Ethics

Editors:

Adam P. Klausner, MD

Authors:

Jennifer Markusic Wimberly, MD

Last Updated:

Sunday, March 5, 2023

1. Introduction to Medical Ethics

Ethical behavior is central to core competencies for residency education as defined by the Accreditation Council for Graduate Medical Education (ACGME).[1] There are six core competencies. Many of these competencies are directly or indirectly related to ethical behavior. This issue is not only important for resident education but remains critical in the transition to clinical practice. Lapses in ethical behavior are a major cause of malpractice, sanctions against physicians, and even criminal convictions. In 2003, TAP Pharmaceuticals settled a case with the Federal Government for $875 million[2] in which financial incentives were provided by the company to urologists for Lupron® prescriptions resulting in criminal convictions and jail terms for several urologists. A general guide for ethical behavior for urologic residents is available as an AUA update entitled "Ethics Training for Residents: Teaching and Learning Medical Professionalism."[3] The six core competencies are detailed below:

1.1 Patient Care and Procedural Skills

Residents must be able to provide patient care that is ***compassionate***, **appropriate, and effective** for the treatment of health problems and the promotion of health.

1.2 Medical Knowledge

Residents must demonstrate knowledge of established and evolving **biomedical, clinical, epidemiological** and **social-behavioral sciences**, as well as the application of this knowledge to patient care.

1.3 Practice-Based Learning and Improvement

Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on **constant self-evaluation** and **life-long learning.**

1.4 Interpersonal and Communication Skills

Residents must demonstrate interpersonal and communication skills that result in the **effective**

exchange of information and collaboration with patients, their families, and health professionals.

1.5 Professionalism

Residents must demonstrate a commitment to carrying out professional responsibilities and an **adherence to ethical principles.**

1.6 Systems-Based Practice

Residents must demonstrate an **awareness of and responsiveness to the larger context and system of health care**, as well as the ability to call effectively on other resources in the system to provide optimal health care.

2. A Brief History of Medical Ethics

2.1 The Hippocratic Oath

See Reference 4

The oath, which dates from the late 4th Century B.C. begins with the statement, "*I swear by Apollo...*" which establishes a "sacred" context, like swearing on a Bible. These "ancient" tenets remain remarkably applicable in modern medical and surgical practice, even after 2500 years. The tenets include: **doing good, avoiding harm, respect for persons, respect for life, respect for privacy, and standards for practice and behavior**. The majority of graduating medical students swear some form of Oath and a review of some of the underlying ethical principles is therefore warranted:

Doing Good and Avoiding Harm

"I will prescribe regimens for the **good of my patients** according to my ability and my judgment and **never do harm to anyone**." These important tenets are central to ethical practice. However, it is important to recognize that the commonly quoted phrase *"First, do no harm"* does not actually appear in the Hippocratic Oath but comes from another text in the Hippocratic Corpus.[4]

Affirming a Commitment to Ethical Practice

"I will preserve the purity of my life and my arts." Here the oath-swearer commits to both living and practicing in a manner that is "pure" or ethical.

Setting Behavioral Standards

"In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or men, be they free or slaves." Here, the oath-swearer acknowledges the temptations that lead physicians to deviate from the course of ethical practice. The relevance of this ancient text in the modern world is astounding. We are all aware of urologists and other physicians who, at the peak of their careers, have fallen from grace because of sexual scandals, financial corruptions, or other inappropriate behaviors.

Establishing Clinical Competency

"I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art."

Maintaining Privacy

"All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal." The oath clearly outlines a commitment to respect patient privacy. This long-held ethical principle has become more of legal obligation since the passage of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Respect for Life

"I will give no deadly medicine to any one if asked, nor suggest any such counsel."

Respect for Life

"I will not give a woman a pessary to cause an abortion."

Rewards and Consequences

"If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all humanity and in all times; but if I swerve from it or violate it, may the reverse be my life."

3. The Tuskegee Experiments

See Reference 5

From 1932-1972, a US Public Health Service study was conducted at The Tuskegee Institute in Tuskegee, Alabama. The purpose was to study the natural progression of untreated Syphilis. The participants were African-American male share croppers from rural Alabama, 399 with known Syphilis and 201 controls without the disease. There were several ethics concerns regarding this study and the treatment of the subjects. (i) Subjects were ***unaware*** that they had Syphilis and were never told of the diagnosis (ii) Incentives were potentially ***coercive*** for poor and uneducated patients and included free medical care, free meals, & free burial insurance, and (iii) Treatment was ***withheld***.

4. Milgram Experiments

See Reference 5, 6

In 1963, Stanley Milgram, a psychologist from Yale University published an "obedience" experiment to help explain Nazi atrocities. The participants in this Word-Pair Memory and learning study, included a: "Learner," "Teacher," and "Experimenter" who acted as an authoritarian observer and prompter. Fake electric shocks were administered by the "teacher" to a fake "learner" (hidden behind a wall) if he/she got the answers wrong. In the case of continued wrong answers, higher and higher levels of shock were administered to clearly lethal levels (450 volts). The recorded "responses" were played after each shock level, including screaming, begging for mercy, banging on the wall, and then silence, indicating possible unconsciousness. During the study, the authoritarian experimenter gave

verbal prods, urging the teacher to continue administering shocks. The prods were as follows: (1) "Please continue" (2) "The experiment requires that you continue" (3) "It is absolutely essential that you continue", and (4) "You have no other choice, you must go on." In the end, 65% (26 of 40) of the subjects continued to administer the maximal level shocks. The experiments received national attention, less about the nature of Nazi atrocities and more about the psychological trauma inflicted on the subjects, some of whom experience long-lasting emotional problems. The study prompted a national debate about the ethics of medical research and more broadly about the boundaries of the doctor/patient relationship.

5. The Origin of Informed Consent

A full discussion of informed consent can be found in the AUA's online "Clinical Ethics for Urologists"[4] and in a 2012 issue of the AUA Update Series entitled, "Informed Consent."[7]

5.1 The Case of Parmelia Davis

The use of Informed consent became required after several landmark court cases in the early 20th century. In 1905, **Parmelia Davis,**[8] a 40-Year-Old epileptic woman, had a hysterectomy and oopherectomy by a prominent physician without her permission as treatment for progressively worsening epilepsy. The physician admitted that he intentionally deceived the patient so that she would not be able to refuse the procedure. In this case, the Illinois Supreme Court brought into question the concept of "Caring Custody" whereby a physician should have the ultimate authority over the patient with regards to medical decision making.

5.2 The Case of Schloendorff vs. The Society of NY Hospital

In the case of Schloendorff vs. The Society of NY Hospital, argued in New York State Supreme Court in 1914, a patient gave permission only for an exam under anesthesia but underwent resection of a pelvic tumor, detected during the examination, without her permission. The surgery was complicated by sepsis and gangrene resulting in loss of some fingers and damage to one leg. Justice Benjamin Cardozo, later a US Supreme Court Justice, wrote in his opinion, "In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every adult of sound mind has the right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent **commits an assault** for which he is liable for damages..."[8]

5.3 The Canterbury Case

Canterbury v. Spence is a landmark case outlining the patient's right to self-determination regarding informed consent. The patient had not had the 1% risk of paralysis disclosed by the physician for a laminectomy for severe back pain. He suffered paralysis after a fall from the hospital bed in his post-operative course. The court's ruling established a limitation to a professional discretion in disclosure, ruling the information disclosed should be "in terms of what a prudent person in the patient's position would [decide] if suitably informed.[9]

5.4 Definition of Informed Consent

Informed consent can be defined as "a legal doctrine based on the principle of autonomy in which information about a proposed procedure or treatment, including the risks/benefits/alternatives, must be provided so the patient or surrogate can decide if he/she is willing to participate."[10] To be valid, the consent must: 1) be voluntary so that the consenter is not being subject to coercion, (2) be informed so that the consenter is given adequate disclosure, (3) be provided to consenter (patient or surrogate) that has decision-making capacity. [10]

5.5 Capacity and Competence

Capacity can be defined as condition in which the patient or surrogate must be able to understand the information being presented (**cognition**) and the ability to apply his/her values to the decision at hand (**insight**). The threshold for capacity varies based on the decision being made.[8] For example, the decision-making capacity needed to name a health care proxy is very low while the decision-making capacity to be a living organ donor is very high. Competence, on the other hand, is a legal term that is often mistakenly used interchangeably with capacity. Decision-making capacity is determined by a ***physician*** while competence is determined by a ***judge***.

6. Bioethical Principles

Popularized by Beachamp and Childress' textbook "Principles of Biomedical Ethics,"[10] **four ethical principles form the foundation** of many modern approaches to bioethics (**Table 1**). The four principles are all of equal importance and often conflict with one another. For example, allowing a patient to refuse potentially life-saving surgery puts respect for autonomy and non-maleficence in tension. Many bioethical dilemmas are centered on resolving these sorts of conflicts between principles: Additional ethical terms are described in **Table 2**.

Table 1. Core Principles of Biomedical Ethics

Principle	Definition
Beneficence	The obligation to seek the patient's benefit or good
Non-Maleficence	The obligation to avoid or minimize harms to the patient
Respect for Autonomy	The obligation to respect the capacity and outcomes of self-determination by individuals.
Justice	The obligation to seek and achieve fairness in the distribution of benefits and risks

Adapted from Beauchamp and Childress[10]

Table 2. Glossary of Relevant Terms in Medical Ethics

Term	Definition
Confidentiality	The principle that one should keep one's promises about not disclosing information.
Duty	Action due by either moral or legal obligation.
Informed Consent	A legal doctrine based on the principle of autonomy in which information about a proposed procedure or treatment, including the risks/benefits/alternatives, must be provided so the patient or surrogate can decide if he/she is willing to participate.
Paternalism	An ethical principle in which the concept of impairment (that others are not capable of making a sound choice) is used by the decision-maker.
Pluralism	The ethical stance that no single ethical theory or single method can resolve all moral disagreements between reasonable persons.
Right to privacy	The principle that an individual has the right to limit access to one's body and/or mind and to be able to assert control over many aspects of one's person.

Adapted from Beauchamp and Childress[10]

7. AUA Code of Ethics

The **AUA established a 12** paragraph Code of Ethics outlining our ethical obligations to patients, urologists, and society.[11] The code of ethics can be analyzed according to the virtues of the good physician:[12] **(i) Fidelity to trust (ii) Benevolence (iii) Intellectualy Honesty (iv) Courage (v) Compassion (vi) Truthfulness.**

8. The Profession of Urology

Underlying the AUA Code of Ethics is the concept of Urology as a unique profession. For an entity to be considered a "profession" several important criteria must be met (**Table 3**).[13] These include: **(i) Possessing a special body of knowledge (ii) Practicing within an ethical framework (iii) Fulfilling a societal need (iv) Social mandate to set education/performance standards (self-regulation).**

Table 3. Ethical Requirements

Definition of a Profession[13]	Virtues of the Good Physician[12]
Special Body of Knowledge	Fidelity to trust
Practice within an Ethical Framework	Benevolence
Societal Need	Intellectual honesty
Social Mandate to Create Standards for Education and Performance (Self-Regulation)	Courage
	Compassion
	Truthfulness

Adapted from Freidson[13] and Pellegrino.[12]

9. Case Histories

Selected case histories are presented from a published article entitled "A study of Ethically Challenging Issues in Urologic Practice."[14] In the study, a cased-based survey of ethically challenging clinical scenarios was sent to urologists in private practice, urologists in academic practice, medical students, hospital ethicists, and risk managers. The results were used to determine ethical attitudes and norms. The data demonstrated broad-based differences in ethical attitudes based on age, geographic location, and practice type. When used as a teaching tool it is important to review the answers in terms of what is ethically most appropriate. The following examples outline the ethical issues for each sample case.

Case 1: Cancer diagnosis in an elderly man:

Question: A mentally incompetent 83 year-old male presents for results after a recent prostate biopsy. The pathology reveals prostate cancer. His daughter states that the family does not want him to know it is cancer because he "wouldn't be able to handle that information".

The urologist should:

A. Explain the obligation to fully disclose and inform the patient regarding his diagnosis.
B. Ask the patient how much he would like to know about his biopsy.
C. Comply with the daughter's request, but ensure adequate follow-up.

Ethical Issues:

The "C" Word:

Disclosing a **C**ancer diagnosis to a patient and family makes for an emotionally and ethically-charged situation. In a landmark Study: "What to tell cancer patients: A study of Medical Attitudes," Donald Oken, JAMA, 1961.[15] Surveyed 219 physicians about ***revealing*** a cancer diagnosis to their patients and 90% indicated that they ***WOULD NOT TELL.*** Factors listed in the decision were clinical experience (75%) but analysis showed no relationship to actual physician age or experience and fear of adverse psychiatric patient reactions (i.e. suicide).

Therapeutic Privilege:

Therapeutic privilege is the concept that 'the Doctor should have the right to provide the treatment that he or she thinks is best.' However, the concept has been largely discredited by empirical studies. The same survey about disclosure of a cancer diagnosis was given to university hospital medical staff at the same institution in 1977 with 97% of 264 Indicated preference for "telling."[16]

- Demonstrates a complete reversal in attitudes corresponding to the social awakenings of the 1960s and 1970s
- Evidence now clearly suggests that patients want the truth about their medical options[17]

Too much already!:

Can too much knowledge be damaging? Applying the principles of *autonomy and respect for persons* an ethical approach to patient care would be for the urologist to first ask how much the patient wants to know. In a study entitled, "Truth Telling and Patient Diagnosis:"[18]

- 97% of patients want to be told dx of a life-threatening condition.
- Only 62% of ***patients*** want ***ALL*** details regarding illnesses/treatments.
- Only 42% of ***physicians*** feel patients want ***ALL*** details.

Case 2: A 16-year-old girl with a sexually transmitted disease:

Question: A 16 year old female presents to the urologist accompanied by her father, with a urinary tract infection. The work-up reveals a sexually transmitted disease. She asks you not to reveal the true diagnosis to her father.

The urologist should:

1. Not inform the father
2. Inform the father

Survey Results (**Figure 2** and **Figure 3**)

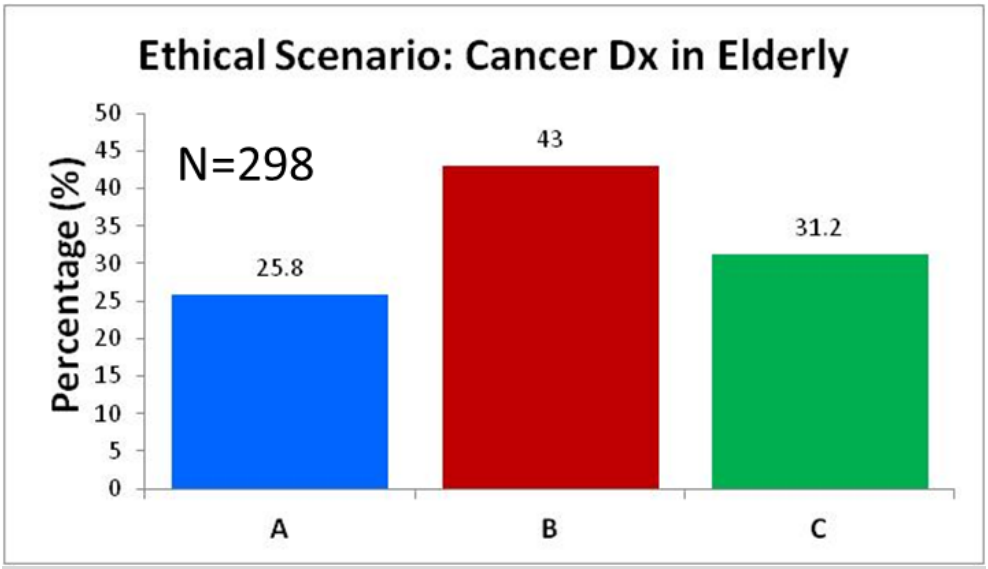

Figure 1: Cancer Dx in Elderly

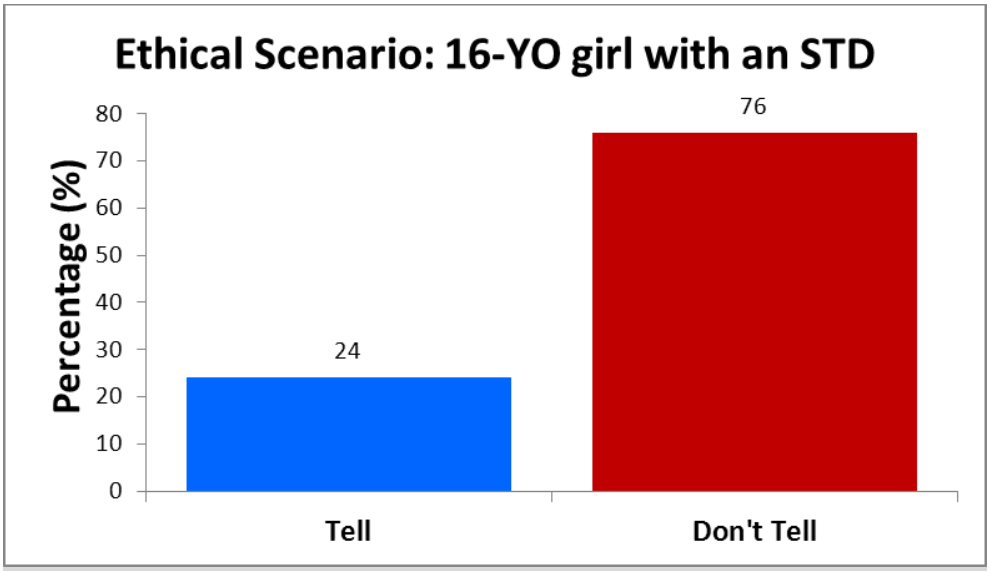

Figure 2: 16 year old girl with an STD

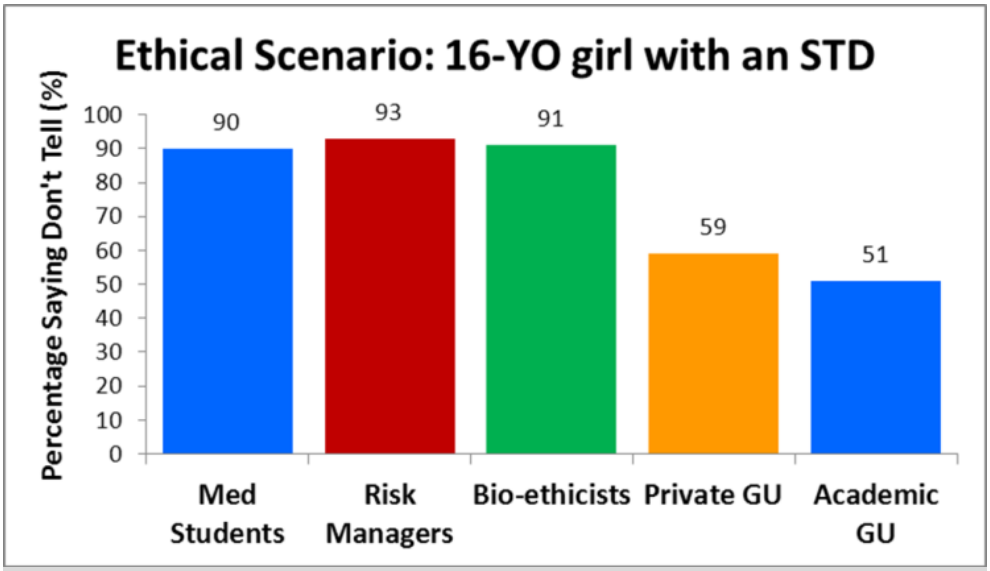

Figure 3: 16 year old girl with an STD

Figures 1 - 3 where adapted from Klausner et al.15

Ethical Issues:

1. Ethical Competency: Disclosing the sexually transmitted disease status of an adolescent, even to a parent, is ***illegal*** in every state.[19] The findings suggest that there is limited awareness of the law (ethical competency) and potentially suggests that urologists may believe that the law is "interpretable" depending on their own experiences/practice.

10. Glossary of Ethics Terms

Right to Privacy

Related to autonomy, self-determination and personal integrity

Definition
: The obligation for one to limit access to one's body and/or mind and to assert control over many aspects of one's person.

Secondary Principles
: The right to non-interference

Confidentiality

Definition
: A subset of fidelity. The principle that one should keep one's promises about not disclosing information.

Duty

Definition
: Action due by either moral or legal obligation. Rights derived principally from autonomy, beneficence, non-maleficence and justice, create these accompanying duties.

Paternalism

Definition
: The ethical principle of restricting self-harm is extent, but paternalism towards others involves the concept of impairment, that others are not capable of making a sound choice. This has now been replaced largely by ethical concept of autonomy.

Informed Consent

Definition
: A legal doctrine based on the principal of autonomy. Information about a proposed procedure or treatment, including the risks/benefits/alternatives, must be provided so the patient or surrogate can decide if he/she is willing to participate.

Criteria for validity
: To be valid, consent must have three elements (i) Voluntary: Free of coercion (ii) Informed: Adequate disclosure and (iii) Capacity: Patient/surrogate must have decision-making capacity.

Capacity

Definition
: The patient/surrogate must be able to understand the information being presented (cognition) and the ability to apply his/her values to the decision at hand (insight).

Threshold for capacity
: Varies based on the decision being made. For example, the decision-making capacity needed to name a health care proxy is very low while the decision-making capacity to be a living organ donor is very high.

Competence

Definition
: A legal term that is often mistakenly used interchangeably with capacity. Decision-making capacity is determined by a physician while competence is determined by a judge.

Profession and Professionalism

Definition
: (i) Special body of knowledge (ii) Practice within ethical framework (iii) Fulfill societal need (iv) Social mandate to create standards for education and performance of its members and (v) Self-regulation.

Special Claim To "Profession" Requires

Dedication to something other than self-interest. (i) Altruism: "Professed" or publicly committed to the welfare of those who seek their help and (ii) Trust.

Virtues of the Good Physician

(i) Fidelity to trust (ii) Benevolence (iii) Intellectual honesty (iv) Courage (v) Compassionand and (vi) Truthfulness.

References

1 Accreditation Council for Graduate Medical Education: Program Requirements.

2 Studdert DM, Mello MM, Brennan TA. Financial conflicts of interest in physicians' relationships with the pharmaceutical industry--self-regulation in the shadow of federal prosecution. N Engl J Med. Oct 28 2004;351(18):1891-1900.

3 ☆ Bahnson RR. Ethics training for residents: teaching and learning medical professionalism. AUA Update Series. 2007;26(25).

4 ☆ Davis FD. American Urological Association: Clinical Ethics For Urologists: Module 6 - Informed Consent. in Klausner AP, Lightner D, eds.

5 Milgram S. Behavioral Study of Obedience. J Abnorm Psychol. Oct 1963;67:371-378.

† Milgram S. Behavioral Study of Obedience. J Abnorm Psychol. Oct 1963;67:371-378.

6 This sentinel work by Stanley Milgram describes a famous psychological experiment that was devised in order to study how normal people can be pushed to commit attrocities in the face of authoritarianism. The study involved a word-pair memory study with the adminstration of fake electric shocks.

7 ☆ DeCaro JJ, Angell J, Issa MM, Ritenour CWM. Informed Consent. AUA Update Series. 2012;31(26).

8 Demme RA, Singer EA, Greenlaw J, Quill TE. Ethical issues in palliative care. Anesthesiol Clin. Mar 2006;24(1):129-144.

9 Faden, Ruth R., et al. A History and Theory of Informed Consent. Oxford University Press, 1986. (citing Canterbury v. Spence 464 F.2d. 772 D.C. Cir. 1972).

† Beauchamp TL, Childress JF. Principles of Biomedical Ethics. New York: Oxford University Press; 2001.

10 This text book is a core reference for any student of biomedical ethics. It covers all aspects fo the field of biomedical ethics and was authored by some fo the most well-known authorities in this area.

☆ † Association AU. Code of Ethics: Available at: https://http://www.auanet.org/common/pdf/myaua/Code-of-Ethics.pdf

11 The AUA's code of ethics is document with 12 parts that establishes and ethical code for practicing urologists. Although not a formal part of residency graduation or certification from the American Board of Urology, this document describes the key aspects for ethical practice as specifically related to the profession of urology.

12 Pellegrino ED. Professionalism, profession and the virtues of the good physician. Mt Sinai J Med. Nov 2002;69(6):378-384.

13 Freidson E. Profession of Medicine: A Study of the Sociology of Applied Knowledge. Chicago (IL): University of Chicago Press; 1988.

☆ † Klausner AP, King AB, Velasquez M, et al. A survey of ethically challenging issues in urological practice. J Urol. Apr 2011;185(4):1407-1411.

14 This article represents the only published work in the urology specifically designed to study ethical attitudes among urologists and other individuals. The article uses a survey of 10 ethically challenging urologic cases to show that there are significant differences in clinical approaches depending on age, practice type, and geographic location.

† Oken D. What to tell cancer patients. A study of medical attitudes. JAMA. Apr 1 1961;175:1120-1128.

15 This sentinel article from the early 1960s highlights the paternalistic nature of medical practice at that time period. The results demonstrated that the majority of physicians would not reveal a cancer diagnosis to a patient. Similar studies published in susquent decades how shown a dramatic shift to away from paternalism and towards a generalized respect for autonomy consistent with the political, cultural, and social changes of the 1960s and 70's.

16 Novack DH, Plumer R, Smith RL, Ochitill H, Morrow GR, Bennett JM. Changes in physicians' attitudes toward telling the cancer patient. JAMA. Mar 2 1979;241(9):897-900.

17 Howard BE. "Tell me the truth". Am J Hosp Palliat Care. May-Jun 2002;19(3):211-212.

18 Sullivan RJ, Menapace LW, White RM. Truth-telling and patient diagnoses. J Med Ethics. Jun 2001;27(3):192-197.

19 Berlan ED, Bravender T. Confidentiality, consent, and caring for the adolescent patient. Curr Opin Pediatr. Aug 2009;21(4):450-456.