Module on
Teaching Health Ethics in Undergraduate Medical Education in Bangladesh

Developed by

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&

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Foreword

The Bangladesh Medical & Dental Council, since it was established and as mandated by BM&DC Act. XVI of 1980, has been taking measures to ensure ethical medical practice of its registered medical & dental practitioners. In the medical and health professions, ethics has transcended centuries of evolution from the time of Hippocrates. It is the pride of any health practitioner to honour and uphold the oath. The simple message conveyed by the oath can be summarized as “do no harm”

The BM&DC measure have included among others the approval and publishing the Code of Medical Ethics in 1983. The published related booklet includes general ethical guidelines which the Council expects the egested medical & dental practitioners, who are duly registered to follow and reserves the right of the Disciplinary Committee to judge each individual case on merits. Since then continuous efforts has been done to make the registered members aware of the published Code of Medical Ethics and monitoring its implementation, as well as taking the necessary action in case of its violation.

Globally, with the rapid growth and increase commercialization of medical education and practice, the need for promoting ethical medical practice becomes more felt and it has been recognized that related action should start early in medical education. Therefore, WHO SEARO came forward and developed “Health Ethics Teaching Guidelines”, on the basis of which BM&DC has been assisted by the Centre for Medical Education and supported by WHO Bangladesh, in developing the “Module for Teaching Health Ethics in Undergraduate Medical Education”. The Module was developed in a participatory process, in which a wide range of resource persons and stakeholders were involved in and later has been approved by BM&DC.

While wishing making good use of the module by the teachers of medical colleges in Bangladesh, I would like to express my appreciation to the effort of the resource persons from the Centre for Medical Education and other institutes, who contributed to the development of the Module and my sincere thanks to WHO Bangladesh for the technical and financial support.

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List of Contents Page No.

- **Introduction of the Module** 4
- **Introduction to Medical Ethics** 6
  - Medical Ethics
  - History of Medical Ethics
  - Geneva Declaration
  - Ethical Dilemma

- **Central Areas of Health Ethics given by WHO** 8
  - **Physician Patient Relationship** 8
    - Components of the physician-patient relationship
    - Models of physician patient relationship
    - Factors on which Physician-patient Relationship mainly depends
      - Informed consent
      - Truth telling in serious illness
      - Patient autonomy
      - Conflict and conflict resolution

- **Fairness and Equity** 19
    - Choosing patients for treatment under resource constraints
    - Considering the economic situation of patients and families

- **Specific Health Issues** 23
    - HIV/AIDS
    - Mental illness
    - End -of-life decisions
    - Organ donation/transplantation
    - Medical Termination of Pregnancy (MTP)

- **Different Jargons in the Field of Medical Ethics** 32
    - Medical Etiquette
    - Professional Infamous Conduct
    - Covering
    - Professional Death Sentence
    - Dichotomy or Fee Splitting
    - Professional Secrecy
    - Privileged Communication
    - Malpractices (Professional Negligence)
    - Two types of Malpractices
    - Euthanasia and its types
    - Patients' Rights
    - Rights and Responsibilities of Registered Physician

- **Code of Medical Ethics of BM&DC** 36
- **Reference** 40

Introduction of the Module

Background:

World Health Organisation (WHO), SEARO has developed a module for "Teaching Health Ethics as a Resource Materials" for this regional countries. Considering the country context and need, on the basis of that resource material with the objective to teach health ethics at undergraduate medical education in Bangladesh this module has been developed. The module is primarily intended for the teaching & training of medical students of undergraduate medical education in Bangladesh.

Purpose:

The overall purpose of this module is to stimulate teaching-learning and discussions of health ethics among students and physicians in the undergraduate medical education by providing scenario-based education materials

Objectives:

The objectives of the module are:

- to provide conceptual teaching - learning tools for health ethics;
- to sensitize medical students and teachers/physicians on ethical issues;
- to strengthen capacity to address ethical dilemmas in medical practice.

Target Groups: Undergraduate medical students mainly and teachers/physicians involved in teaching at undergraduate level

Use of the Module in Different Settings of Teaching

This module can be used in various teaching settings, and a few suggestions are outlined below for inspiration. Actual use of the module should always be tailor-made according to departmental/institutional learning needs and available facilities and resources.

- Teaching in formal programmes (as in Forensic Medicine) on ethics in the undergraduate medical curriculum
- Teaching in the undergraduate medical curriculum with no formal teaching of ethics in all clinical disciplines
- Phase two co-ordinator can organize integrated teaching with phase two students at the beginning of the phase
- Teaching in continuing education programmes ,two to trhice a year.

The module will help the facilitator to select the learning scenarios that are suited to raise discussions about specific ethical issues.

Teaching Method:

- Interactive discussion
- Small group teaching
- Presentation of cases
- Integrated teaching

Evaluation:

- Question –answer
- Written examination
- Observation

Instructions for the Users of the Module:

The basic notion of this module is the notion of ethical dilemma. An ethical dilemma arises when different treatment options involve conflict between ethical principles that the physician otherwise wishes to adhere to. Hence, an ethical dilemma is a dilemma between different ethical principles which, under particular circumstances, are in conflict with each other. In this situation, the physician has to choose which value is more important.

An ethical dilemma of this nature cannot be resolved once and for all since every case involves different issues. Therefore, this module is not intended to provide answers for any given situation. Rather, they are guidelines that will help the teacher/ facilitator in pointing to such dilemmas and stimulate open discussion during teaching sessions and outside. Such discussions should help to improve students' and physicians' ability to identify ethical dilemmas and to reflect on the values and principles that underlie their own and others' decision-making in clinical practice.

The module is constituted by a wide range of situations where clinicians in teaching hospitals of Bangladesh face ethical dilemmas. Scenarios have been divided into different parts, allowing for the unfolding of a problem. The scenarios are classified under three central broad topics, which each addresses a number o specific issues. The learning scenarios can be accessed in two different modes: standard mode for reading through the module, and another is presentation mode. The facilitator should have full control over if and when to make use of the discussion points.

The module is not intended as a fixed set of rules. The facilitator may select any number and combination of learning scenarios to achieve and optimal combination for a particular target group and set of learning objectives. Examples of ethical dilemmas from the local setting or from experience can be added to discuss. The teaching guidelines focus on certain interesting aspects that are illustrated in the learning scenarios. However, the module may also inspire other discussions than those suggested in the teaching guidelines.

It is hoped that this module will serve to encourage and facilitate systematic as well as informal discussions on ethical issues among teachers and students alike.

Introduction To Medical Ethics

Objectives:

At the end of this section the students will be able to-

- define medical ethics
- define ethical dilemma
- mention the history of medical ethics
- narrate different points of Geneva Declaration

Medical Ethics

Ethics is the understanding of moral values. Medical ethics means the moral principles, which should guide the members of the medical profession in the course of their practice of medicine and in relationship with their patients and other members of the profession.[1] Medical ethics is a code of conduct for the member of the medical profession in order to render the best possible service to the humanity and to maintain the honour and dignity of the profession.

It is the code containing the main principles for the information & guidance of registered medical practitioners in course of their medical practice, which defines the duties of the doctors in general, their duties towards the sick & their duties towards one another.

Central areas of health ethics :

In the context of fairness and equity the physician should consider the economic situation of patient & family, choosing patients for treatment under resource constraints.

WHO has given special emphasizes to work on some specific health issues like treating HIV/ AIDS patients, patients with mental illness, making end-of-life decision (Euthanasia), organ donation and transplantation and medical termination of pregnancy. Physicians of government and non-governmental organizations, lawmakers and member of the civil society should jointly come up with a policy to deal with these specific health issues mentioned by WHO[2].

History of Medical Ethics:

The history of medical ethics is since the Code of Hammurabi about 2200 BC. Then Greek physician Hippocrates declared a oath known as Hippocratic oath within 460 to 377 B.C. The modern principles of medical ethics was prepared by Thomas Percival in 1803. Lastly Geneva declaration was declared in 1948 and was accepted by the General Assembly of the World Medical Association in London, on October 12, 1949. Till this day we are abide by those points of Geneva Declaration which are as follows--.

1. I solemnly pledge myself to consecrate my life to the service of humanity
2. I will give to my teachers the respect & gratitude which is their due
3. I will practice my profession with conscience & dignity
4. The health of my patient will be my first consideration
5. I will respect the secrets which are confided in me.
6. I will maintain, by all means in my power, the honour & noble traditions of medical profession
7. My colleagues will be my brothers.
8. I will not permit considerations of religion, nationality, race, party politics or socials standing to intervene between my duty & my patient.
9. I will maintain the utmost respect for human life from the time of conception
10. Even under threat I will not use my medical knowledge contrary to the laws of humanity
11. I make these promise solemnly, freely & upon my honour.

Ethical Dilemma

There are times when physicians are at a confusing state and thus suffering from indecision about what to do regarding a case management in ethical ground. That in ethical term is callked Ethical dilemma. WHO has described ethical dilemma as a dilemma between different values, which are seen as important or beneficial, but which in particular cases and circumstances are in conflict with each other. In such cases, the physician has to choose which value is more important, or (s) he may refer to additional values and contexts to be able to make a decision[3].

Central Areas of Health Ethics

At the end of this section the students will be able to-

- explain the different central areas of health ethics given by WHO

Considering the global context in the field of health ethics WHO has identified three central areas of health ethics, which are as follows[4]-

- The physician-patient relationship
- Fairness and equity
- Specific health issues

Physician –Patient Relationship

Physician-patient relationship

At the end of this section the students will be able to-

- mention the factors related to physician –patients relationship
- discuss the components of physician –patients relationship
- describe different models of physician –patients relationship

The relationship between a physician and a patient should base on mutual trust and confidence. It is the doctor, with whose manner, attitude and speech should make the patient feel comfortable and it depends mainly on the doctor.

This physician patient relationship depends on different events. But it can be maintained and nurtured properly by taking informed consent, telling truth in serious illness, honouring patient autonomy and caring conflict management

Components of the Physician-Patient Relationship[5]:

i. **Trust and confidence.** The physician must attempt to practice medicine in the best interest of the patient for acquiring trust and confidence of the patients

ii. **Instillation of hope and minimization of fear and doubt.** The physician must reassure the patient that the best possible treatment will be provided and that pain and suffering will be minimized without misleading the patient when symptom or a terminal diagnosis exists.

iii. **Empathy** wherein the physician places himself in the patient's position, helps the physician understand how the patient feels.

iv. **A personal relationship based on concern** should be afforded every patient. The patient should be seen as a total human being, rather than a vector of altered physiology and should receive treatment for both illness and disease

a. **Disease** is a pathologic alteration in normal anatomy or physiology that produces signs and symptoms, affects quality of life, and is apprehended by the objective diagnostic skill of the physician.

b. **Illness** is experienced by the patient and is perceived as subjectively unique in terms of feeling unwell and creating suffering for both the patient and her family.

c. **Treatment** of disease requires knowledge and technical skill, whereas treatment of illness requires knowledge and empathy. Both activities require communication between the patient and the physician.

v. **Communication -**an important aspect of the physician -patient relationship-is a difficult task that requires training, experience and skill. By allowing a patient to relate his story and his voice concerns, a physician helps to strengthen the important relationship they share.

vi. **Bridging cultural gaps-** Cultures differ in how they view disease causation and treatment. Treatments that may be labeled "folk remedies" by Western Medicine should be understood by the physicians. Failure of the physician to acknowledge the patients cultural beliefs will result in poor communication with the patient and limited compliance by the patient of Western medical treatments.

Different Models of The Physician Patient Relationship[5] : Emanuel described the four basic models of the physician -patient relationship. All four of these models may be used in different situations (Table).

A. **Paternalistic model-** In this model the physician describes what is best based solely on medical information and the physician's judgment. The physician acts as a guardian and determines from his/her own perspective what is the best for the patient. This style is exemplified by the physician who demands that his patient with carcinoma of the breast without nodal extension undergo a modified radical mastectomy despite the patient's wishes to preserve her breast. The problem with this model is that the patient and the physician may have different values. This model is best reserved for emergency care.

B. **Informative model-** In this model, the physician gives the patient all of the relevant information about his disease and possible treatments without attention to the patient's values. The physician is a purveyor of technical expertise. For example, a physician could offer a patient with metastatic colon carcinoma, statistics on the success of chemotherapy without considering the patient's life situation, personality, or views on pain, suffering, and death. Such an approach would very often cause the patient anxiety and distress. This approach lacks the compassion that is necessary in a physician and unrealistically views the patient as totally autonomous. This model may be appropriated when a patient is seen for a minor illness, on a one-time basis, such as in a walk -in clinic. Many patients cannot decide independently what is the best treatment and must work with the physician to develop a mutually acceptable plan.

C. **Interpretative model-** This model combines the informative model with a consideration of the patient's life history, values, and personality. This model is most appropriate for patients with conflicting values so that they can understand the nature of the conflicts and come to an informed decision based on both medical information and personal values. This approach demands that the physician understand the patient's needs and desires. Concurrent with this understanding, the physician provides technical information about the specific disease and treatments available. The physician is an advisor or counsellor. For example, the physician treating a patient with metastatic colon cancer who has a controlling, orderly personality style would outline the risks and benefits of chemotherapy in a factual manner but also emphasize the ability to provide palliative care and minimize suffering in whatever course of treatment chosen by the patient. This style demands that the physician develop skills in fully elucidating the patient's value system in the context of her/his life history. Such data are not always available for the consultant specialist who sees the patient on a limited basis. Nevertheless, it is imperative that every physician, no matter how limited the relationship, ascertain the patient's personality style and understanding of and reaction to the disease.

A. **Deliberative model-** In this model, the physician acts as a teacher or friend who articulates and persuades the patient to pursue the "best course" based on mutual understanding of the patient's values and medical information. The limitation of this model is that it is not the physician's task to judge values. However, a physician may involve his/her in health -related issues in the context of clinical care. Thus, it is appropriate for a physician to strongly advise a homosexual man to practice safe sex as a health precaution against HIV infection, but not to castigate the patient for his sexual orientation. This model may be preferred in public health settings.

Table : Use of Physician -Patient Relationship Models

Model	Clinical Setting
Paternalistic	Emergency situations
Informative	Walk -in clinic
	One-visit situation with minor illness
Interpretative	Ongoing clinical care
Deliberative	Public health setting

(Thomas N. Wise)

Ethical Dilemma in Physician-patient relationship

Ethical dilemmas in the physician-patient relationship often involve the management of important information concerning the patient's diagnosis, prognosis and treatment options. There are underlying issues of patients' rights and physicians' obligations. Sometimes, the patient must rely upon the assistance of a third party, as in the case of a minor child and the parents, or a mentally ill person and the guardian. Sometimes, patients are not given information about their health status for other reasons, even if they are otherwise legally capable of autonomous decision-making.

Patient autonomy, i.e., the patient's right to make certain kinds of decisions based on the information provided. Another set is about truth-telling in serious illness. Here, the role of the family is often important in determining the level of information given to the patient. In the third set of scenario this theme is further pursued under the heading of informed consent, i.e., information to the patient and prior approval from the patient of the treatment carried out. The issue here is on what basis decisions on sharing of information with the patient (or the patient's legal representative) are made. The final set of scenario deal with conflicts and conflict-resolution. Conflicts may involve physician, patient and relatives, but may also develop among physicians.

The physician-patient relationship mainly depends on --

a.1 Patient autonomy

a.2 Truth-telling in serious illness

a.3 Informed consent

a.4 Conflict and conflict-solving

(WHO)

a.1 Patient autonomy

At the end of this section the students will be able to-

- formulate the principles of autonomy and paternalism and can apply these principles to the discussion of actual clinical situations.
- formulate justifiable exceptions to the principle of autonomy.

It has often been said that there has been a dramatic change of values from paternalism to autonomy in the physician-patient relationship. Traditionally, it was globally accepted that the physician knew best and should decide what should be done to patients, without informing them and without involving them in the decisions. Today, it is no longer valid that physicians make decisions without involving their patients and/or the patients' relatives. The principle of patient autonomy prescribes that he/she should be the one to ultimately decide what should be done in the clinical encounter. There are, however, limits to patient autonomy and some of these are probably dependent on the specific cultural conditions in a country. The question to be discussed in this sessions is how one should understand the principle of patient autonomy in the clinical setting, and in what circumstances can one legitimately override the patient's preferences.

a.1.1 Life-saving treatment

Sometimes a patient refuses a life-saving intervention in a critical situation. Under certain circumstances, the physician may decide to set aside the patient's decision.

a.1.2 Non-life-saving treatment

Contrast the above situation

a.1.3 Patient autonomy versus family autonomy

It has sometimes been argued, especially in Asian countries, that the family is the decision-making unit, and therefore the concept of patient autonomy should be replaced by a concept of family autonomy. While the family is certainly often very important in negotiations about health care, and while the patient is often depending on his/her social network for treatment and care, there are also some important difficulties if the concept of family autonomy is given more importance than the concern for the best interests of the patient,

LEARNING SCENARIOS:

The man who did not want his leg amputated

Physician: This was a 64-year-old man who had had a stroke which had affected his mental condition, though his awareness was good. He also suffered from diabetes mellitus and hypertension. One day gangrene was found on his leg with sepsis, high fever, and it was a progressive gangrene. I advised him and his family to have an amputation. The family agreed,

but the patient did not. The family followed my reasoning, that is, I did not want the patient to die merely because of gangrene and diabetes. Then I suggested to the family that if the patient falls into a coma, I would have the right to undertake a professional intervention to save his life without having to obtain his approval. Once the patient went into coma, I asked the family to sign the informed consent for the amputation. The amputation was finally done.

When the patient became conscious, he was delighted because he felt that he had recovered. He was able to sit and became quite happy and felt that he still had his two legs. When he became completely conscious, and was about to descend from the bed and walk, he realized that he had been amputated. He was shocked. He flew into an extraordinary rage and threatened that he would prosecute me and his family. He was a former lawyer. He was aware of his rights and he had not permitted that his leg be amputated. The dilemma here was: first, we had to fulfil the principle of autonomy, and, second, we had to save a life. There were two aspects that quite contradicted each other. An extraordinary process of negotiation after the operation followed, and as the patient showed spiteful hatred against me, I had to delegate the care to others for the time being. When the negotiation was over, we finally came to terms. The patient survived and had the opportunity to witness a marriage in his family.

<u>Questions</u>

Q *Consider this case. Is the doctor justified in awaiting the coma and then intervene with the family's consent?*

Q The doctor states that the patient's mental condition had been affected due to the stroke. If that were not the case, would it make a difference?

Q Is it possible that the doctor sees the patient's mental capabilities as decreased because the patient opposes the amputation? If the patient's mental condition is affected so as to cause him to make irrational decisions, would the physician then need to await the coma before obtaining the family's consent?

Q Why do you think the patient may have wanted to oppose the life-saving amputation?

The elderly woman who did not want surgery

Physician: One patient was a doctor's mother who had a vulval dysplasia. There was a doubt of malignancy. So we did a biopsy that showed a carcinoma. This lady was not at all willing to undergo a second surgery. She said, "No, I just do not want to have the second surgery." She was over 70 years old. She said "I have no symptoms. There was a little growth, which you have already removed, so why should I have a second surgery?" She was medically fit so I wanted to convince her that the surgery would not harm her. But the patient was absolutely not willing. We all had a tough time – her husband, her daughter and I. We continued putting pressure on her but it was a tough decision for her to accept that she needed a second surgery. At the same time we did not want to tell her that she had a cancer. I convinced her that she must get herself operated. If she had not agreed to the surgery, then she would have persisted with the disease and any day this could have become invasive. She would have landed up in more problems and with a more extensive surgery. Now it was only simple vulvectomy; later she would have required a radical *vulvectomy.*

Questions
Q *Consider this case. Is the physician justified in putting pressure on the patient in this case until she finally accepts the surgical intervention? Why/why not?*
Q Can the patient give informed consent to the operation when she is not informed of the diagnosis? Do you find the degree of involvement of the patient in the decision-making process ethically justifiable? Why/why not?
Q Under what circumstances should the physician accept the patient's right to refuse a treatment offered?

The patient with a brain tumor

Physician: There was a man aged 75 years who had a primary malignant tumour of the occipital lobe. The dilemma was whether to operate on him or just give him symptomatic treatment. Because I had explained to the family that even if we operated on him and then gave him chemotherapy and radiotherapy post-operatively, then most likely his life span would not extend beyond one- or one-and-a-half years, even after full treatment. On the other hand, if we left him without surgery and subjected him to supportive therapy, he might then survive for about 6-9 months. Now, really, I was quite confused whether to take a decision in favour of the surgery or to manage his condition conservatively, because he was not a very good surgical candidate. He was obese and hypertensive. I left the final decision to the family.

Questions
Q This physician leaves the decision concerning treatment to the family without giving a clear recommendation and without involving the patient. Discuss the ethical implications. Do you find this process agreeable? Why/why not?

a.2 Truth-telling in serious illness

At the end of this section the students will be able to-

- identify conflicts of interest between the patient, the physician and the family in relation to diagnostic information,
- identify the values that guide the physician's management of the diagnostic information in serious illness in the learning scenario provided in this section.

In line with the change from paternalism to autonomy, there has been a general trend towards more openness in physician-patient communication. A few decades ago, in all countries, physicians usually did not inform patients about serious conditions such as cancer. Today, most would accept that there is a general obligation to be truthful to patients about their conditions, but there are important limitations to how much information it might be appropriate to convey to patients.

a.2.1 Truth-telling and hope

Serious illness can be tragic for the person(s) involved and it can be difficult for physicians to deal with, particularly when it comes as a surprise to the concerned people.

a.2.2 Truth-telling and compliance

a.2.3 Truth-telling and rejection of treatment

a.2.4 Truth-telling in case of wrong diagnosis

LEARNING SCENARIO:

The child with encephalitis

Physician: This case was a boy aged two years whom I admitted. His previous growth was good. He had been able to walk and talk. His teeth grew well. However, all of a sudden he had an infection with symptoms of high body temperature followed by seizures. The seizures lasted rather long and he had to be treated at the hospital, where the child had very high body temperature and went into coma. In fact, there was a disorder in liquor spinalis. Thus, the working diagnosis by laboratory at that time was encephalitis. The patient's parents were highly educated. At a meeting with us, the father asked whether his child would be able to recover or not. As a physician, of course we should make efforts, be optimistic and hope that the child would recover. However, he pursued us with the question of whether his child would be able to walk again as before. That's where the dilemma lay, because the diagnosis was encephalitis. While this child could possibly be saved, statistically, in most cases a sequel would occur. It meant that there would be a mental and motoric disorder. That was my dilemma, whether I should let the father know the truth and inform that the child could be saved but they should be prepared that he may not be able to walk any more. He could have paralysis along with possible mental disorder and retardation.

<u>Questions</u>

Q Think about this case and identify the pros and cons of providing full information concerning the prognosis of the child.

Q Given the direct question of the father, is the physician justified to hold back the information?

Physician: I did not tell him the prognosis that I knew and believed. However, I did not cover it up either. So, I said that the child might survive with the treatment and care we provided. Nevertheless, because it involved the nerves and the brain, there might be some resistant symptoms. We did not say that the child would not be able to walk and see and might have a mental disorder. At that time, I did not have the heart to inform them in detail, although in my conscience, I felt that I should let the parents know about it. Perhaps it was not the right time.

Interviewer: So, in providing the explanation which included the prognosis, you decided to give only limited information.

Physician: That's right. I tried to infuse some optimism. However, in the dilemma that I faced, I also felt some pessimism in the resistant symptoms, even though the child might survive.

Questions

***Q** The physician provides technical information to the parents that they may not fully understand, thereby infusing optimism without violating his obligation to inform. In general, how do you see the physician's obligation to ensure that the patient and/or relatives understand the information given in connection with informed consent?*

Q While the prognosis is surely a difficult message to give to the parents, do you think that it helps the parents in any way that they are not informed? Would it help them in any way if they were informed? Would it help the physician in terms of the treatment plan? Would it help the patient?

a.3 Informed consent

At the end of this section the students will be able to-

- identify and critically assess the reasons for giving or not giving information to a patient concerning his/her health status, medical interventions and likely treatment outcome.
- determine whether it is justifiable to deny a person information because of his/her educational or socioeconomic level, or in order to ensure compliance.

The principles that patients should be given information about their condition and should be involved in decision-making are joined in the principle of informed consent. The basic concept implies that patients are provided information that enables them to take an informed decision. In the context of widespread poverty and lack of education among big population groups, and with scarce resources available for health care, providing information on the medical status and best treatment from a purely medical perspective may not necessarily empower the patient to decide on a given treatment option. Exceptions to the principle of informed consent also occur with regard to persons with impaired or diminished autonomy, such as children or seriously incapacitated mentally ill persons, who are usually represented by a third party, such as parents or other close relatives, vis-à-vis the physician. However, it is sometimes argued that in some countries the family rather than the patient should be seen as the main counterpart to be informed by the physician.

a.3.1 Informed consent denied due to educational level

In this use the physician decides not to give important information concerning diagnosis or prognosis to the patient and/or relatives for a number of reasons. The issue is, whether these reasons justify setting aside the patient's right to informed consent.

a.3.2 Informed consent denied to ensure compliance

a.3.3 Informed consent for a procedure different than the one carried out

LEARNING SCENARIO:

The child with non-Hodgkin's lymphoma

Physician: A 5-year-old boy who came from a district 80 miles north of the city is presently admitted in our ward. He was quite ill when he came to the hospital. We investigated the case

and it turned out to be a case of non-Hodgkin's lymphoma (NHL). When he got the diagnosis, we routinely referred him to the oncologist concerned. The oncologist advised a treatment regime and we gave the treatment to the boy in the ward. We sent the patient to the oncologist for follow-up and the treatment was changed. Here, what bothers me is that... we did what we could for the child. As for the parents, they came to this hospital as it is a big hospital and they had faith in us. They asked us about the condition of the child. We replied that the child was ill, but we would try our best, that is what we told them.

Questions

Q What procedures for obtaining informed consent would you consider in connection with the child's treatment?

Q Would you have any special concerns when discussing the diagnosis, the prognosis and the treatment with the parents?

Physician: But we did not tell anything to the patient's parents about the treatment being given. We have not explained. The reason that we did not inform them about the treatment was that they were peasants from the country and would not understand what we were saying.

Questions

Q How do you view the physician's decision not to inform the parents of the treatment?

Physician: I feel uncomfortable with the treatment given to the patient. What I had read and what I know is that for NHL, depending on the cell types, there are at least four types of treatment available. Frankly, those are trial drugs. The National Cancer Institute of Britain has also another regime. With that regime there are favourable five-year survival rates and mortality rates. Most of the latest regimes have 80-85% five-year survival rates. Nearly all of them have more than 70% five-year survival rates. In spite of that, for the children with this disease in our country, we do not give those regimes. We do not give these standard drugs. We have to give the drugs that are available. By available drugs I mean what the oncologist supplies free. Mostly, injections of Oncovin, Dexamethasone, and Endoxan are available and are given. That's all.

Questions

Q Do you think that the physician's inability to offer the best drugs to the child influences his decision not to discuss treatment options with the family?

Q Which factor do you see as more important as a barrier to full informed consent – the educational status of the parents or the physician not being comfortable with the treatment he can offer?

Interviewer: What did you tell the parents?

Physician: That's what made me unhappy. Do we hold back the information? What I have heard is that in Western countries physicians explain to the patients beforehand, what treatment they are going to give, and what are the possible outcomes and untoward side-effects. Here, we do not do anything like that. The patients and their families have great expectations from us. Is it fair that we do not tell them anything? We do our best, but we also foresee the outcome of the treatment. We know that in most of such cases the patients are not going to be all right. I feel sorry for that.

Questions

Q Do you think that the parents in this case should have the option to say no to a treatment with known serious side-effects if it is expected not to be very helpful for their child?
Q The physician makes a judgment that the family members would not be able to understand the relevant information concerning the treatment even if he had attempted to tell them. How do you see the concept of informed consent for patients with limited or no education?

a.4 Conflict management

At the end of this section the students will be able to-

- identify the interests of these persons
- assess the pros and cons of the management strategy adopted in handling a given conflict as presented in the scenarios.
- identify and explain the underlying ethical principles.
- identify alternatives to the conflict-solving processes

In this issue the student will work through a number of learning scenarios dealing with conflict and conflict-solving. The focus is not primarily on medico-legal issues, though some conflicts eventually become court cases. The issue here is how a physician deals with conflicts between a colleague and a patient in which the physician becomes a party, or conflicts between the physician him/herself and the patient. This type of conflict is an everyday occurrence in medical practice, and the nature of the conflicts differs considerably.

a.4.1 Conflict over referral of patient

a.4.2 'Doctor-shopping'

If patients, on their own initiative, go from one doctor to another with a given ailment, it is sometimes called 'doctor-shopping'. While doctor-shopping may be unpopular among physicians, it also places the physician in an ethical dilemma because it may not be realized from the outset that the patient has been seen by a colleague. In such cases, the physician has to decide whether to continue treatment or send the patient back to the previous physician.

a.4.3 Adverse events in medical treatment

The occurrence of adverse events and medical errors in medical practice is not always in itself an ethical issue, but the way such errors are subsequently managed may involve ethical issues.

a.4.4 Serious allegations against a colleague

Sometimes, a physician comes across an instance of a colleague's obviously unethical conduct,

a.4.5 Allopathic and alternative medicine

In most societies different systems of medicine and treatment exist; this is known as medical pluralism. Patients often shift form one system to another, or use several systems simultaneously.

LEARNING SCENARIO:
The infant who was not referred for proper treatment

Physician: One of the neonatal cases came from a district hospital in the suburb of the city. The obstetrician and the paediatrician there did not have a good relationship. The baby was a forceps delivery, and it had birth injury resulting in haematoma of the head, which is a precipitating factor for neonatal jaundice. We should look for jaundice from day 1. There was a history of exchange transfusion in a previous child. The history of exchange transfusion was not taken. It was blood group "O". Thus, the birth injury, haematoma of the head, blood group "O" and history of exchange transfusion in the sibling, all suggested monitoring neonatal jaundice in the newborn baby. In spite of that, the obstetrician did not consult the paediatrician in the same hospital. She looked after the baby by herself. At last, the baby had intense yellow coloration (of the skin). In spite of that, she did not refer the baby to us. She sent the mother to consult a paediatrician who was practicing privately in that district. When the baby finally arrived here on day 5, he had impending kernicterus. However, in spite of our efforts to save the child with exchange transfusion, the condition deteriorated and the baby died after two hours of exchange transfusion.

Questions

Q *Summarize the important factors in this case and list ethical issues involved.*

Q Given the circumstances, do you find that this physician has an ethical obligation to take action to address the fatal lack of collaboration between the obstetrician and the pediatrician? Why/why not? What would you do in a similar situation?

b. Fairness and equity

At the end of this section the students will be able to-

- identify how ethical principles and values can be applied to the context of scares resources
- decide whether they agree or disagree with the relevance of the implied values for the decisions in question.

Physicians often face resource constraints when treating patients.

Not all patients that could potentially benefit from treatment can be treated because of lack of resources. One then has to decide which patients should get priority, and the issue is on what basis those decisions are made.

b.1 Choosing patients for treatment under resource constraints

- There may be too many patients in number to be treated
- There may be too many categories of patients to be treated
- There may be too many options of treatment
- There may be different levels of outcomes

b.2 Considering the economic situation of patients and families

(WHO)

b.1 Choosing patients for treatment under resource constraints (Allocation of scarce resources)

As a result of scarce resources, the health facility cannot provide treatment to all patients who need treatment, and the physicians/staff will have to decide who they should treat when they cannot treat everybody. The issue is how, or on what basis, the physician should make these types of decisions. One general principle is that one can choose the patient who will benefit the most from treatment.

b.1.1 Giving preference to the patient with the most serious condition

It has often necessary to treat patients whose life is threatened or suffering from major sickness, irrespective of their chance to benefit from the treatment.

b.1.2 Treating patients to whom one has special relationships

Some have argued that the usual principles of justice are impersonal, and that this does not place enough emphasis on the importance of personal relationships in moral decision-making.

b.1.3 Differentiating between life-saving treatment vs. treatment that improves quality of life

It is often necessary to resolve the issues between the treatment of life saving and improving quality of life.

LEARNING SCENARIO:
The paraplegic versus the quadriplegic patient

Physician: Because of the constraints of the number of beds in the ward, we have to make certain decisions which bother us ethically. If we have two patients and we have one bed, we tend to look at that person where we can have a better result. Suppose we have one patient with quadriplegia and another with paraplegia. From the patient's point of view, quadriplegia is a more serious condition because the hands and legs would be paralysed. And paraplegia is comparatively less grave from the point of view of the patient. We look at it from another angle: The number of hours or the amount of labour we spend on the paraplegic, we will be getting better results, whereas it will be more labour and less results in the case of the quadriplegic. So, we have to make a choice: who would be a better person to be admitted for one available bed. Naturally, as per this logic, we decide that those who can get more benefit should be preferred. So we admit a paraplegic rather than a quadriplegic. Though from the patient's point of view, we are making a mistake because the quadriplegic needs more attention. This is one of the problems, which I think would be bothering a number of doctors. We cannot decide ethically what is right and what is wrong.

Questions

Q Formulate the two selection principles that the physician uses here.

Physician: This occurred recently, when we admitted a paraplegic patient. We had one patient of C6-7 quadriplegia and another of L1 paraplegia. We admitted the L1 paraplegic.

Interviewer: How old was this patient and what was his prognosis?

Physician: The quadriplegic patient was a 38-year-old male. He had quadriplegia for the last three months. And the prognosis was uncertain because we do not know what is going to be the outcome. So far he has not shown any recovery, whereas the L1 paraplegic is a 28-year-old male who has minimal power in the hip muscles. The upper extremities and the trunk are fine. Four months back he developed paraplegia. The prognosis is that since he has shown some improvement in the hip muscle, he might improve a little, but at the same time, even if he does not improve, we think he will be able to walk. That makes a tremendous difference. The quadriplegic patient will have to use a wheelchair. The last three months, he has not shown much recovery. So we are not very sure if he is going to recover further or not. Recovery as such is not the only factor which makes you decide whether to admit or not. Besides the prognosis, the quadriplegic, despite an intervention, would remain dependant to a large extent. The paraplegic, with a smaller intervention, becomes independent to a greater extent. That is how we weigh the prognosis.

Questions

Q Do you agree with the physician that one should choose the paraplegic patient, and why/why not?

Interviewer: You said that there is a shortage of beds. But in both these cases, the intervention that you are planning would consist primarily of physiotherapy. So, do you think they have other options, such as coming to the OPD or do you have some intervention which can be done only in the ward?

Physician: For both the patients the intervention can be done in the OPD as well. Both patients had certain other problems like bedsores which I thought would be better managed in the ward. And since they do not live in the city, they have no other place to stay. Both the patients would be eligible to be admitted. I think it would be better if they are admitted in the ward because the amount of money they need to spend on transportation and the number of people they would require to go from home to the hospital would be much more.

Interviewer: Are you happy with the decision you have taken and would you repeat this if you faced a similar situation again?

Physician: Frankly, I am not very happy. But, in view of the circumstances, I think I will do the same. I wish I did not have to. I would like to have more patients admitted but we have to make a decision one way or another. I do not think anywhere in the world there are beds for all patients. We have to make a choice which one would benefit more.

Questions

Q *The doctor does not question that maximum benefit for the patient should guide prioritization of scarce resources. Discuss what role seriousness of illness should play for decision-making, if any, and how to weigh the two against each other.*

b.2 Considering the economic situation of patients and families

The case in this section deal with the issue of what to do when patients cannot pay for beneficial treatments. This issue is relevant in all health care systems, as there will always be some potentially beneficial treatment that is not available within a publicly financed system, or that is not covered by a patient's health insurance. This issue is much more pressing in resource-poor settings, where the range of potentially beneficial treatments that is not accessible for financial reasons is much larger.

b.2.1 The right to pursue an existing treatment at own cost

Once a treatment is started, patients may see it as their right to pursue it at their own cost even if the physician is not satisfied with the progress.

b.2.2 The futility of treatment

The patient would die no matter what is done for him. At the most, life could be extended by a few months, but even then the treatment itself could hasten death. The treatment would be very expensive for the patient and his family.

b.2.3 Potentially life-saving, but expensive treatments

b.2.4 Practical decision-making

LEARNING SCENARIO:

The boy with sclerosis and encephalitis in Interferon treatment

Physician: Today, we had a 7-year-old boy in our unit with a diagnosis of sub-acute sclerosis and encephalitis. This is supposed to be a long-term sequela of measles. There is no known treatment for this disease, but there are some reports that one very expensive drug called Interferon can help. Now, this is a middle class family. They are farmers. Last time they had come, they were explained that the prognosis was quite bad and the child was not going to live for long. But there was one alternative that might help the child, though the child was not going to be completely normal. This is the only child in the family. They wanted to save the child at any cost. They took the first course of Interferon, which is very expensive, one vial costs around 200 USD. They took the first course and went home. They found that the child was showing some improvement. When we re-assessed the child we could not find any significant improvement apart from a slight improvement in the frequency of convulsions. They have now

come back for the second course. They have sold some of their land and are willing to sell some more of their property to pay for the child's treatment. We tried to explain to them that we were not sure how much we would be able to help the child, and yet they are insisting that they would like to give full treatment to the child even if they had to sell more of their property. There is a tremendous psychological pressure on the parents all the time, because they see the child just lying on the bed and they can't do anything. The child's condition keeps deteriorating in front of them because it is a chronic disease. He is not going to survive. Since he is a boy, they are taking more care. Probably, if this patient was a girl, they might have said no to treatment. This will definitely affect the family, especially if there is another sibling who is normal. The care of that baby will be neglected. But they will only realize later when they have lost the child.

Questions

Q Think about this case. The parents have presumably understood the prognosis and made a conscious decision to spend their resources on an expensive treatment. Is the physician justified in her reluctance to continue the treatment in a case like this?

Q Would it make a difference if the family was rich? Why/why not?

Q Is the concern for a possible future sibling relevant in this case?

Q Some physicians choose not to inform their patients of expensive treatment options if they believe they cannot afford them. How do you view this issue?

c. Specific health issues

A number of health issues are associated with certain specific ethical problems, either because of particular characteristics of a disease (such as HIV/AIDS and mental illness), or because of certain specific challenges involved in certain types of treatment. Given below are a number of specific health issues. It is the aim of this section to introduce the student to some of the ethical dilemmas that are commonly encountered in this connection

c.1 HIV/AIDS
c.2 Mental illness
c.3 End-of-life decisions
c.4 Organ donation/transplant
c.5 Medical termination of pregnancy

(WHO)

c.1 HIV/AIDS

At the end of this section the students will be able to-

- describe the balance of the best interests of the person with HIV-infection and the risk of infection in the community and in the country.
- explain the negative role of stigma at both individual and community levels and can relate this to ethical issues of confidentiality, patient rights and non-maleficence.

In this section, students will be working through a case that deal with ethical issues pertaining to testing, counselling and managing people with HIV infection and AIDS. AIDS is now treatable

with antiretroviral (ARV) combination therapy, and intensive efforts have been undertaken to increase coverage world-wide. Still, many HIV-infected persons in the world have no access to ARV treatment, and in many resource-poor communities the disease is seen as 100% fatal. In addition to the physical deterioration of the body, patients suffer under stigma and social exclusion because of undue fear of attracting the infection, fear of death, or moral condemnation of the infection.

In this environment there may be little incentive for a person to undergo an HIV test. A caring environment in the health services towards AIDS victims is necessary to help curbing the HIV epidemic.

c.1.1 Rights of the patient vis-à-vis concerns for public good in connection with HIV testing

With an asymptomatic latency period of many years in HIV infection, it can be argued that testing a few patients with AIDS produces a false sense of security. Ideally, measures should be in place to protect health care staff from the risk of infection based on the assumption that any patient may potentially be infected. This implies that there may be little or no justification for testing patients without their consent. Furthermore, a secretive testing procedure can be counterproductive because it establishes a difficult platform for subsequent counseling.

c.1.2 Rights of the patient vis-à-vis concerns for third party in counseling

Confidentiality of information may conflict with the need to protect a third party from contracting a life-threatening infection such as HIV.

c.1.3 Management of HIV infected patients

The HIV epidemic constitutes a major challenge for the health care systems in most countries in South and South-east Asia.

c.1.4 HIV and vulnerability

LEARNING SCENARIO:

The case of a HIV positive man and his HIV negative wife

A 50-year-old man was admitted to a hospital with multiple non-specific symptoms for investigation. His HIV test turned out to be positive. Without informing the man of the test or its outcome, the doctor discussed the situation with the patient's wife and encouraged her to undergo an HIV test. She turned out to be negative. Though the wife was quite upset about the situation she showed that she was a bold woman. She asked the doctor several questions on the disease transmission, treatment and curability. Later she came to the doctor and made just one request. The husband and wife were living with the wife's brother, "Please don't tell my brother that my husband is HIV-positive. We are labourers without any land and need my brother's help for shelter and survival. If he finds out about this he may ask us to leave the house."

Questions

Q *Why do you think the HIV test was done on this patient?*

Q *The test was carried out without his knowledge and consent. Describe the ethical problems involved in this action.*

Q *Consider the fact that no counselling can be done without informing the patient of the diagnosis. Do you think that not obtaining informed consent is a barrier for counselling? Discuss the ethical implications.*

Q *Can you think of any situations where HIV testing is justifiable without the consent of the patient? Explain why, and identify ethical problems.*

Q *Do you think that the doctor in this case was justified* in adopting this testing procedure *and managing the information in this way?*

Q *What would you do next in this case?*

The doctor never discussed the diagnosis with the husband. But when the wife's brother came and enquired about his brother-in-law's condition he was told that the patient was HIV-positive. After that, it was very difficult to discharge the patient:

Physician: From the medical point of view it is perfectly all right to give him a discharge certificate, because the patient has been cured for his lung infection and he has not got any other superadded infections. The only problem is, he is HIV-positive, he hasn't got a home, he has to go back to his wife's brother's house, who is willing to take him in if he is not HIV-positive, but who will refuse him shelter very strongly because he is HIV-positive. So that's a very big problem.

Interviewer: What were the options, when you took the decision?

Physician: Well, I had two options: One was to tell the wife's brother, the other one was not to tell him anything. I think those were the only two options. In any other disease, the problem wouldn't be so great, but people are very health conscious these days, especially with AIDS. They may not be afraid of any other disease but they are really afraid of AIDS and no one, I can understand, wants an AIDS patient in his house. That's one thing. The other thing is the status of the patient. If he had a house of his own, this problem would not have arisen.

Questions

Q *Do you agree with the decision to inform the wife's brother? Why/why not?*

Q *The physician justifies his decision with reference to the widespread fear of aids in the public. From a scientific perspective, what is the risk of non-sexual HIV transmission within a household?*

Q *Do you think that the actions of the physician in this case served to increase or decrease public fear of HIV? Discuss the ethical implications* both in connection with this *specific case and in view of the HIV epidemic.*

c.2 Mental Illness

At the end of this section the students will be able to-

- sensitise to the special ethical obligations for physicians dealing with mentally ill patients.

Some of the ethical issues that often arise in connection with the treatment of mentally ill patients. The management of mentally ill patients involves complex ethical issues. Here, the aim is to introduce the student to some of these. A cross-cutting issue in connection with mental illness concerns the extent to which the patient can be considered capable of autonomous decision-making. Also, the issue of making treatment available for the mentally ill in resource-poor environments remains an important focus for the discussion of ethics.

The facilitator using the scenario provided in this section should involve psychiatric expertise and should consider national legislation and institutional policies of relevance for the issues raised.

c.2.1 Treatment against the patient's wish

c.2.2 Mental illness and stigma

The fear associated with loss of control over one's own actions contributes to the widespread stigma and social exclusion of patients with mental illness. At the same time, patients often depend on the support of their close relatives. The issue is, how physicians should inform relatives of the disease in cases where this is believed to have serious negative consequences for the patient.

c.2.3 Legal-administrative barriers to treatment

Legislation concerning mental illness differs among countries. In addition, there may be policies at the institutional level that determine case management in particular circumstances. Sometimes, physicians may be placed in a situation, where the circumstances under which the patient is brought to the hospital form a barrier to necessary treatment.

c.2.4 Protection of vulnerable patients

Mentally ill patients may in different ways be more vulnerable than others.

LEARNING SCENARIO:

The man who was admitted against his will at his family's request

Physician: It happened when I was on emergency duty last Monday that a 30-year-old male patient was brought. I had already seen him more than three times before. The patient had no overt psychotic features when I saw him. However, his relatives forced me to admit the patient in the hospital against his will because the patient was very hostile to the family members, he spent a lot of money, he was aggressive at times, and he damaged the family possessions. When I saw the patient, he talked and acted very normally. He answered my questions as a normal individual. However, his personality seemed to be a little odd - somewhat antisocial behaviour, like a sociopath. This kind of behaviour is very common in psychiatric patients who are drug addicts or have alcohol-dependence syndrome.

Questions

Q *Consider the sentence "his relatives forced me to admit the patient in the hospital" and discuss its ethical implications.*

Physician: When I saw the patient, there were no overt psychotic features. Nevertheless, I decided to put the patient in the hospital as a crisis intervention between the patient and the family.

Interviewer: What did the family ask?

Physician: They asked for forced admission in our hospital.

Interviewer: How did the patient respond?

Physician: The patient refused to be admitted. However, I ordered his admission but we cannot do anything for that patient in the hospital. The patient settled in the ward. He had no psychotic features, and we did not give him any medicine or treatment. Another option would have been to discharge the patient, have regular follow-ups, listen to the patient's problems, and discuss means of problem-solving. Then, we would have had the family section for both the patient and the family. But because of lack of time and because the family was neglecting his condition it was not possible.

But now the patient is behaving very well in the ward. He is polite and obeys all orders. Sometimes he even helps us to distribute medicines to other patients. I have a feeling of guilt because I put the person in the hospital against his will and without a strong justification.

Questions

Q *How do you view the diagnosis 'sociopath' in this context?*

Q How do you view admission against the patient's will as a means to solve a family crisis?

Q In your country, would this admission procedure be legally acceptable for a case like this?

c.3 End-of-life decisions

At the end of this section the students will be able to-

- identify the ethical issues involved in end-of-life decisions. In particular, students will understand the conflict between a physician's duty to save lives and other values, such as using the resources to improve the health of others.
- identify on whom should make these decisions, and how.

Students will explore issues pertaining to end-of-life decisions. Decisions such as when and how to stop attempts to resuscitate terminally ill patients, and when to switch off machines that enable basic bodily functions to continue in brain-dead or deeply comatose patients, are universally difficult. In resource-poor contexts other patients may benefit more from the equipment, and the long-term treatment costs may threaten the economy of the patient's family.

The facilitator using the scenario provided in this section should involve relevant expertise and should consider national legislation and institutional policies of relevance for the issues raised, particularly concerning the status of brain death in the country.

c.3.1 Switching off a ventilator

The basic bodily functions may be kept running for a very long time in a ventilator, even if there is no hope that the patient will ever be able to regain consciousness. The issue is, when and how the decision to switch off the ventilator should be made. Often, the relatives find it very difficult to consent to this decision.

c.3.2 Use of aggressive treatment in terminal illness

The balance between 'doing harm' and 'doing good' in terminal illness can be difficult. This dilemma is often aggravated by the strong emotions of relatives involved, particularly in cases where the patient may not be capable of autonomous decision-making.

LEARNING SCENARIO:

The brain-dead patient and the family's dilemma

Physician: There is a patient in the ward who is on ventilator. He is around 40-45 years. He suffered major injuries is now brain dead. The family members have been explained everything. They are in a dazed state and don't know what to do. Probably, their heart does not allow them to let their loved one go and take the responsibility of switching off the ventilator.

Interviewer: So what do your colleagues have to say on that?

Physician: We cannot do anything. We may discuss it among ourselves but it is pointless. Switching off the ventilator is euthanasia which is not permitted. It also depends upon the family. If they are well educated and reconciled to the idea, then some of them do decide that, OK, you can switch off the support system. But it can go on for days or weeks. In the past, whenever this situation came up, it has gone on like this. Ultimately, when the patient's heart failed, Nature took the final decision.

Questions

Q *Can a group of physicians take a decision to switch off the ventilator in this case if it is needed by another patient?*

Q *Should the group be assisted by a person with legal expertise?*

Q *Discuss legal versus ethical issues in this case.*

c.4 Organ donation and transplantation

Certain ethical issues related to organ donation/harvesting and transplantation. Decisions on whom to offer this expensive treatment in a resource-poor environment, where it may be difficult for some patients and families to follow subsequent necessary lifelong follow-up treatment, have to be made in a context of chronic shortage of organs.

c.4.1 Offering organ transplantation

At the end of this section the students will be able to-

- identify the ethical issues involved in organ harvesting and transplant treatment.

An organ transplant operation is very expensive, both in terms of the immediate costs in connection with the operation and in terms of its life-long follow-up treatment, and some doctors may consider it futile in certain cases to offer this type of treatment.

c.4.2 Donation of an organ

In some countries organ donation is allowed from live donors (in contrast to brain-dead patients) if there are close familial ties between the donor and the recipient. This is meant to ensure that the organ is donated out of compassion for the recipient, the underlying assumption being that a family member would not be pressurized to donate an organ. This issue is complicated by the existence of illegal trade with organs at national and international levels.

LEARNING SCENARIO:
The baby with biliary atresia who needed a liver

Physician: We had a 7-month-old boy with biliary atresia. He had been operated elsewhere. The operation had not been successful and the child had developed liver failure. The only option available was a liver transplant. However, the parents were poor and could not afford the operation and post-operative treatment with immunosuppressant. I told the parents that they would not be able to afford it. Knowing that this treatment is available, we were in a dilemma whether to go ahead with preparations for this treatment or tell the parents, "look this is the end of the road for your child."

Questions

Q *The physician in this case assesses the family's economic situation and informs accordingly. What are the ethical implications of this approach?*

Q What would have been the deciding factors if the family had sufficient resources?

The baby with biliary atresia who needed a liver

Physician: The prognosis of the disease itself is very poor, but following liver transplantation, at least in Western centres, it is very good. We have not yet done liver transplantation in children, but having had some training in the procedure, I am quite confident I can do it. But the reasons for not offering it to the parents were economic and various technical problems associated with liver transplantation. As things stand at the moment in this country, donors have to be taken either from brain dead individuals or living relatives, mostly parents. Now, the problem was that both the parents were earning members of the family. Particularly in a low socioeconomic group, if one of the earning members has to go out of job for more than one or two months, then the family has a difficult time trying to make ends meet. I thought I would be doing the family a favour by not offering this kind of treatment.

Questions

Q *The physician feels confident that he could do liver transplant surgery. Discuss confidence versus competence in this case.*

Q *Consider the child's prognosis with and without treatment. Do you agree that the physician is doing the family a favour by not informing them of the existing treatment options?*

Q *In this case the patient is a baby. In your opinion, would it make a difference if the patient had been seven years old? Or if he had been 17 years?*

c.5 Medical termination of pregnancy

At the end of this section the students will be able to-

- discern the ethical principles that are applied when physicians agree or reject to perform MTP in a given legislative context.
- identify and discuss ethical dilemmas involved in MTP.

Under this topic, there is a learning scenario on ethical issues pertaining to medical termination of pregnancy (MTP). National legislation differs widely and in important ways on this issue. The ethical dilemmas that appear in this section would be evaluated differently in different legislative contexts. This section should be used in connection with detailed information on the relevant legislation in our country.

It is important to note that the guidelines below may not take all legal matters into considerations. It remains the responsibility of the user of this material to ensure that students are advised according to the existing legislation of the country concerned. In some countries, MTP is offered according to certain criteria, such as the pregnancy endangering the life of the mother, or the foetus having severe malformations or genetic diseases, and in other countries it may not be legal under any circumstances. Prior to using the learning scenario, the facilitator should determine the relevance of the scenario in the context of national legislation in the country. For advanced discussions, the scenario can also be used to compare ethical issues under different legislative frameworks.

It has often been argued that women should have the right over their own body, including pregnancy. Particularly in resource-poor contexts involving gender inequity, lack of basic education and high birth rates, it may not be the choice of the woman to become pregnant. At the same time, all religions consider life as sacred, and some see termination of pregnancy as violating the basic tenets of their religion. So all these things should be taken in consideration in discussing this issue.

c.5.1 Pregnancy endangering the life of the woman

MTP is legal when a pregnancy involves a significant risk to the life of the pregnant woman.

c.5.2 Prenatal diagnosis

Prenatal diagnostic techniques have made it possible to detect serious disease in the foetus. In some countries this is a legally valid reason to perform MTP within a certain gestation period. This raises the question whether diagnostic testing should also not be performed after that point in time, but again it should be supported by country law.

c.5.3 MTP versus prevention

In countries where MTP is legal, physicians may find it ethically problematic if they believe that this procedure in some cases merely replaces the use of available prevention methods.

LEARNING SCENARIO:

Request for medically terminated pregnancy not met

Physician: After a caesarean section, adequate spacing before the next pregnancy is recommended, because the operation requires a recovery, and the child requires sufficient attention from the parents. If the mother is pregnant too soon, it would be hazardous and also limit her attention to her child. I had a case where I suggested that the mother should participate in family planning. However, the husband was not very supportive and the wife became pregnant again only three months after the caesarean section. She pleaded, "Please help me, doctor. My child is still very young". I was not only concerned with the caesarean section, but also spontaneous delivery. It would be difficult if the mother became pregnant again while her child was only three months old. She gave various reasons such as her occupation, etc. From our perspective, it is difficult. How to deal with it from a religious point of view? Whether it could be aborted or not. That's where our dilemma lied. We suggested her to continue with her pregnancy. I explained to her about the indications for abortion, such as congenital anomalies. The couple did not take family planning seriously. She remained insistent. However, I kept suggesting to her to continue her pregnancy, unless there was bleeding or heart disease or another dangerous condition, in which case there was no other choice. But I knew for sure that it would endanger the mother to go through with the pregnancy because I had performed the caesarean section myself. However, if all proceeded smoothly, I would convince the patient that there would be no problem. I could easily have referred the patient to a colleague who usually performs abortion.

Questions

Q *Think about this case and consider the following issues:*

- *Prevention has been advised following the caesarean section but has not been practiced;*
- *The husband has not cooperated to avoid pregnancy;*
- *The mother has a strong wish to terminate the pregnancy;*
- *The pregnancy may be dangerous for the mother, given the recent caesarean section.*

Q How do you view the decision of the physician in this case?

Q How do you weigh the above factors?

Different Jargons in the Field of Medical Ethics

At the end of this section the students will be able to-

- define medical etiquette
- define professional infamous conduct
- describe covering, professional death sentence, dichotomy or fee splitting
- differentiate between professional secrecy and privileged communication
- define negligence and malpractice and explain different types of malpractices
- narrate the patient's rights
- mention the rights and responsibilities of registered physician

Medical Etiquette:

It is the conventional law of courtesy among the members of the medical profession. A physician should consider it as a pleasure and privilege to render gratuitous to all physicians and their immediate family dependants. The physician does not criticize the other physician.

Professional Infamous Conduct:

It is something done by medical man in pursuit of his profession, with regard to which it would be reasonably regarded as disgraceful or dishonorable by his professional brethren of good repute & competency.

A. Professional Infamous Conducts Are: (6As)

- Adultery
- Abortion (Unlawful)
- Alcohol(Drinking)
- Addiction(Drug)
- Association with bad people/manufacturer/ unqualified & unregistered persons.
- Advertisement to promote practice

B. Professional Infamous Conducts Are: (3Cs)

1) Conviction (except political).
2) Contravention (of drug act)
3) Covering

C. Others:

1) Issuing false certificate.
2) Depreciation of Professional brethren.
3) Dichotomy.
4) Selling schedule poisons to member of the public other than his patient.
5) All other criminal cases.

Advertising: Soliciting of patients directly or indirectly, by a physician, by a group of physicians or by institutions or organizations, is unethical.

Conviction: of different charges like misconduct, adultery, addiction (drugs, alcohol etc.) Abuse of professional position by committing adultery or improper conduct with a patient or by maintaining an improper association with a patient will render a physician liable for disciplinary action.

Contravention: A registered medical practitioner shall not contravene the provisions of the Drugs Act and regulations

Covering:
The term 'covering' means association with unqualified or unregistered person practicing medicine.

Issuing false certificate: Registered medical practitioners are in certain cases bound by law to give, or may from time to time be called upon or requested to give, certificates, notification, reports and other documents of similar character signed by them in their professional capacity for subsequent use in the courts or for administrative purposes etc. In any case a physician cannot issue a false certificate, notification, report. It is considered as infamous conduct. A registered medical practitioner should not issue certificates of efficiency in modern medicine to unqualified or non-medical persons.

Dichotomy: Is receiving/giving commission or other benefits from/to medical practitioner or consultant for introduction of a patient. Such practice is called fee splitting or dichotomy.

Professional Secrecy :

It is the implied term of contract between the medical practitioner & his patient by which the medical man is obliged both legally & ethically keep the secrets of his patients which is learnt by him in course of treatment & disclosure of which without the consept of the patient is breach of contract & punishable under law.

Privileged Communication

It is a statement made by a doctor to the legal authorities in the interests of the country or the public towards whom he has a legal, social or moral duty, although such communication under normal conditions contravenes general rule of professional secrecy.

A physician should not commit any of the following acts which are unethical:

Negligence

Means doing something that is not supposed to do or failing to do something that is supposed to do.

Malpractices (Professional Negligence):

Professional negligence is defined as absence of reasonable care and skill, or willful negligence of a medical practitioner in the treatment of a patient which causes bodily injury or death of the patient[6].

Two Types of Malpractices -

- Civil
- Criminal

Civil Mal- Practices: It is a form of negligence in which a patient brings an action against his medical attendant for injury or damage caused to him as a result of breach of his legal duty to exercise skill & care, i.e. his professional duty necessary in the circumstances of the case.

Criminal Mal- practices or Criminal Professional Negligence:

It is a from of negligence in which the physician exhibits gross lack of competence, gross inattention, criminal indifference to the patients safety, or gross negligence in the selection & application of remedies.

To be criminal the negligence must be willful, wanton, gross or culpable

Patients' Rights

Right in its simplistic meaning is fairness. Application of the concept of a "right" varies in the different domains of legal terminology. Patients' rights vary in different countries and in different jurisdictions, often depending upon prevailing cultural and social norms. Patient rights have recently become the center of attention in the practice of medicine. The push for legislation of a patients' bill of rights is to provide laws that would prevent patients' rights becoming subjugated. But what exactly are the patients' rights? Often, people do not realize their specific rights at the time of their care because those rights are often not clearly defined. Every patient has right to-

i. **Choice:** To choose his own doctor freely

ii. **Access**: To health care facilities available regardless of age, sex, religion, economy & social status & access to emergency service.

iii. **Dignity** :To be treated with care, compactions, respect & dignity without any discrimination.

iv. **Privacy**: To be treated in privacy during consultation and therapy

v. **Confidentiality :** All information about his illness and any other be kept confidential

vi. **Information:** To receive full information about his diagnosis, investigation, treatment & alternative available.

vii. **Safely:** Right to information should also include safety of procedures/diagnosis/therapeutic modality, complications/side effects/expected results as well as facilities available in the institution and other places.

viii. **Information**: day to day progress, line of action diagnosis and prognosis.

ix. **Refusal :** Right to consent or refuse any specific or all measures

x. **Second option**: at any time

xi. **Records:** Access to his medical records & demand summery or other details pertaining to it

xii. **Continuity:** To receive continuous care for his illness from the physician or institution

xiii. **Comfort:** To be treated in comfort during illness and follow up

xiv. **Complain:** Right to complain & redressal of grievances

xv. **Compensation:** Obtain compensation for medical injuries/negligence

Rights and Responsibilities of Registered Physician[6]:

i. Right to choose a patient

ii. Right to practice medicine

iii. Right to dispense medicine

iv. Right to posses and supply dangerous drugs to his patient

v. Right to add title, description etc. to the name

vi. Right to recovery of fees

vii. Right for appointment to public and local hospital

viii. Right to issue medical certificates

ix. Right to give evidence as an expert

x. Exemption from serving as a juror at an inquest

Code of Medical Ethics of Bangladesh Medical & Dental Council (BM&DC)

(Function, Procedures and Disciplinary Jurisdiction of BM&DC)

At the end of this section the students will be able to-

- mention the function of BM&DC
- narrate the procedures and disciplinary jurisdiction of BM&DC
- describe the guidelines for ethical practices given by BM&DC

JURISDICTION :

The Bangladesh Medical and Dental Council was duly Constituted under the Medical and Dental Council Act No XVI of 1980, on 9, 1980 is empowered to look after:

(a) Public interest - by Maintaining Proper Medical Dental Standards.

(b) Medical Dental Education in the country.

(c) Maintain a register of qualified Medical/Dental Practitioners qualifying from duly recognised institutions or recognised dentists registered as per section 15 (3) of the act.

(d) Take such disciplinary actions which may be required for criminal convictions or serious professional misconduct of a Medical/Dental practitioner. The Council is not an Association or a Union for protecting professional interests.

The following general advice given by Professor Saund by to Medical/Dental practitioners will be found exceedingly valuable:

"The duty that a medical/dental man owes to the profession of which he is a member is one of the highest he is called upon to fulfill, as his obligations to his country can alone be allowed to have greater claims upon him. He should cherish a proper pride in his calling and disparage it neither by act nor word, but endeavour to increase the public esteem in which it is held by good and worthy deeds. His life should be discreet and sober, avoiding excess or extravagance of dress and de-mean our.

He should regard with respect the regulations of all duly constituted professional bodies which are set in authority over him by the laws of his country or by the rules of those medical/dental societies of which he is voluntarily a member, and he should obey them in spirit as well as in letter.

He should respect professional option, and not stand aloof from movements designed to promote the interest of the profession; if unable to agree with the course adopted by the majority, he should

abstain from manifesting publicly his dissent by addressing letters to lay news-paper but should confine him- self to urging his opinions in those professional journals which are open to him.

In all dealings with patients the interest and advantage of their health should along influence his conduct towards them. As their trust to their profession is great so tbe obligation to be true to their interest is greater and any single failure in this respect is wholly discreditable and inexcusable.

The consequences of breach of this rule may be most serious from a professional point of view, involving even the removal of the offender's name from the Medical/ Dental register, but only the grossest cases are thus brought to light. In most instances the individual's conscinence is the sole arbiter, for no can judge motives, hence there is urgent need to avoid those light departures from rectitude by which the sensitiveness of this private monitor may become deadened.

The Medical/Dental practitioner must not only deal honestly with his fellowmen, but he is called upon to how more than usual benevolence towards them so as to maintain the honourable tradition by which the physician is regarded as the friend of all person, without respect to race, creed or social position."

The Medical and Dental Council Act, Section 28 Provides that if any registered Medical/ Dental Practitioner or registered Dentist has been convicted of any criminal offence of after due inquiry found guilty of infamous conduct in any professional respect by the Council, the Council may in its discretion direct the removal of the name of the medical Practitioner or dentist from the register. The word "Convicted" is obviously used in relation to a duly constituted court. In a well known passage in infamous conduct in any Professional respect was defined by lord justice Lopas of England as follows:

"If a Medical/Dental man in the pursuit of his profession has done some thing with regard to it which will be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency, then it is open to the General Medical Council, England if that be shown, to say that he has been guilty of infamous conduct in a Professional respect"

The question which the Council would have to ask themselves, therefore, is:-

Is it in the Public interest to leave the name of this Medical /Dental Practitioner on the Register?

The Council have the discretion either to suspend temporarily or remove Permanently the name from the register depending on the facts of the case and the nature of misconduct.

The following guidelines will help Medical & Dental Practitioners

1. CERTIFICATES:

No registered Medical/ Dental Practitioner shall give any certificate in his professional capacity which contains any false statements. Any Practitioner who issues a certificate which is untrue, misleading or improper shall be liable to be suspended or have his name remove from the register. This refers to all certificates including those for births, deaths, insurance, workmen's compensation, medical fitness etc, Medical Practitioner having category Registration Certificate should not issue Medical Certificates.

2. ATTEMPTS TO MAKE IMPROPER PROFIT.

Any registered Medical/Dental Practitioner who accepts any illegal gratification from a patient in the course of his professional duty, is liable to be suspended or have his name removed from the Register.

3. ABUSE OF PROFESSIONAL KNOWLEDGE, SKILL OR PRIVILEGES:

Any registered Medical/Dental Practitioner found guilty of causing an illegal abortion or of prescribing drugs in violation of the Dangerous Drugs Act, or who becomes addicted to a drug himself, or is convicted of driving under the influence of alcohol or other drug, is liable to be suspended or have his name removed from Register.

4. ABUSE OF MEDICAL / DENTAL PRACTITIONER- PATIENT ELATIONSHIP:

(a) Any Medical/ Dental Practitioner who commits adulteration or has an improper association with a person with whom he has a professional relationship at the material time is liable to disciplinary proceedings. In the case of doctor who has been cited a party in divorce proceedings, and has been found to be guilty misconduct by a court of law, the finding of the court will accepted as conclusive, and action will be taken accordingly.

b) No Medical & Dental Practitioner shall disclose any information obtained in confidence from a patient except when necessary to do so in the interests of the security of the State or the maintenance of law and order in the country.

5. DISREGARD OF PERSONAL RESPONSIBILITY TO PATIENT:

(a) Gross negligence in respect of his professional duties to the patient may be regarded as misconduct sufficient to justify the suspension or the removal of the name of a Medical & Dental practitioner from the Register.

(b) Assisting an unregistered person to practice medicine or dentistry etc, or a professional association with such a person performing the functions of a practitioner in relation medicine,

surgery and midwifery, dentistry etc, knowingly make a registered practitioner liable to disciplinary action. ' dose not preclude a Medical/Dental Practitioner from imparting proper training to Medical/Dental students, Nurses, Midwives and other Paramedical personnel, provided the doctor concerned keeps a strict supervision over such individuals when treating patients.

6. OFFENSES DISCREDITABLE TO THE MEDICAL/DENTAL PRACTITIONER AND HIS PROFESSION:

Any Medical/ Dental Practitioner convicted of false pretences, forgery, fraud, theft, indecent behavior or assault, is liable to disciplinary action by the Council.

7. ABUSE OF FINANCIAL AND OPPORTUNITIES AFFORDED BY THE MEDICAL/DENTAL PRACTICE:

No Medical/ Dental practitioner shall commercialize any secret remedy of share any professional fees with any other Medical/Dental practitioner or other person in the form of a commission.

8. CANVASSING, ADVERTISING AND USING FALSE TITLE ETC.

Canvassing and advertising for the purpose or obtaining patient and advancing the professional interest of a Medical /Dental practitioner, whether done directly or indirectly through an agent, association or other persons and organizations is professional misconduct and may make the Medical/Dental Practitioner liable to disciplinary action.

The publication of matter or comments calculated to advertise the qualifications, professional skill, knowledge or services of any Medical /Dental practitioner for the purpose of advancing his Professional interests, when procured or instigated by the Medical /Dental practitioner, or by individuals or associations or other organizations friendly to or associated with the Medical /Dental practitioner knowingly connived at by the Medical/Dental practitioner liable to disciplinary action.

Notice announcements and leaflets, published or circulated by a Medical Dental practitioner, may if in excess of the customary limits or propriety observed by the profession, be regarded as advertising, amounting to professional misconduct. Similarly matter published in books, letters news papers and magazines, or through the medium of talks on the Radio or Appearances on Television, may, if published for the purpose of advertising a Medical Dental practitioner, be regarded as professional misconduct.

Prohibition for using false title etc. by registered medical practitioner or registered dentist shall use or publish in any way what so ever any name, title, description or symbol indicating or calculated to lead persons to infer that he possesses an additional or other professional qualification unless the same has been conferred upon him by a legally constituted authority within or out outside Bangladesh.

9. ANNOUNCEMENT, RADIO TELEVISION:

When announcing their appearance on the radio or the television on professional subjects, Medical/Dental practitioners shall not disclose their identity or allow it to be disclosed. This restriction shall not apply to Medical Dental practitioner who are not actively engaged in private practice or when appearing in a non-professional capacity. Appearance on Television and Radio shall be limited to the purpose of health education only.

10. CHANGE OF ADDRESS OR CONDITIONS OF PRACTICE:

Any change of address or of the hours of practice may be suitable announced :-
(a) Through the local branch of the B.M.A. or the medical journal for information of other doctors.

(b) In the local press either once in three papers, or three times in the same paper on three consecutive days and the announcement should be made in normal manner and not unduly prominently as by big advertising blocks.

11. There is no rule preventing Medical/Dental practitioners from charging one another for their services : It is generally regarded as a pleasure and privilege to give one's services free to a professional brother, his wife and children, and to Medical Dental student and their parents[7].

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