she was (a) 12 years old and (b) 21 years old?

5 If your country had decided to introduce legislation controlling organ transplantation, what provisions should be included about financial or other inducements being offered to potential donors?

6 Which members of the population would be most at risk if commercial donor transplantation was legalised?

## 4.4 Medical research

**Guiding Principle: Health professionals should not participate in medical research unless it conforms with internationally accepted guidelines.**

### Case study A

On a visit to a South East Asian country Dr Kelly, who is interested in the socio-demographic impact of AIDS in developing countries, visits a drop-in centre for commercial sex workers run by a charity which also provides a personal development programme for the women concerned. He finds that the women bitterly resent the activities of international drug companies for which purpose blood samples are taken from them at monthly intervals for testing the efficacy of anti-HIV drugs. Some of them are given the active ingredient and others are used as controls. Some of them continue in the programme and others do not.

The women are given no information about the purpose of the research and are not told the results of their blood tests. They have asked to see details of the research protocols but their requests have been ignored. It would be counter-productive to raise the matter with the Ministry of Health as most of the women are illegal immigrants and, therefore, have no official existence. As a result the charity has to maintain a low profile.

The charity workers believe that the women's human rights are being violated by the drug companies which are failing to observe the requirements of the *Declaration of Helsinki*.

#### Questions for discussion

1 What arrangements should be made to check protocols for research to be carried out in developing countries before they can be regarded as ethically acceptable?

2 Should the requirement for obtaining the informed consent of research subjects be modified in developing countries to take account of the relatively high proportion of functional illiteracy?

3 What ethical responsibilities do pharmaceutical companies have towards subjects on which they are carrying out research?

4 What effective steps could the charity workers take to protect the women from violation of their human rights and from unethical practices by pharmaceutical companies and research workers?

5 What steps should be taken by Dr Kelly ?

# Annexes

Contents

# ANNEXE 1
# *GUIDING PRINCIPLES ON HUMAN ORGAN TRANSPLANTATION (WHO)*

## Preamble

1. As the Director-General's report to the seventy-ninth session of the Executive Board pointed out, human organ transplantation began with a series of experimental studies at the beginning of this century. That report drew attention to some of the major clinical and scientific advances in the field since Alexis Carrel was awarded the Nobel Prize in 1912 for his pioneering work. Surgical transplantation of human organs from deceased, as well as living donors to sick and dying patients began after the Second World War. Over the past 30 years, organ transplantation has become a worldwide practice and has saved many thousands of lives. It has also improved the quality of life of countless other persons. Continuous improvements in medical technology, particularly in relation to tissue 'rejection', have brought about expansion of the practice and an increase in the demand for organs. A feature of organ transplantation since its commencement has been the shortage of available organs. Supply has never satisfied demand, and this has led to the continuous development in many countries of procedures and systems to increase supply. Rational argument can be made to the effect that shortage has led to the rise of commercial traffic in human organs, particularly from living donors who are unrelated to recipients. There is clear evidence of such traffic in recent years, and fears have arisen of the possibility of related traffic in human beings. World Health Assembly resolutions WHA40.13 and WHA42.5 are an expression of international concern over these developments.

2. These Guiding Principles are intended to provide an orderly, ethical and acceptable framework for regulating the acquisition and transplantation of human organs for therapeutic purposes. The term 'human organ' is understood to include organs and tissues but does not extend to reproductive tissues, namely ova, sperm, ovaries, testicles or embryos, nor is it intended to deal with blood or blood constituents for transfusion purposes. The Guiding Principles prohibit giving and receiving money, as well as any other commercial dealing in this field, but do not affect payment of expenditures incurred in organ recovery, preservation and supply. Of particular concern to WHO is the protection of minors and other vulnerable persons from coercion and improper inducement to donate organs.

   Organs and tissues (referred to in this text as 'organs') may be removed from the bodies of deceased and living persons for the purpose of transplantation only in accordance with the following Guiding Principles.

## Commentary:

The purpose of this introductory proposition is to establish a comprehensive and exclusive system for the removal of organs from deceased and living donors for transplantation. As cadaver donation is best dealt with by national legislation, each jurisdiction will determine the definition of 'deceased person' and criteria of death, as well as the means of implementing the Guiding Principles.

## Guiding principle 1

Organs may be removed from the bodies of deceased persons for the purpose of transplantation if:

a) any consents required by law are obtained: and

b) there is no reason to believe that the deceased person objected to such removal, in the absence of any formal consent given during the person's lifetime.

### Commentary:

There are two systems dealing with the obtaining of organs from deceased persons. These are the 'opting in'/'contracting in' ('explicit consent') system of post mortem organ removal, in which deceased persons expressly state before death that they approve such removal, or an appropriate family member expresses approval when the deceased person left no statement or other evidence to the contrary, and the 'opting out'/'contracting in' ('presumed consent') system. This presumes that organs may be removed for transplantation from the bodies of deceased persons unless those persons when alive stated their objections, or perhaps others who were close to them stated at an appropriate time that the persons objected to their deceased bodies being so treated. In the case of both the opting in and opting out systems, any statements or other adequate indications of opposition by persons to posthumous organ removal from their bodies will prevent such removal.

When a deceased person leaves no evidence of opposition to removal, the opting in system normally requires consent of an appropriate family member for organ removal. In the opting out system, no consent is required, but family members may take initiatives to state the opposition of the deceased person or of themselves.

### Guiding principle 2

Physicians determining that the death of a potential donor has occurred should not be directly involved in organ removal from the donor and subsequent transplantation procedures, or be responsible for the care of potential recipients of such organs.

### Commentary:

This provision is designed to reduce the possibility of a conflict of interest that would arise if the physician or physicians determining the death of a potential donor were also involved in organ removal or implantation.

### Guiding principle 3

Organs for transplantation should be removed preferably from the bodies of deceased persons. However, adult living persons may donate organs, but in general such donors should be genetically related to the recipients. Exceptions may be made in the case of transplantation of bone marrow and other acceptable regenerative tissues.

An organ may be removed from the body of a adult living donor for the purpose of transplantation if the donor gives free consent. The donor should be free of any undue influence and pressure and sufficiently informed to be able to understand and weigh the risks, benefits and consequences of consent.

### Commentary:

The first paragraph of this principle is intended to emphasize the importance of developing cadaveric donation programmes in countries where this is culturally acceptable, and to discourage donations from living, genetically unrelated donors, except for transplantation of bone marrow and of other acceptable regenerative tissues.

The second paragraph seeks to protect potential donors from undue pressure and undue inducements from others. It emphasizes the necessity for complete and objective information to be given to the donor. It also takes into account issues relating to persons (other than minors) who are legally incompetent to fulfil the requirements for 'free consent' or the other conditions specified in this paragraph.

### Guiding principle 4

No organ should be removed from the body of a living minor for the purpose of transplantation. Exceptions may be made under national law in the case of regenerative tissues.

### Commentary:

This principle provides for absolute prohibition of the removal or organs for transplantation from legal minors. However, an exception concerning regenerative tissues may be allowed by national legislation. In such cases, the protection of minors could be assured by requiring, among other conditions, the minor's comprehending consent and the consent of the parent(s) or the legal guardian. The parent(s) or the legal guardian may have a conflict of interest, for example if they are responsible for the welfare of an intended recipient of the donated tissues. In such a case, prior permission of an independent body, such as a court or other appropriate authority of comparable independence or status, should be required. However, an objection by the minor should take effect and prevail over any other consent.

### Guiding principle 5

The human body and its parts cannot be the subject of commercial transactions. Accordingly, giving or receiving payment (including any other compensation or reward) for organs should be prohibited.

### Commentary:

This principle is designed to prohibit traffic in human organs for payment. The method of prohibition, including sanctions, will be determined independently by each jurisdiction. The principle does not prohibit payment of reasonable expenses incurred in donation, recovery, preservation and supply of organs for transplantation.

### Guiding principle 6

Advertising the need for or availability of organs, with a view to offering or seeking payment, should be prohibited.

### Commentary:

The intention of this principle is to prohibit advertisements that have a commercial (profit-making) purpose. Promotion and encouragement of altruistic donation of human organs and tissues by means of advertisement or public appeal are not affected by this principle.

### Guiding principle 7

It should be prohibited for physicians and other health professionals to engage in organ transplantation procedures if they have reason to believe that the organs concerned have been the subject of commercial transactions.

### Commentary:

This provision addresses medical professional and other involvement in removal, intermediate management and implantation of organs with knowledge, actual or constructive, that commercial transactions have occurred.

### Guiding principle 8

It should be prohibited for any person or facility involved in organ transplantation procedures to receive any payment that exceeds a justifiable fee for the services rendered.

### Commentary:

This provision reinforces guiding principle 7 by restricting entrepreneurial practice in organ recovery and implantation. A medical or other health practitioner uncertain whether a fee proposed to be charged is justifiable may seek the opinion of an appropriate licensing or disciplinary authority before the fee is proposed or levied.

### Guiding principle 9

In the light of the principles of distributive justice and equity, donated organs should be made available to patients on the basis of medical need and not on the basis of financial or other considerations.

### Commentary:

This provision is self-explanatory.

# ANNEXE 2
# *DECLARATION OF HELSINKI (WORLD MEDICAL ASSOCIATION)*

## Recommendations guiding physicians in biomedical research involving human subjects

Adopted by the 18th World Medical Assembly Helsinki, 1964 as amended by the 29th World Medical assembly Tokyo, 1975; the 35th World Medical Assembly Venice, 1983 and the 41st World Medical Assembly Hong Kong, 1989

### Introduction

It is the mission of the physician to safeguard the health of the people. His or her knowledge and conscience are dedicated to the fulfilment of this mission. The *Declaration of Geneva* of the World Medical Association binds the physician with the words, "The health of my patient will be my first consideration", and the *International Code of Medical Ethics* declares that, "A physician shall act only in the patient's interest when providing medical care which might have the effect of weakening the physical and mental pathogenesis of disease". In current medical practice most diagnostic, therapeutic or prophylactic procedures involve hazards. This applies especially to biomedical research. Medical progress is based on research which ultimately must rest in part on experimentation involving human subjects.

In the field of biomedical research a fundamental distinction must be recognised between medical research in which the aim is essentially diagnostic or therapeutic for a patient, and medical research, the essential object of which is purely scientific and without implying direct diagnostic or therapeutic value to the person subjected to the research. Special caution must be exercised in the conduct of research which may affect the environment, and the welfare of animals used for research must be respected.

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to every physician in biomedical research involving human subjects. They should be kept under review in the future. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Physicians are not relieved from criminal, civil and ethical responsibilities under the law of their own countries.

### I Basic principles

1 Biomedical research involving human subjects must conform to generally accepted scientific principles and should be based on adequately performed laboratory and animal experimentation and on a thorough knowledge of the scientific literature.

2 The design and performance of each experimental procedure involving human subjects should be clearly formulated in an experimental protocol which should be transmitted for consideration, comment and guidance to a specially appointed committee independent of the investigator and the sponsor provided that this independent committee is in conformity with the laws and regulations of the country in which the research experiment is performed.

3 Biomedical research involving human subjects should be conducted only by scientifically qualified persons and under the supervision of a clinically competent medical person. The responsibility for the human subject must always rest with a medically qualified person and never rest on the subject of the research, even though the subject has given his or her consent.

4 Biomedical research involving human subjects cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

5 Every biomedical research project involving human subjects should be preceded by careful assessment of predictable risks in comparison with foreseeable benefits to the subject or to others. Concern for the interests of the subject must always prevail over the interests of science and society.

6 The right of the research subject to safeguard his or her integrity must always be respected. Every precaution should be taken to respect the privacy of the subject and to minimize the impact of the study on the subject's physical and mental integrity and on the personality of the subject.

7 Physicians should abstain from engaging in research projects involving human subjects unless they are satisfied that the hazards involved are believed to be predictable. Physicians should cease any investigation if the hazards are found to outweigh the potential benefits.

8 In publication of the results of his or her research, the physician is obliged to preserve the accuracy of the results. Reports of experimentation not in accordance with the principles laid down in this Declaration should not be accepted for publication.

9 In any research on human beings, each potential subject must be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and the discomfort it may entail. He or she should be informed that he or she is at liberty to abstain from participation in the study and that he or she is free to withdraw his or her consent to participation at any time. The physician should then obtain the subject's freely-given informed consent, preferably in writing.

10 When obtaining informed consent for the research project the physician should be particularly cautious if the subject is in a dependent relationship to him or her or may consent under duress. In that case the informed consent should be obtained by a physician who is not engaged in the investigation and who is completely independent of this official relationship.

11 In case of legal incompetence, informed consent should be obtained from the legal guardian in accordance with national legislation. Where physical or mental incapacity makes it impossible to obtain informed consent, or when the subject is a minor, permission from the responsible relative replaces that of the subject in accordance with national legislation.

Whenever the minor child is in fact able to give consent, the minor's consent must be obtained in addition to the consent of the minor's legal guardian.

12 The research protocol should always contain a statement of the ethical considerations involved and should indicate that the principles enunciated in the present Declaration are complied with.

## II Medical research combined with professional care (clinical research)

1 In the treatment of the sick person, the physician must be free to use a new diagnostic and therapeutic measure, if in his or her judgement it offers hope of saving life, re-establishing health or alleviating suffering.

2 The potential benefits, hazards and discomfort of a new method should be weighed against the advantages of the best current diagnostic and therapeutic methods.

3 In any medical study, every patient — including those of a control group, if any — should be assured of the best proven diagnostic and therapeutic method.

4 The refusal of the patient to participate in a study must never interfere with the physician-patient relationship.

5 If the physician considers it essential not to obtain informed consent, the specific reasons for this proposal should be stated in the experimental protocol for transmission to the independent committee. (I,2)

6 The physician can combine medical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that medical research is justified by its potential diagnostic or therapeutic value for the patient.

## III Non-therapeutic biomedical research involving human subjects (non-clinical biomedical research)

1 In the purely scientific application of medical research carried out on a human being, it is the duty of the physician to remain the protector of the life and health of that person on whom biomedical research is being carried out.

2 The subjects should be volunteers — either healthy persons or patients for whom the experimental design is not related to the patient's illness.

3 The investigator of the investigating team should discontinue the research if in his/her or their judgement it may, if continued, be harmful to the individual.

4 In research on man, the interest of science and society should never take precedence over considerations related to the wellbeing of the subject.

## ANNEXE 3
## Chart of ratifications of the six internationally recognised human rights treaties as of 31 March 1999

| | *International Covenant on Economic, Social and Cultural Rights* | *International Covenant on Civil and Political Rights* | *International Convention on the Elimination of All Forms of Racial Discrimination* | *Convention on the Rights of the Child* | *Convention on the Elimination of All Forms of Discrimination Against Women* | *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* |
|---|---|---|---|---|---|---|
| Afghanistan | X | X | X | X | S | X |
| Albania | X | X | X | X | X | X |
| Algeria | X | X | X | X | X | X |
| Andorra | | | | X | X | |
| Angola | X | X | | X | X | |
| Antigua and Barbuda | | | X | X | X | X |
| Argentina | X | X | X | X | X | X |
| Armenia | X | X | X | X | X | X |
| Australia | X | X | X | X | X | X |
| Austria | X | X | X | X | X | X |
| Azerbaijan | X | X | X | X | X | X |
| Bahamas | | | X | X | X | |
| Bahrain | | | X | X | | X |
| Bangladesh | X | | X | X | X | X |
| Barbados | X | X | X | X | X | |
| Belarus | X | X | X | X | X | X |
| Belgium | X | X | X | X | X | S |
| Belize | | X | | X | X | X |
| Benin | X | X | S | X | X | X |
| Bhutan | | | S | X | X | |
| Bolivia | X | X | X | X | X | X |
| Bosnia and Herzegovina | X | X | X | X | X | X |
| Botswana | | | X | X | X | |
| Brazil | X | X | X | X | X | X |
| Brunei Darussalam | | | | X | | |
| Bulgaria | X | X | X | X | X | X |
| Burkina Faso | X | X | X | X | X | X |
| Burundi | X | X | X | X | X | X |
| Cambodia | X | X | X | X | X | X |
| Cameroon | X | X | X | X | X | X |
| Canada | X | X | X | X | X | X |
| Cape Verde | X | X | X | X | X | X |
| Central African Republic | X | X | X | X | X | |
| Chad | X | X | X | X | X | X |
| Chile | X | X | X | X | X | X |
| China | S | S | X | X | X | X |
| Colombia | X | X | X | X | X | X |
| Comoros | | | | X | X | |
| Congo | X | X | X | X | X | |
| Cook Islands | | | | X | | |
| Costa Rica | X | X | X | X | X | X |
| Côte d'Ivoire | X | X | X | X | X | X |
| Croatia | X | X | X | X | X | X |

| | *International Covenant on Economic, Social and Cultural Rights* | *International Covenant on Civil and Political Rights* | *International Convention on the Elimination of All Forms of Racial Discrimination* | *Convention on the Rights of the Child* | *Convention on the Elimination of All Forms of Discrimination Against Women* | *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* |
|---|---|---|---|---|---|---|
| Cuba | | | X | X | X | X |
| Cyprus | X | X | X | X | X | X |
| Czech Republic | X | X | X | X | X | X |
| Democratic People's Repubic of Korea | X | X | | X | | |
| Democratic Republic of the Congo | X | X | X | X | X | X |
| Denmark | X | X | X | X | X | X |
| Djibouti | | | | X | X | |
| Dominica | X | X | | X | X | |
| Dominican Republic | X | X | X | X | X | X |
| Ecuador | X | X | X | X | X | X |
| Egypt | X | X | X | X | X | X |
| El Salvador | X | X | X | X | X | X |
| Equatorial Guinea | X | X | | X | X | |
| Eritrea | | | | X | X | |
| Estonia | X | X | X | X | X | X |
| Ethiopia | X | X | X | X | X | X |
| Fiji | | | X | X | X | |
| Finland | X | X | X | X | X | X |
| France | X | X | X | X | X | X |
| Gabon | X | X | X | X | X | S |
| Gambia | X | X | X | X | X | S |
| Georgia | X | X | | X | X | X |
| Germany | X | X | X | X | X | X |
| Ghana | | | X | X | X | |
| Greece | X | X | X | X | X | X |
| Grenada | X | X | S | X | X | |
| Guatemala | X | X | X | X | X | X |
| Guinea | X | X | X | X | X | X |
| Guinea-Bissau | X | | | X | X | |
| Guyana | X | X | X | X | X | X |
| Haiti | | X | X | X | X | |
| Holy See | | | X | X | | |
| Honduras | X | X | | X | X | X |
| Hungary | X | X | X | X | X | X |
| Iceland | X | X | X | X | X | X |
| India | X | X | X | X | X | S |
| Indonesia | | | | X | X | X |
| Iran (Islamic Republic of) | X | X | X | X | | |
| Iraq | X | X | X | X | X | |
| Ireland | X | X | S | X | X | S |
| Israel | X | X | X | X | X | X |

| | *International Covenant on Economic, Social and Cultural Rights* | *International Covenant on Civil and Political Rights* | *International Convention on the Elimination of All Forms of Racial Discrimination* | *Convention on the Rights of the Child* | *Convention on the Elimination of All Forms of Discrimination Against Women* | *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* |
|---|---|---|---|---|---|---|
| Italy | X | X | X | X | X | X |
| Jamaica | X | X | X | X | X | |
| Japan | X | X | X | X | X | |
| Jordan | X | X | X | X | X | X |
| Kazakhstan | | | X | X | X | X |
| Kenya | X | X | | X | X | X |
| Kiribati | | | | X | | |
| Kuwait | X | X | X | X | X | X |
| Kyrgyzstan | X | X | X | X | X | X |
| People's Democratic Republic of Lao | | | X | X | X | |
| Latvia | X | X | X | X | X | X |
| Lebanon | X | X | X | X | X | |
| Lesotho | X | X | X | X | X | |
| Liberia | S | S | X | X | X | |
| Libyan Arab Jamahiriya | X | X | X | X | X | X |
| Liechtenstein | X | X | | X | X | X |
| Lithuania | X | X | X | X | X | X |
| Luxembourg | X | X | X | X | X | X |
| Madagascar | X | X | X | X | X | |
| Malawi | X | X | X | X | X | X |
| Malaysia | | | | X | X | |
| Maldives | | | X | X | X | |
| Mali | X | X | X | X | X | X |
| Malta | X | X | X | X | X | X |
| Marshall Islands | | | | X | | |
| Mauritania | | | X | X | | |
| Mauritius | X | X | X | X | X | X |
| Mexico | X | X | X | X | X | X |
| Micronesia (Federated States of) | | | | X | | |
| Monaco | X | X | X | X | | X |
| Mongolia | X | X | X | X | X | |
| Morocco | X | X | X | X | X | X |
| Mozambique | | X | X | X | X | |
| Myanmar | | | | X | X | |
| Namibia | X | X | X | X | X | X |
| Nauru | | | | X | | |
| Nepal | X | X | X | X | X | X |
| Netherlands | X | X | X | X | X | X |
| New Zealand | X | X | X | X | X | X |
| Nicaragua | X | X | X | X | X | S |
| Niger | X | X | X | X | | X |
| Nigeria | X | X | X | X | X | S |
| Niue | | | | X | | |

| | *International Covenant on Economic, Social and Cultural Rights* | *International Covenant on Civil and Political Rights* | *International Convention on the Elimination of All Forms of Racial Discrimination* | *Convention on the Rights of the Child* | *Convention on the Elimination of All Forms of Discrimination Against Women* | *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* |
|---|---|---|---|---|---|---|
| Norway | X | X | X | X | X | X |
| Oman | | | | X | | |
| Palau | | | | X | | |
| Pakistan | | | X | X | X | |
| Panama | X | X | X | X | X | X |
| Papua New Guinea | | | X | X | X | |
| Paraguay | X | X | | X | X | X |
| Peru | X | X | X | X | X | X |
| Philippines | X | X | X | X | X | X |
| Poland | X | X | X | X | X | X |
| Portugal | X | X | X | X | X | X |
| Qatar | | | X | X | | |
| Republic of Korea | X | X | X | X | X | X |
| Republic of Moldova | X | X | X | X | X | X |
| Romania | X | X | X | X | X | X |
| Russian Federation | X | X | X | X | X | X |
| Rwanda | X | X | X | X | X | |
| St Kitts and Nevis | | | | X | X | |
| St Lucia | | | X | X | X | |
| St Vincent and the Grenadines | X | X | X | X | X | |
| Samoa | | | | X | X | |
| San Marino | X | X | | X | | |
| Sao Tome and Principe | S | S | | X | S | |
| Saudia Arabia | | | X | X | | X |
| Senegal | X | X | X | X | X | X |
| Seychelles | X | X | X | X | X | X |
| Sierre Leone | X | X | X | X | X | S |
| Singapore | | | | X | X | |
| Slovakia | X | X | X | X | X | X |
| Slovenia | X | X | X | X | X | X |
| Solomon Islands | X | | X | X | | |
| Somalia | X | X | X | | | X |
| South Africa | S | X | X | X | X | X |
| Spain | X | X | X | X | X | X |
| Sri Lanka | X | X | X | X | X | X |
| Sudan | X | X | X | X | | S |
| Suriname | X | X | X | X | X | |
| Swaziland | | | X | X | | |
| Sweden | X | X | X | X | X | X |
| Switzerland | X | X | X | X | X | X |
| Syrian Arab Republic | X | X | X | X | | |

| | *International Covenant on Economic, Social and Cultural Rights* | *International Covenant on Civil and Political Rights* | *International Convention on the Elimination of All Forms of Racial Discrimination* | *Convention on the Rights of the Child* | *Convention on the Elimination of All Forms of Discrimination Against Women* | *Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment* |
|---|---|---|---|---|---|---|
| Tajikistan | X | X | X | X | X | X |
| Thailand | | X | | X | X | |
| The former Yugoslav Republic of Macedonia | X | X | X | X | X | X |
| Togo | X | X | X | X | X | X |
| Tonga | | | X | X | | |
| Trinidad & Tobago | X | X | X | X | X | |
| Tunisia | X | X | X | X | X | X |
| Turkey | | | S | X | X | X |
| Turkmenistan | X | X | X | X | X | |
| Tuvalu | | | | X | | |
| Uganda | X | X | X | X | X | X |
| Ukraine | X | X | X | X | X | X |
| United Arab Emirates | | | X | X | | |
| United Kingdom | X | X | X | X | X | X |
| United Republic of Tanzania | X | X | X | X | X | |
| United States of America | S | X | X | S | S | X |
| Uruguay | X | X | X | X | X | X |
| Uzbekistan | X | X | X | X | X | X |
| Vanuatu | | | | X | X | |
| Venezuela | X | X | X | X | X | X |
| Viet Nam | X | X | X | X | X | |
| Yemen | X | X | X | X | X | X |
| Yugoslavia | X | X | X | X | X | X |
| Zambia | X | X | X | X | X | X |
| Zimbabwe | X | X | X | X | X | |
| TOTAL NUMBER OF STATES PARTIES | 141 | 144 | 153 | 191 | 163 | 115 |
| SIGNATURES NOT FOLLOWED BY RATIFICATION | 5 | 3 | 5 | 1 | 3 | 9 |

X Ratification, accession, approval, notification or succession, acceptance or definitive signature
S Signature not yet followed by ratification

## ERRATUM

The following corrections should be made to Section III (Case Studies) of the Manual:

**Relationships with other health workers**

Case Study B (p 3-21) should appear under the Case Studies for **Consent to Medical Procedures** (pp 3-11 – 3-13)

Case Study E (pp 3-22 – 3-23) The reference to 'senior medical officer' in question 1 for discussion should be deleted and replaced by 'doctors and nurses concerned with the case'.

**Responsibility to the Community**

Case Study E, p 4-29 should appear under the Case Studies for **Relationships with other Health Workers** (pp 3-21 – 3-23)


Commonwealth Medical Association Trust
BMA House
Tavistock Square
London, WC1H 9JP
United Kingdom