REVIEW ARTICLE

Medical Ethics and Ethical Dilemmas

Iyalomhe G B S, *MBBS MA MSc PhD*

Department of Pharmacology & Therapeutics College of Medicine Ambrose Alli University Ekpoma, Nigeria

Abstract

Background: *Ethical problems routinely arise in the hospital and outpatient practice settings and times of dilemma do occur such that practitioners and patients are at cross-roads where choice and decision making become difficult in terms of ethics. This paper attempts a synopsis of the basic principles of medical ethics, identifies some ethical dilemmas that doctors often encounter and discusses some strategies to address them as well as emphasizes the need for enhanced ethics education both for physicians and patients particularly in Nigeria.*

Method: *Literature and computer programmes (Medline and PsychoInfo databases) were searched for relevant information.*

Result: *The search showed that the fundamental principles suggested by ethicists to assist doctors to evaluate the ethics of a situation while making a decision include respect for autonomy, beneficence, non-maleficence and justice. Although the above principles do not give answers as to how to handle a particular situation, they serve as a guide to doctors on what principles ought to apply to actual circumstances. The principles sometimes conflict with each other leading to ethical dilemmas when applied to issues such as abortion, contraception, euthanasia, professional misconduct, confidentiality, truth telling, professional relationship with relatives, religion, traditional medicine and business concerns. Resolution of dilemmas demand the best of the doctor's knowledge of relevant laws and ethics, his training and experience, his religious conviction and moral principles as well as his readiness to benefit from ethics consultation and the advice of his colleagues.*

Conclusion: *Ethics education should begin from the impressionable age in homes, continued in the medical schools and after graduation to ensure that doctors develop good ethical practices and acquire the ability to effectively handle ethical dilemmas. Also, education of patients and sanction of unethical behaviour will reduce ethical dilemmas.*

Date accepted for publication 3rd July 2008
Nig J Med 2009; 8-16

Introduction

Over the years, there have been great advances and progressively widening scope in medical practice to the extent that in many areas there exists complex moral issues from which there are debatable or no clear-cut guidelines for the practitioner. Such uncertainties surround current topics such as abortion, contraception, euthanasia and artificial insemination. Ethics is the study of the nature of behaviour and grounds of moral obligations, distinguishing what is right from what is wrong. On the other hand, medical ethics is the discipline that deals with the application of moral values to situations or relationships in medical practice.[1-3] In many cases, moral values can be in conflict and ethical dilemmas result.

MEDICAL ETHICS

As a professional regulatory system, medical ethics has been one of the most visionary and socially valuable creations of the medical profession. Its beneficial influence has extended beyond physician/patient relations, to the shaping of many key humanistic and egalitarian features of the world's legal and political institutions. It has played morally inspirational, educational, disciplinary, and normative roles from its location in traditional professional paths, codes prepared by medical associations, as well as guidelines applied by clinical and research ethics committees. Contemporary medical ethics is conceptually enriched by influential texts and academic articles summarizing and categorizing its core professional virtues and principles.

Within medical education, it has two main tasks. One is concerned with teaching and learning the standards of professional competence and conduct that the medical profession expects of its members. The other is concerned with teaching and learning how to articulate and analyze the increasing number of ethical problems raised by the practice of medicine, to many which there are no obvious agreed answers.

Evolution of medical ethics: Evolution of medical ethics customarily begins with the virtues and principles

Correspondence to ***Dr. G.B.S. Iyalomhe*** *E-mail:goddyiyalo@yahoo.com*

originally found in documents such as the Hippocratic Oath and Epidemics, both attributed to Hippocrates of Cos, a descendant of Asclepius, in the 4th century BC. These include the virtues of professional self respect, collegiality and competence, as well as the principles of respect for patient confidentiality, beneficence, non-maleficence, respect for life and egalitarian treatment.[4] Proving a breach of the Hippocratic Oath's ethical obligation to "do no harm" was central to the conviction of the Nazi doctors at the Nuremberg Trials after the Second World War for non-consensual, brutal experimentation, sterilization and active non-voluntary euthanasia.[5-6] Those proceedings spurred creation of a collection of documents that remain central to medical ethics: the Declaration of Geneva (or the modernized Hippocratic Oath),[7] the Nuremberg Declaration on Human Experimentation,[8] the Helsinki Declaration[9] and the International Code of Medical Ethics.[10] An amendment of the Geneva Declaration was necessitated in 1964 in Sydney Australia when a statement was laid down on the criteria for the pronouncement of death, and to check arbitrary removal of viable organs from the body of a cadaver for transplantation purposes. The Nuremberg and Helsinki Declarations were meant to check the abuses of human experimentation and clinical research.[6] The norms of contemporary medical ethics are often interpreted by courts in order to determine the professional standard of care, or to assist in resolving difficult cases, where no settled and definitive legal rule exists. One example of the latter was the decision of the US Supreme court in Roe vs. Wade, in which considerable space was devoted to an analysis of the Hippocratic Oath's alleged prohibition on abortion.[11] Particular controversy, in this regard, has arisen over reinterpretations of the World Medical Association's Declaration of Helsinki. Some contentious issues concerned the distinction between "therapeutic" and "non-therapeutic" research and the use of "best proven treatment" or placebo in controls.[12] There are now innumerable tribunals both within the United Nations and on regional level, authoritatively interpreting the norms of international human rights concerning doctor/patient relations. Cases concerning new productive technologies, end of life decisions, privacy and informed consent, are now heavily influenced by international human rights laws.[13]

Principles of medical ethics: In its contemporary quest for continued regulatory relevance, medical ethics is often cast as the relatively easy to communicate "four principles plus scope" developed by Beauchamp and Childress.[14] The "four principles plus scope" approach provides a simple, accessible and culturally neutral approach to thinking about ethical issues in healthcare. The approach is based on four common basic prima facie moral commitments respect for autonomy, beneficence, non-maleficence, and justice plus concern for all their scope of application. It offers a common, basic moral analytical framework and a common basic moral language. Although they do not provide ordered rules, these principles can help doctors and other healthcare workers to make decisions when reflecting on moral issues that arise at work.

Respect for autonomy is the moral obligation to respect the autonomy of others in so far as such respect is compatible with equal respect for the autonomy of all potentially affected. It is also sometimes described, in Kantian terms, as treating others as ends in themselves and never merely as means one of Kant's formulations of his "categorical imperatives".[15] In healthcare, respecting people's autonomy has many implications. It requires us to consult people and obtain their agreement before we do things to help them.

Medical confidentiality is another implication of respecting people's autonomy. Without such promises like confidentiality, patients are also far less likely to divulge the often highly private and sensitive information that is needed for their optimal care; thus maintaining confidentiality not only respect patients' autonomy but also increases the likelihood of our being able to help them. Respect for autonomy requires doctors not to deceive them, for example about their diagnosed illness for it is when patients know the truth that they or their surrogates can give reasoned informed consent. Good communication with patients and clients about treatments/interventions is essential to respect their autonomy and will prevent bad feelings and disagreement between patients and the healthcare team, between family members or between members of medical community and reduce ethical dilemmas.

The principles of beneficence (acting in the best interest of the patient) and non-maleficence (first, do no harm) must be considered together because whenever we try to help patients, we risk harming them. The aim, therefore, is to heed the traditional Hippocratic moral obligation to provide net medical benefit to patients with no or minimal harm. To achieve this objective, healthcare professionals must commit themselves to certain moral obligations engage in rigorous education and training both before and during professional lives, be clear about risks and probability when assessing

harm and benefits of proposed interventions/treatments, give information based on effective medical research and seek to empower patients and clients to be more in control of their health and healthcare. Non-maleficence, is a legal definable concept violation of which is the subject of medical malpractice. A phenomenon of "double effect"[15] occurs when an intervention benefits a patient and at the same time does him/her potential harm. A good example of this is the use of morphine in a dying patient it eases the pains and sufferings while simultaneously hastening the demise of the patient through suppression of the respiratory drive.

Justice is concerned with using limited medical resources fairly, legally and in accordance with human rights' principles. Equality is at the heart of justice, but as Aristotle[16] argued so long ago, justice is more than mere equality for people can be treated unjustly even though treated equally. The obligations of healthcare professionals are to recognize and acknowledge the competing moral concerns in allocating health resources, provide sufficient healthcare to meet needs of all who need it where this is possible, provide equal access to health facilities, allow patients and clients as much as possible to select their health needs and maximize the benefit produced by available resources.

The "four principles plus scope" approach is clearly not without its critics. The approach, however, does not purport to offer a method of dealing with conflicts between the principles. Nevertheless, it is hard to find anyone who seriously argues that he/she cannot accept these prima facie principles or find plausible examples of concerns about healthcare ethics that require additional moral principles.

Principles do not give answers as to how to handle a particular situation, but guide doctors on what principles ought to apply to actual circumstances. The principles sometimes contradict each other leading to ethical dilemmas.[17-19] For example, the principles of autonomy and beneficence clash when patients refuse life-saving blood transfusion, and truthfulness may not always be upheld regarding the use of placebos in some instances. To reconcile conflicting principles, Bernard Gert,[3] a philosopher who specializes in medical ethics, propounds a theory that would require us to advocate our action publicly if we were to violate any basic moral principles (e.g. break a promise in order to save a life). Other philosophers, such as R.M. Hare[20] would require us to formulate a universal prescription in conformance with logic, such that all rational parties, including the patient (assuming he is rational), would subscribe to the same action in all circumstances that share the same essential properties.

Ethical Dilemmas

Dilemmas occur because the doctor has his own conscience which he tries to obey. Furthermore the profession has its codes and standards. The society too has its own morality and the patient has his/her own conscience. In trying to marry these various demands, the doctor will invariably face dilemmas over certain medico-social issues.

Abortion: A doctor may have great difficulty in establishing rapport with a patient who asks for a badly needed service, which the doctor's conscience or the law forbids him to give. A patient pressing a doctor to "help" her procure a non-therapeutic abortion particularly in a country like Nigeria where abortion is illegal, is a case in point. In resolving the above dilemma, reason and understanding of the situation, ethics and law should prevail. In the case of a patient who wants an abortion for whatever reason, even in countries where abortion is legalized, there is the conscience clause[2] e.g. in the UK and Singapore, by which a doctor whose conscience does not allow him need not perform abortion.

Indeed, abortion has provoked so much debate and concern in the camps of pro-abortionists and anti-abortionists. Pro-abortionists argue that since the time of ensoulment or animation[21-23] (when life begins) is uncertain, the foetus is not yet a person and so can be aborted. They add that abortion rids the woman the rigours of carrying a "mistaken or unwanted"[24] pregnancy which may be due to failed contraception, rape, or incest and economic difficulty; obviates the problem of illegitimate children; serves as an effective means of population control following Malthusian theory[25] that population growth would outstrip world's food supply and halt development and maintain that confirmed pathological condition of the foetus and the mother's physical or mental health justify legalized therapeutic abortion.

The anti-abortionists assert that life begins immediately after conception and since it is the conceptus that grows into a newborn baby, the foetus is therefore a person, created in the image of God.[25, 26-28] Unfortunately, the Supreme Court of the United States of America ruled in 1973 that foetal viability is the criterion for determining whether the foetus is a person or not, and that this

occurs in the last trimester of pregnancy.[22-23] The anti-abortionists argue that abortion violates the right of the foetus to life and may lead to voluntary euthanasia particularly of the deformed foetus.[29] Abortion, they add, dehumanizes and it is an act that is bad in itself because it encourages sexual permissiveness and promiscuity which may increase morbidity and mortality.[30]

With the rise of secular humanism as a major force in shaping western ethical thinking, it is not surprising that abortion has turned the tide in medical ethics and practice. Nowhere is this more evident than in attitudes and practice with regard to abortion. Since 1948 there has been a gradual escalation in so-called therapeutic abortion and worldwide there are now over 50 million such abortions a year. In the UK the annual figure is 180,000 or one abortion for every five live births. This is an average figure for the western world. In the USA the figures are one in three, in several Eastern European countries there are more abortions than live births[31]. The vast majority of these (99%) are not for the "welcome" indications of rape, severe congenital disease or to save the life of the mother but rather to preserve the mother's mental health. In practice, this means abortion is usually performed on no more solid grounds than social inconvenience, unwanted pregnancy, failed contraception or economic difficulty.

These abortions are performed mostly by doctors. How is this possible in the light of the ethical declarations of the medical profession? In 1970 the World Medical Association adopted the Declaration of Oslo[32] which established the precedent for "therapeutic abortion" in circumstances "where the vital interests of the mother conflict with those of the unborn child". Although the "utmost respect for human life from the time of conception" as laid out in the Declaration of Geneva was affirmed, it was recognized that there was a "diversity of attitudes towards the life of the unborn child". Accordingly it was allowed that "where the law allows therapeutic abortion to be performed … and this is not against the policy of the national medical association", then "abortion should be performed" under certain provisos. This declaration thus laid the framework for doctors to perform abortions if their "individual conviction and conscience" allowed it and the law and the national medical association were not in disagreement. This appears to be a very minor change but it represented a fundamental shift in the whole presuppositional framework of medical ethics.

As the abortion rate worldwide continued to soar in this new ethical environment, and new birth technologies came into being as a result of in vitro fertilization, it was clear that medical practice was increasingly out of step with the Declaration of Geneva[7] and the International Code of Medical Ethics.[10] To achieve consistency either medical practice had to be changed or the codes had to be amended. The latter course was chosen. At the 35th World Medical Assembly held in Venice in October 1983 the words "from time of conception" were amended to "from its beginning" thus begging the question of when human life begins. Amendments to the International Code of Medical Ethics were even more radical. The words "from the time of conception until death" were excised such that the revisited version now reads "A physician must always bear in mind the obligation of preserving human life" only. Neither the time at which human life begins not the time at which it ends are defined but presumably left open to "individual conviction and conscience which must be respected".

Contraception: When a doctor is confronted by a 13-year old girl of a close family and she requests for a prescription of oral contraceptives and the doctor knowing that the parents will disapprove of her using the pills, what would he do? A couple who needs family planning badly for family welfare may refuse this treatment for any reason, what then does the doctor do? To address this issue, the pertinent questions that arise are: Does contraception promote sexual promiscuity? Does it oppose the purpose of God for the family? Is it inimical to true religion? Counseling and patient/client education are essential in cases of this nature.

Artificial insemination, in vitro fertilization and cloning: Similarly, artificial insemination by donor (AID) and in vitro fertilization (IVF) using donor sperms raise serious ethical problems, for the woman is the mother of the baby but the man is not the father. Legal problems may also arise thereafter. Animal and attempted human cloning too have raised a lot of ethical debates and concern particularly in the developed world. Abiding by the relevant laws and ethics together with respect of the patient's wish are essential in resolving these issues.

Euthanasia: Anecdotal reports abound in Nigeria about the ethical dilemma of euthanasia particularly involving the chronically ill, the malformed and babies of disputed paternities.[33-35] When a chronically ill patient requests that his treatment be stopped or the family members wish to discharge a comatose patient against medical advice because of treatment they envisage will be unsuccessful or for inability to pay bill, what does the doctor do? Euthanasia is an issue that occasions a serious moral dilemma to the doctor, the nurses and the wider society. To sum up a list of professional definitions,

euthanasia is the willful (direct or indirect) killing of the incurably sick, for the sole purpose of relieving pain, suffering, disgrace, family stigma (e.g. defective or illegitimate child, insanity, social taboos like albinos and multiple births, insane or senile old parents/relatives) who have constituted a nuisance and economically unviable, be it at their request , or be it at the request of the parents/guardians or any other legal representative in the care of incurables incapable of deciding for themselves (e.g. infants, the comatose or mental defectives), or be it at no other's request except for the wish or predilection of the administrator.[25, 33-35] Although Unomah and Onuminya[35] averred that euthanasia service is alien to African culture, they rightly agreed that the practice might well be going on unnoticed both at the village and urban settings.

Euthanasia violates the four basic principles of medical ethics. Medical prognosis may be embarrassingly wrong as chronically ill patients have recovered after months in an apparently hopeless state, and some have returned to a more or less normal life.[35] Deliberate death acceleration by neglect or other means would take the medical profession and society over a dividing line they cross at their peril. Although there is disagreement in the medical circle concerning euthanasia, the experience in the Netherlands demonstrates beyond reasonable doubt that abuse follows the use of euthanasia as an instrument to relieve terminal pain and distress.[36-37] Without trying to over-simplify the doctor's dilemma to preserve life and relieve suffering when a terminally ill patient is close to death, preserving life becomes increasingly meaningless and emphasis must be on relieving suffering. Now that agents are available to relieve terminal pains such as administration of several non-steroidal anti-inflammatory drugs by suppository or intravenous (i.v.) infusion, i. v. morphine/diamorphine, i.v. diazepam/chlorpromazine, i.v. amylobarbital/thiopental, i.v. phenobarbital etc, efforts should be concentrated on implementing programmes of palliative care, rather than yielding to pressure for euthanasia, often achieved by giving i.v. potassium chloride, curare or air.[38]

Dilemmas occasioning professional misconduct: How does a doctor react to the request for excuse duty certificate which is not justified on medical grounds e.g. when relatives request for death certificates for patients who discharged against medical advice or after refusing hospital treatment outright? Some patients refuse orthodox treatment for certain illnesses e.g. fractures, schizophrenia, stroke but would want excuse duty certificates to cover periods of absence from work after treatment with traditional medicine. Should a doctor certify that which he has not witnessed/verified? To resolve the dilemma in respect of the issuance of death certificates in patients who died at home, I suggest that a doctor can direct members of the family to depose to an affidavit in a court of competent jurisdiction and proceed to birth/death registry to obtain a certificate and on the strength of this the doctor can issue that medical certificate which may be badly needed for official matters.

Also, on the traditional medical scene, disease is often seen as a punishment for some wrongdoing or it is attributed to some evil supernatural influences or the handiwork of malevolent human agents. While doctors elucidate the causes of disease by observation, examination and laboratory tests, they often prefer to consult the oracles. It is sometimes found that patients secretly or openly combine traditional remedies with medical treatment. Considering that traditional medicine has been with our people for generations and considering that orthodox medicine is still in short supply, what should the attitude of the doctor be to a dilemma like this? There is no gainsaying the fact that some of the traditional herbs/medicines are efficacious but the problem is that their proper dosages and adverse effects are not documented. Patients should be made to understand this. Anecdotal reports abound about doctors who combine orthodox drugs with traditional herbal preparations in collaboration with the traditional healers. This amounts to association with unqualified people which is a professional misconduct.[39] Patients should be advised to restrict themselves to either orthodox or traditional medicine at particular times.

Dilemmas can also arise in relation to what the attitude of the doctor should be in a situation where there is conflict of claims between a patient's wish and his interest as seen by the doctor? For example, what should be done with a patient who needs to take an injection but refuses? Conversely should a doctor succumb to the demand by a patient for an injection which in the practitioner's view is unnecessary though harmless? In another consideration, what should the attitude of a prison doctor be to a prisoner who is on hunger strike? Forcible feeding amounts to assault. Whenever there is conflict of interest between the doctor and the patient, the doctor should sympathetically guide the patient on the right course of action while he tows the path of honour.

In addition to the above examples there are times when conflict arises between the doctor's duty to his patient and the practitioner's duty as a good citizen. What should the attitude of the doctor be to a patient who

presents with injuries which evidently have been sustained in a criminal exercise e.g. armed robbery? The doctor as a good citizen would want the law to take its normal course but also wants to act in his patient's best interest. A patient suspected to be a criminal should be given emergency treatment while a report is made to the law enforcement agents immediately. The same thing applies to treatment of cases of criminal abortion particularly those with complications. Failure to inform the police will make the doctor guilty of complicity and hence infamous conduct.[39-40]

There is also the phenomenon of transference when a male doctor, particularly the kind and sympathetic one, becomes the father-figure (the confidant) of his female patient who falls in love with him leading to an ethical dilemma. He should not for any reason, whether the phenomenon of transference[41] has taken place or due to the inability to pay bill, convert the patient to his girl-friend. One pundit declares to doctors "You can make your girl-friend your patient, but you cannot make your patient your girl-friend."[42] To obviate this dilemma, the contractual model of doctor-patient relationship propounded by Robert Yeatch[41] is ideal because the contract between the doctor and patient is a non-legalistic statement of obligations and benefits for both parties. In his own interest, the doctor should guard against the famous "7As" viz: Abuse of privilege, Abortion, Adultery, Advertising, Association with unqualified people, Addiction to drugs or Alcoholism and Any conviction in a competent law court; to avoid serious professional misconduct.[39-40]

Confidentiality: Another dilemma is in the area of confidentiality. How should findings at pre-employment medical examinations be treated in the interest of our patients and also in the interest of the employer establishment that request our expert opinion? How should adverse findings at insurance medical examinations be treated in the interest of our patients? Information about the patient must be treated and the report, with the consent of the patient, sent to the appropriate quarters. Otherwise, the report should be sent undoctored, even without the consent of the patient, because of the interest of the larger society.[43]

Truth telling: Telling the truth as it relates to patients' state of health can often constitute a dilemma. A patient has the right to expect the truth. But all the truth all the time, may not always be in the patients' best interest. A 60-year old Nigerian male was diagnosed as a case of inoperable prostatic cancer in a Nigerian hospital but the diagnosis was not disclosed to him. Two years later he developed a hemiplegia resulting from prostatic mestastes and the true diagnosis was made bare to him in a US hospital. The patient died and on bringing the corpse to Nigeria, the patient's relatives accused the Nigerian hospital of not telling them the correct diagnosis. Should not the Nigerian doctor have told the patient and family that the problem was an inoperable cancer from the beginning?
An elitist young man who admitted having sexual intercourse with his wife before presenting in the hospital was diagnosed of gonococcal urethritis. It is necessary to treat the wife but how can the doctor get at her? Should the husband be made to confess to his wife and let her seek treatment? It is clear that the truth should be told however unpalatable in terms of diagnosis, treatment and prognosis. The manner and extent to which the truth should be told, rests upon the clinical judgment of the doctor as to what is in the best interest of the patient. In telling the truth the rule is, "Do no harm so far as it is possible".[1, 2, 39-40] For patients with unstable personalities or with high susceptibility to depression and suicide, the assistance of the social worker, counselor or pastor may be solicited.[43] The patient with an inoperable cancer should have been so informed because in this society such a practice of withholding information often leads to misunderstanding. The husband with gonococcal urethritis ought to be advised to bring his wife for treatment even for the most trivial complaints. The doctor has to exercise great caution because the stability of a marriage is involved.

Religious sects: There are some religious sects that believe it is wrong to take medicines. A Nigerian engineer with a fulminating infective hepatitis believed fervently he should not take drugs but should concentrate on prayer for spiritual healing. All attempts at persuading him to reconsider what looked like a suicidal plunge failed. He eventually survived without drug treatment. But there are others who took a similar stand but were not as fortunate. How does a doctor do his best for his patient in a situation where there is conflict in belief like in the case quoted? Many pregnant women have laboured to the point of exhaustion in church premises in the belief that that is the best place for prayers to be offered for safe delivery. Some eventually come to hospital with severe complications. Admittedly, others make it. These observations are not intended to suggest that prayer has no place in the healing process for as we often posit, "We care but God heals". Caution and a sympathetic patient education are what I advocate in matters of faith healing particularly in those in which operation is indicated.

There is the dilemma that relates to religious sects that refuse blood transfusion on religious grounds, notably

Jehovah's Witnesses. This is the case where an established procedure which could be life-saving is indicated but is forbidden by the patient's religion. How should a doctor react in a situation like this in his patient's best interest? Since 1945 when a decision was made by the Jehovah's Witnesses, a religious sect established in the late 19th century by Charles Russel[44] that members should refuse blood transfusion[45], physicians have had to contend with the clinical, medicolegal and ethical challenges of the decision.[46] Refusal of blood transfusion[47-48] is a cardinal belief hinged on Biblical passages[49] that forbid "eating of blood" which were interpreted to preclude "transfusion of blood". They generally accept volume expanders crystalloids, colloids and perfluorochemicals as well as some therapeutic agents for managing anaemia e.g. iron dextran, folic acid, erythropoietin, granulocyte colony stimulating factor and vitamin $B_{12.}$ The use of whole blood, homologous or autologous and all forms of blood components are generally refused.[50] The right of an adult to refuse specific therapies had been legally established;[51] however the right of parents to refuse a life-saving therapy for their child on religious basis is still a subject of controversy.[52] The doctor must therefore assess individual cases critically and take a definite decision, sometimes in concert with relevant authorities when the underage is involved, and save the child from parental pejorative desires. In some cases, parents can sign a form that absolves the doctor from responsibility of any consequences.

Treatment of relatives: Ethical dilemmas also arise when family members insist that their own doctor relative must treat them. Increasingly, it is seen as inappropriate for doctors to treat members of their own family (partners, parents, children, etc)[53] particularly if the ailment is serious. The reasons given for this is that the patients may not be open and honest about their condition, given the family relationship, and that the family relationship may be used to pressurize the patient to agree to treatment they might otherwise have not, thus interfering with their autonomy. On the other hand, however, patients with a doctor in their family may prefer to seek treatment from him, due to the greater trust they have in him, the greater convenience he represents, and in some cases their ability to use the family relationship to pressurize or manipulate the physician into providing treatment he might otherwise see as inappropriate in the patient's circumstances (e.g. appetite suppressants, drugs of addiction).

Ethical dilemmas in medicine as a humanitarian calling and a business: Ethical considerations in relation to the practice of medicine as a humanitarian calling and at the same time as a business show clearly that gratifications have been offered to the physician from time immemorial. These have been in the form of gifts or money. The pervasiveness of medical advertising and material rewards to doctors for prescribing drugs which they are "bombarded" with possibly placing emphasis on profits rather than the patient's well-being, constitutes an ethical dilemma as this would violate the principle of beneficence.[54] The doctor must always act in the best interest of the patient. For example, he should not use a costly new drug where an old and useful but inexpensive alternative exists.

A major dilemma today arises from the need to maintain a delicate balance whereby the practice of medicine will not be seen just as a charity effort but at the same time will not lose its humanitarian tradition in the face of rising costs. In the realization of this delicate balance, questions arise. At what point for instance is a physician's charge unduly high? What should physicians do with patients who cannot pay the bill for treatment badly needed? In a situation where patients are given to taking undue advantage of humanitarian intentions, how do we recognize patients who genuinely cannot pay? Should medical practice conform to the ordinary rules and motives of business? The doctor-patient relationship is a relationship of one human being towards another. Ethical dilemmas that come in the way of this relationship can be resolved by the application of the golden rule, "Do unto others (your patients) as you wish them do unto you".[57] Therefore, the doctor must never cease to care. Patients after treatment should be encouraged to pay bills even if the extended family members have to be contacted. The doctor must not take undue advantage of the patient (because he can pay) by deliberately increasing the cost of treatment.[55] Those who are genuinely indigent like the orphans, the fatherless, the widows or the unassisted aged, could be pauperized and discharged.

Doctors also face an ethical dilemma in regard to managed care which makes cost containment or profit taking as its end at the expense of meeting legitimate needs of patients. Managed care violates the principles of medical ethics for apart from the fact that it is bad enough to be sick, it is equally bad enough not to be adequately treated.[56]

There is also the dilemma of doctors going on strike which has recently become a weapon in the hands of doctors in public service to press for improved working conditions. Are doctors justified to go on strike? There is little doubt that doctors have the freedom and the right to

strike. The question is not the legality of doctors striking so much as to its morality. Strikes which withdraw all medical services from all patients are still deemed indefensible. At the very least, the acutely ill and the injured must be cared for. The recent more radical view is that doctors should sometimes strike to preserve and improve their working standards because it is on these that the welfare of the patients ultimately depends.[58]

ETHICS CONSULTATION

Ethics consultation services, now available in the developed societies, assist doctors and patients in resolving ethical dilemmas or disputes, particularly those involving end-of-life decisions, patient autonomy, justice and conflict resolution.[59-61] In considering how ethics consultants should interact with doctors, several authors have argued that the role of the clinical ethicist is not to dictate the "right" solution but to help create the enabling environment and time in which ethical deliberation and mediation can take place.[62-64] Younger doctors have a lot to gain from the wealth of experience of senior colleagues and they should take full benefit of this when resolving ethical dilemmas.

Conclusion

Medical ethics is the study of moral values as they apply to medicine. In many cases, moral values can be in conflict and ethical dilemmas result. Ethical dilemmas are protean in medical practice today and are assuming gigantic dimensions as a result of technological advancement and decline in global moral values. Adherence to the Physician's Oath, the principles of medical ethics, ethical consultation and guidance from senior colleagues, will assist the doctor to address ethical dilemmas. In addition, there should be effective avenues for the discipline of unethical conduct, to serve as deterrent to others.

Education of patients will reduce their pressure on doctors to act unethically. There is a crying need for enhanced moral education, which should start at the impressionable childhood age, and this will greatly aid the teaching of ethics to medical students and resident doctors. I advocate continuing medical ethics education programmes for all doctors because the doctors need sound ethical values to be able to give sound treatment and advice to the patients and people they meet on daily basis. The well-known altruistic commitment and devotion of nuns and missionary medical personnel throughout the ages testify to this.

References

1. Akpata ES. (ed). Medical ethics. Lagos: Lagos University Press, 1982: 51-74.
2. British Medical Association. The handbook of medical ethics. London: British Medical Association, 1981: 1-19.
3. Haring B. Medical ethics. London: St Paul's Publications, 1972: 1-18.
4. Smith DC. The Hippocratic Oath and modern medicine. J Hist Med Allied Sci 1996; 51: 484-500.
5. Litton RJ. The Nazi doctors: medical killing and the psychology of genocide. New York: Basic Books, 1986: 1-322.
6. Iyalomhe GBS, Imomoh PA. Ethics of clinical trials. Nig J Med 2007; 16(4): 301-306.
7. Declaration of Geneva. Adopted by the 22nd World Medical Assembly (WMA) held in Geneva, Switzerland, September, 1948. Amended by the 22nd WMA in Sydney, Australia in August 1968 and the 35th WMA Stockholm in Sweden in September 1994.
8. The Nuremberg Code. In: Trials of war criminals before the Nuremberg Military Tribunals under Control Council Law No 10. Nuremberg, Oct Apr 1946-1949.
9. Declaration of Helsinki, Adopted by the 18th WMA held at Helsinki, Finland in 1964.
10. International Code of Medical Ethics adopted by 3rd World Medical Assembly London England, October 1949.
11. Roe vs. Wade 410 US 116 (1973).
12. Left B, Black J. The Declaration of Helsinki and research in vulnerable populations. Med J All St 2000; 172: 292-295.
13. Faunce TA. Will international human rights subsume medical ethics? Intersections in UNESCO Universal Bioethics Declaration. J Med Ethics 2005; 31: 173-178.
14. Beauchamp TL, Childress JF. Principles of biomedical ethics. (4th ed). Oxford: Oxford University Press, 1994: 15,37,101,462.
15. Gillon R. Medical ethics: four principles plus attention to scope. BMJ 1994; 309: 184-189.
16. McKeon R. (ed). Aristotle Nichomachean ethics book 5. The basic works of Aristotle. New York: Random House, 1941: 41-48.
17. Crisp R, Slote M. (eds). Virtue ethics. Oxford University Press, 1997: 19-25.
18. Lo B, Schroeder S. Frequency of ethical dilemmas in a medical inpatient service. Arch Intern Med 1981; 141: 1062-1064.
19. Connelly J, DalleMura S. Ethical problems in the medical office. J Am Med Assoc 1988; 260: 812-815.
20. Hare RM. Moral thinking. Oxford: Clarendon Press, 1981: 1-60.
21. American College of Physicians. Ethics manual. 4th edition. Ann Intern Med 1998; 128: 576-594.
22. Verga AC. The main issues in bioethics. New York: Paulist Press, 1979: 60-63.
23. Thompson JJ. A defence of abortion. In: Bur JR. (ed). Philosophy and contemporary issues. New York: Macmillian, 1976: 96-211.

24. Monge MA. Ethical practices in health and disease. Manila: Singa-tala Publishers, 1994: 54-62.
25. Aigbodioh JA. Practical issues in applied ethics: the facts, arguments and options. Benin City: Teredia Technical Enterprises, 1999: 66-119.
26. Engelhardt HT. Medicine and the concept of person. In: Beauchamp TL, Waters L. (eds). Contemporary issues in bioethics, 2nd ed. Belmont, California: Wadsworth Publishers, 1982: 20-21.
27. The Holy Bible passages alluding to the personality of the foetus: Psalm 139:13; Isaiah 44:2; Jeremiah 1:5.
28. The Holy Bible Genesis 1: 26-27.
29. Koop CE. The right to live: the right to die. Illinois: Tyndale House, 1976: 69.
30. Uduigwomen AF. Contemporary issues and problems in biomedical ethics. Calabar: Vision Connections, 2003: 133-141.
31. Callahan D. Abortion, law, choice and morality. New York: Macmillian, 1970: 50-61.
32. Declaration of Oslo: Statement on Therapeutic Abortion adopted by the 24th World Medical Assembly, Oslo, Norway August, 1970.
33. Onimhawo JA. Euthanasia and African culture. Ibadan: Stirling-Horden, 1998; 1-60.
34. Onimhawo JA. Ethical, medical and legal perspective on euthanasia. Ibadan, Stirling-Horden Publishers, 1999: 1-139.
35. Unomah EC, Onuminya JE. Euthanasia: a medico-legal dilemma in Nigeria. J Applied Basic Sci 2003; 1: 8-12.
36. Vander Maas PJ, Ban Delden JJM, Pijnenborg L, Looman CWN. Euthanasia and other medical decisions concerning the end of life. Lancet 1991; 338: 669-674.
37. Keown IJ. The law and practice of euthanasia in the Netherlands. Law Quarterly Rev 1992; 108:51-78.
38. WHO Expert Committee Report. Cancer pain relief and palliative care. WHO Technical Report Series. Geneva, WHO, 1990, No 804.
39. Okolo PI. Medical ethics in Nigeria. In: Umerah BC. (ed). Medical practice and the law in Nigeria. Ikeja: Longman Nigeria, 1989: 8-9.
40. Medical and Dental Council of Nigeria. Rules of professional conduct for medical and dental practitioners in Nigeria. Revised ed. 1995.
41. Schwart LA, Solomon P. A handbook of psychiatry. Los Altos California: Lange Medical Publications, 1974: 511.
42. Gartrell N, Milliken N, Goodson N, Themann B, Lo B. Physician-patient sexual contact: prevalence and problems. West J Med 1992; 157(2) 139-143.
43. Odunjo EO. The Nigerian doctor, medical ethics and the protection of the citizen. In: Akpata ES. (ed). Medical ethics. Lagos: Lagos University Press, 1982: 56-74.
44. 2002 Year Book of Jehovah's Witnesses. Pennsylvania: Watch-tower Bible Tract Society. 2002: 31.
45. Watch-tower. Immovable for the right to worship. 1945; 66:195-196.
46. Macklin R. The inner workings of an ethics committee. Latest battle over Jehovah's Witnesses Hastings Cert Rep 1988; 18(1): 15-20.
47. Jehovah's Witnesses and the question of blood. New York, Watch-tower Bible and Tract Society Inc. 1977.
48. Vercillor A. Dupreys J. Jehovah's Witnesses and the transfusion of blood and blood products NY State J Med 1988; 88: 100-102.
49. Genesis 9: 3-4; Leviticus 17: 13-14; Acts 15: 19-20 of The Holy Bible.
50. Watch-tower. Do Jehovah's Witnesses accept injection of a blood fraction such as immune globulin or albumin? 1990; June: 30-31.
51. Schloendorff vs Society of New York Hospital, 105 N.E. 92(1914).
52. Adisa AI, Adeoti MI. Jehovah's Witnesses' stand in severe anemia: the challenges of management. Nig J Gen Practice 2003; 7(3): 24-26.
53. La Puma J, Prist E. Is there a doctor in the house? An analysis of the practice of physicians treating their own families. J Am Med Assoc 1992; 267(13): 1810-1812.
54. Guldal D, Semin S. The influences of drug companies' advertising programmes on physicians. Int J Health Serv 2000; 30(3): 585-595.
55. Swadlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California workers' compensation system as a result of self referral by physicians. Ann Intern Med 1992; 128(7): 576-594.
56. Brody H. Ethical decisions in medicine. Boston, Little and Brown, 1976: 4-20.
57. Matthew 7:12 of The Holy Bible.
58. Ogunde O. Doctors and strikes. In: Akpata ES (ed). Medical ethics. Lagos: Lagos University Press, 1982: 146-147.
59. Purtilo R. Ethics consultation in the hospital. N Engl J Med 1984; 311: 983-986.
60. La Puma J. The clinical ethicist at the bedside. Theor Med 1991; 17: 141-149.
61. Singer P, Pelegrino E, Siegler M. Ethics committees and consultants. J Clin Ethics 1990; 1:263-267.
62. Ausilio M, Arnold R, Youngner S. Healthcare ethics consultation: nature, goals and competencies. A position paper from the Society for Health and Human Values Society for Bioethics Consultation Task Force on Standards for Bioethics Consultation. Ann Intern Med 2000; 133: 59-69.
63. Fletcher J, Siegler M. What are the goals of ethics consultation? A consensus statement. J Clin Ethics 1996; 7: 122-126.
64. Cassereth D, Daskel F, Lentos J. The authority of the clinical ethicist. Hastings Cent Rep 1988; 28: 6-11.