Middle East Research Journal of Nursing
ISSN 2789-8679 (Print) & ISSN: 2958-2016 (Online)
Frequency: Bi-Monthly
DOI: 10.36348/merjn.2024.v04i02.002

KUWAIT SCHOLARS PUBLISHER
Website: http://www.kspublisher.com/
Email: office@kspublisher.com

Ethics in Health Care

Siniša Franjić[1]*
[1]Independent Researcher

Abstract: Ethics has the task not only to acquaint people with the concept of morality, but also to take a critical view of existing moral practice. The purpose of ethics as a philosophical discipline is precisely to know and explain the essence of human action, human practice with regard to its moral quality, to know the action and shaping of moral consciousness. Medical ethics plays an important role in medical education and later in medical careers. It prepares students to be able to discern ethical problems and issues and to analyze and solve them in a logical way. The ability to make ethical decisions is a fundamental attribute for the education of medical and health professionals. Making quality decisions is often impossible without considering certain ethical issues.

Keywords: Ethics, Care, Medicine, Health.

Research Paper

***Corresponding Author:**
Siniša Franjić
Independent Researcher

How to cite this paper:
Siniša Franjić (2024). Ethics in Health Care. *Middle East Res J Nursing, 4*(2): 11-16.

Article History:
| Submit: 24.03.2024 |
| Accepted: 26.04.2024 |
| Published: 27.04.2024 |

Copyright © 2024 The Author(s): This is an open-access article distributed under the terms of the Creative Commons Attribution **4.0 International License (CC BY-NC 4.0)** which permits unrestricted use, distribution, and reproduction in any medium for non-commercial use provided the original author and source are credited.

INTRODUCTION

Ethics features a long and distinguished history, grounding both the practice of medicine and also the laws associated with it [1]. Society considers ethical principles so important that it gives them legal sanction in statutory and case law. Thus, ethical principles, like respect for autonomy and privacy, are translated into laws about informed consent and confidentiality. Issues associated with providing and forgoing health care are governed almost exclusively by state law, however, creating wide variation within the way these matters are handled.

While ethics informs all worthy endeavors, it's special significance within the health care professions due to the fiduciary relationship between practitioners and patients. A fiduciary relationship exists when one party, due to superior knowledge, skill, and authority, assumes responsibility for the welfare of another party who is in a very position of reliance. during this trust-based relationship, fiduciaries have heightened obligations, including the moral imperative to place the interests of reliant parties before their own interests. Patients, whose illness, injury, disability, pain, or suffering make them vulnerable, place themselves within the hands of health care professionals, supported the confidence that their well-being is that the practitioner's highest priority.

Ethical values are based on consensus and religious morals, influencing thinking and practice [2]. Although these principles don't have the force of law, they're guiding principles that are treated with respect when ethical decision-making is required. There are four principles: autonomy, beneficence, nonmaleficence and justice.

"Care" is doubtless among the foremost important concepts in healthcare [3]. The very word "healthcare" bears witness to this fact, indicating what the healthcare system as an entire and therefore the individual actions happening within healthcare are all about—namely, to provide care. The concept of care plays a crucial role for the professional identity of caregivers, and it's a part of the expectation of care receivers. This could easily be forgotten providing publically and academic discourse, issues like costs, prevention, the just distribution of scarce resources and also the patient's personal responsibility often figure more prominently than care.

Care isn't only a descriptive concept, it also conveys a normative orientation. The term "care" enables one to evaluate different courses of action in healthcare. what's more, different courses of action can correspond more or less closely to what one perceives as good care. As there are standards and guidelines for and best practices of good care, care providers can ask themselves whether what they are doing constitutes good care. The question of whether the healthcare system as a full as well as specific regulations and practices within healthcare live up to the ideals of good care is often subject to debate.

Socioeconomic stability may interfere with good care in individual cases, since, as an example, the quantity of your time care providers can allocate to individuals is limited by the amount of cases they're expected to manage. Determining what constitutes good care is hence usually a matter of finding reasonable compromises. In healthcare settings, a typical compromise involves finding a balance between optimal take care of individuals on the one hand and therefore the institutional demands of providing care to several care receivers over long periods of time as well because the limits of what can legitimately be asked of individual care providers on the other.

Autonomy

The principle of autonomy is one given particular prominence in modern health care [2]. Autonomy is that the principle by which a client is given sufficient information about health care and so permitted to make a decision for him- or herself about treatment. This principle is visited several times throughout the book, particularly in regard to informed consent. Adults without mental health problems should be able to understand the advantages and disadvantages of their planned treatment and care. Understanding will, however, involve variety of things, as an example educational level, will they fully understand the explanation? In one in all the authors' experience, a female patient stated that her second hysterectomy had been much more successful than the first, raising the point that she had a poor understanding of both her own anatomy and also the pre-operative instruction that she had received.

The principle of beneficence is worried with the provision of benefit or beneficial treatment to a client, while, broadly opposite to this, non-maleficence seeks to prevent harm to it individual. Important aspects of those two principles are that clients have both biological and psychological needs, which harm might be caused to at least one or other of those. It's now well established that clients who require surgical procedure recover better and experience less pain if both their physical and psychological needs are met. Thus the 2 principles is seen to figure together, physical and psychological preparation along with the surgery itself creating benefit, while the principle of non-maleficence is used in order to prevent complications.

The principle of justice within a health care context is more concerned with wider issues than those posed by individual clients and relates to broader matters. The moral problems with resource allocation are often used to draw examples, which can concern either small or large groups. Media attention and social policy are focused on the number of individuals on waiting lists for hospital treatment, and resources are periodically allocated by central government to ease the matter. Such funds must be found from somewhere. Is it better to withdraw funds from defence money so as to ease the waiting lists for health care? Initially, it'd seem so, but what of the number of individuals and their families who are employed within the defence industry and who may lose their livelihood as a consequence?

Long-term Care

One difficulty that confronts discussion of the problem of autonomy in longterm care is that medical ethics, like medicine itself, is acute care and in-patient oriented [4]. Typically, a patient is institutionalized for brief periods of time for discrete problems: the majority of care is provided by cadres of health professionals, who usually have brief procedure-oriented or task-oriented encounters with the patient. Clinical decision making, too, typically has a short time horizon: the goal is improvement of biological status to the point that allows discharge. Discharge is usually predicated on removal from the unit, not necessarily discharge from the hospital. The goal of resuming normal activities or regaining a premorbid quality of experience and range of activities is rarely explicitly the main object of concern for health professionals although these are typically the preoccupationfor patient andfamily. Restoration of normal blood gases, for instance, may be a primary goal for pulmonologists and nurses in pulmonary and intensive care units, but it's rare for these scores to be related in any meaningful way to the patient’s future lifestyle except, and only until, they're normalized or therapeutic defeat acknowledged. The orientation is thus exceedingly short term, problem defined, and task dominated. Bureaucratic organization of the delivery of services further exacerbates the alienation of health professionals from the patient as a person.

Given the dominance of the acute care orientation in American medicine, it's not at all surprising that bioethical thinking has come to focus on the paradigm cases and problems that arise in acute care medical settings. This focus is typically marked by crisis and conflict. Ethics becomes relevant only if all else fails, because the fundamental orientation is on specific problems, procedures, and tasks. Given the structural features of the way health care is delivered, conflict is inevitable.

ADRT

An ADRT (advance decision to refuse treatment) is considered valid if it [5]:

- Is written by an individual aged 18 or over who had the capacity to create, understand, and communicate the decision when it had been made.
- Has clearly specified which treatments they wish to refuse.
- Has explained the circumstances within which they want to refuse them.
- Is signed by the individual and by a witness if he or she wants to refuse life-sustaining treatment.

- The individual has made the advance decision of their own accord, with none harassment by anyone else.
- The individual has not said or done anything that might contradict the advance decision since it had been made.

Some proformas of ADRTs are available online, and also the National Health Service (NHS) Improving Quality has published guidance in collaboration with the National Council for Palliative Care.

However, significant problems with ADRTs are raised. there's no national registry for ADRTs, then finding whether a patient has one may be difficult. Some general practitioners (GPs) aren't aware of the legal constraints on validity, and some lawyers aren't aware of the details of medical treatments, so that, of the few ADRTs that are written, many aren't valid. a simple wish to not have cardiopulmonary resuscitation (CPR) attempted, for instance, might not be considered valid if the circumstances in which the arrest happened don't seem to be documented. To be legally binding, it'd must be written: 'should my heart stop, i'd not want any attempts at resuscitation, in any circumstance. I understand that this is often a refusal of life-sustaining treatment' then have it dated and signed. But this type of ADRT may force people into extremes they failed to mean to instruct; what a couple of patient who is choking? So then someone might write: 'I don't wish to own resuscitation attempted unless there's a transparent reversible cause'—but then is hyperkalaemia a transparent reversible cause? Would you wait until you knew the potassium before stopping CPR?

One approach to this problem is to make sure that an 'advance statement' coexists with the ADRT. While patients don't have the right to request treatments, they will write about their treatment preferences (e.g. 'I would love to die at home if possible' or 'I would really like all treatments to prolong life to be considered' or 'quality of life is that the most significant thing for me: please only give me treatments if you think that i've got a good chance of retaining my mental functions'). Providing treating clinicians with an 'advance statement' alongside an ADRT allows them to interpret the ADRT for the circumstances that exist. a new charity, 'Advance Decisions Assistance', has mocked up some appropriately legally and medically worded ADRTs and combined them with 'values statements' to go alongside them, to assist patients in understanding what might help ensure their wishes are respected.

Ethics

Modern philosophy links the definitions of morality and ethics [6]. within the simplest forms, morality is that the difference between right and wrong, while ethics represents the critical study of morality. Individuals select from a variety of sources of ethical authority, like religion, cultural norms, politics, and law. As such, persons may regard situations or objects differently, supported the value systems espoused by their source of ethical guidance. Ethics represents the cognitive evaluation of a principle or situation, acknowledging the fact that individuals possess different moral backgrounds. Ethical dilemmas arise when there's a conflict of values between persons arguing for competing moral imperatives – when people cannot agree on what's right and what's wrong.

Medical ethics may be a discipline that studies differences in value systems as they apply to clinical situations. Medical ethics is most commonly taught through classroom discussion, as a method to familiarize providers with common ethical principles. Applied health care ethics is that the practical extension of such discussion, recognizing that like all clinical decision-making, ethical dilemmas require action. The word "applied" then refers to the reality that physicians mediate ethical dilemmas and make tough decisions daily. they're not philosophers, but practitioners of medical philosophy.

Most American physicians guide their ethical decision-making from duty-based concepts referred to as the "principles of biomedical ethics." These principles include respect for autonomy, non-malfeasance, beneficence and justice. Respect for autonomy is demonstrated when the patient is given the flexibility to exhibit self-governance, or self-determination. Patients should be allowed to form choices regarding their own health care. Non-malfeasance is loosely translated into the statement "do no harm." Physicians have an ethical obligation to limit the risks of poor outcomes that will result from diagnostic or therapeutic interventions. Beneficence in health care refers to the elemental challenge to optimize a patient's condition and well-being; this could be through treatment of disease or provision of comfort care. Justice refers to the fair and equal treatment of patients, both in access to and quality of health care. Justice is also manifest through systems and institutional ethics, which in today's marketplace must reply to the reality of limited health care resources.

Health- related quality of life may be a subjective concept, and relates to the perceived effects of health status on the ability to live a fulfilling life [7]. This encompasses functional ability in respect to ability to perform self-care tasks, domestic tasks and mobility, role functioning (e.g. ability to function in work, social roles like parenting, and so forth), the existence and quality of relationships and social interaction, psychological well-being (e.g. life satisfaction, adjustment, coping ability), autonomy and control, and mental health (e.g. anxiety, depression, cognitive state). like the concept, the potential range of dimensions of health- related quality of life that would be measured in studies of health outcomes is wide. A population survey of individuals

aged 65 years that asked them how they perceived quality of life reported that they emphasised psychological characteristics (e.g. outlook on life), health and functional ability, social relationships, neighbourhood (e.g. safety, facilities, transport), having enough money and retaining their independence. Individualised measures are more complex to analyse than standardised questionnaires and scales, but they're invaluable where there's uncertainty about whether all relevant questions are included during a questionnaire, and for informing the things (questions) that compose scales and enhancing their content validity. as an example, respondents' detailed statements about quality of life within the former study were wont to form Likert scale ('Strongly agree' to 'Strongly disagree') statements for the multidimensional Older People's Quality of Life Questionnaire, which the author is currently testing with three national samples of older people, and with good results up to now.

Bias

Moral biases within biomedicine are by no means limited to end-of-life practices [8]. The ethics of clinical research also reflects moral biases. it's been argued that clinical trials are characterized by a "therapeutic orientation," which treats them as essentially a sort of medical care governed by the ethics of the fiduciary doctor–patient relationship. This obscures the way during which clinical trials differ in ethically significant ways from personalized medical care — specifically with relevancy their purpose, characteristic methods, and way within which risks to patient-subjects are justified. Commitment to the ethics of the doctor–patient relationship creates a morally biased account of the planning and conduct of clinical trials. This is reflected within the ethically dubious norm of clinical equipoise, which is intended to create clinical trials in step with the standard ethics of medical care.

Moral biases not only are invoked to legitimate practices by means of false beliefs; they also serve to hide, or divert attention from, the truth about these practices, which could call their legitimacy into question. Describing withdrawing life-sustaining treatment as merely allowing patients to die a natural death from the underlying medical condition that's being treated by medical technology hides the fact that stopping these treatments causes the patient's death and thus conflicts with conventional medical ethics. In describing moral biases as hiding the truth, we don't imply any overt intention to try and do so, although this might be operative in some circumstances. Moral biases hide the reality about underlying incoherence between practices and norms, not just for those that engage within the practices in questions; they also hide the truth from patients, ethicists, and therefore the public.

Moral bias could be a natural psychological tendency to which all of us are liable. In truth, the way the world works often doesn't conform to the way we predict it should; accordingly, when this lack of congruity matters to us, we are often motivated to adopt false beliefs in order that the conflict between "fact" and value is formed to disappear. In other words, people are often motivated to endorse false beliefs in order that they will view themselves and their conduct as appropriate in light of established norms. In view of the psychological function of ethical biases, especially when deeply rooted, there could also be considerable resistance to acknowledging their existence.

Death

Death may be a biological process, rather than an event: this may make it difficult to define when death occurs [9]. Nevertheless, it's important to own a legal definition of death for various reasons. It is important for property purposes, yet as in regard to organising estate and probate matters. Clearly, defining death is additionally vitally important for those involved in organ transplantation from deceased donors, as organs can not be lawfully removed until the donor has been declared dead. This can be underpinned by what's colloquially called the 'dead donor rule', which holds that 'patients must be declared dead before the removal of any vital organs for transplantation'. Historically, it had been relatively easy to work out death – a person's heart ceased to beat, and that they stopped breathing. With advances in medicine and (bio) technology, however, the cessation of the heartbeat or of breathing doesn't necessarily mean an individual is dead. Cardiac arrest has been followed by successful resuscitation and artificial ventilation has also improved techniques in resuscitation and provided life support for those that are severely ill or are seriously injured.

Medicine

Medicine has been preoccupied with right action since healers and shamans began to consider their duties and responsibilities [10]. The Hippocratic oath is believed to have been written within the fifth century BCE, and that we assume earlier standards existed in less codified forms. With the development of modern medicine and therefore the invention of life-supporting technology, the alternatives and costs increased, and decisions became more complicated. The new systems require specialization, leading to fewer family physicians with a long-term physician-patient relationship. This depersonalization of medicine was compounded by urbanization and reimbursement changes. The relatively new intensivist and hospitalist positions remove patients even further from a primary relationship. Health care was increasingly delivered by strangers to persons without a powerful social network. When medicine was less effective, paternalism failed to receive a big challenge; without effective treatments, kindness and caring were indeed the best medicine.

The ethics of who has the right and authority to create decisions, the propriety of these choices, access to care, and ethics surrounding research assumed increasing

importance. In those nations with a dominant theocracy, religion has often provided direction or resolution to moral dilemmas. However, there was essentially no precedent for these dilemmas, and most of the globe lacked one authority. Particularly in pluralistic regions without a unified religion, language, or culture, there has been confusion about authority for addressing these issues, as well as the actual decisions themselves.

Technological progress has been matched by social change [11]. People are less willing to just accept without question the choices of these who exercise power, be they judges, politicians or doctors. Paternalism is out of fashion. Lawyers and philosophers, to not mention parents, wonder why the doctor is best qualified to guage whether a baby's quality of life is like to create life-saving surgery desirable. The power of the doctor to finish life, whether by switching off a ventilator, or by deciding to not put a patient on the active transplant list, disturbs us all. These moral dilemmas are even as acutely felt by doctors. Their difficulties are accentuated by the very fact that the new technology can't be made available to any or all those in need. There's just not enough money or resources within the NHS. Above all, the health profession today faces a society more deeply divided on virtually every moral question than ever before. The general public demands a say in medical decision-making on sensitive ethical issues. Yet from the new potato of whether doctors should help couples to own a 'saviour sibling' to assist their dying child, through to the debates on abortion to euthanasia, the doctor who seeks guidance from public opinion will discover division, bitterness and confusion.

Law

As well as being under a duty to not harm, doctors even have a robust ethical and legal duty to respect the individual autonomy of their patients [12]. This so-called principle of respect for individual autonomy is arguably the foremost central ethical principle in modern medical ethics. It requires health care professionals to respect the authentic choices of their patients about their medical treatment. This implies that if the choice regarding treatment is created by a patient who has the requisite mental capacity to be able to make a choice about their treatment and therefore the relevant information and freedom to create this choice, the decision must be respected by health care professionals, whether or not it seems foolish or unwise to others. The reason why respect for individual autonomy is seen as so fundamental, ethically (and legally) speaking, is that it enables individuals to own control over their own lives. Indeed, this ability to be in control of our own lives is seen to be more important than being protected from the possible harmful consequences of our choices. It's this ethical principle of respect for individual autonomy that underpins the law on consent to treatment in most jurisdictions, making it electric battery to treat without or against a competent patient's consent to the present treatment. Thus, farewell as a patient demonstrates that they need the requisite mental capacity, aren't unduly influenced and have and understand the relevant information, their choices to refuse even lifesaving treatment must be respected.

However, if it is shown that a patient doesn't have the requisite intelligence to produce a sound consent to treatment or refusal of treatment, then the principle of respect for individual autonomy no longer requires that we respect their decisions. This ethical principle only requires that health care professionals respect authentic decisions – that's, decisions that we believe the patient has the mental capacity, information, freedom, and so on, to make. those that don't have the requisite capacity to create decisions about their treatment – as an example, young children, unconscious individuals, individuals whose capacity to process information has been compromised by a psychiatric illness – should be treated in what's considered to be their best interests, so as to protect them from harm.

CONCLUSION

Medical ethics is a professional ethic that applies ethical norms in medicine. As the first contractual relationship between doctor and patient, the Hippocratic oath is taken, with which medicine gets a special place and is separated from magic and abstract speculation. Already Hippocrates sets out certain principles and characteristics without which a physician cannot and must not perform his duty. As treatment is the basic purpose of medicine, medical ethics sets out the principles of respecting life and doing good for man. Medical ethics is the oldest professional ethics in the world. Since the last century, mainly due to technological advances in medicine, it is gaining in increasing importance. As a special ethic, medical ethics is based on an ethical consideration of medical issues.

REFERENCES

1. Post, L. F., & Blustein, J. (2007). „Handbook for Health Care Ethics Committees, Second Edition", Johns Hopkins University Press, Baltimore, USA, pp. 4.
2. Fletcher, L., & Buka, P. (1999). „A Legal Framework for Caring - An Introduction To Law And Ethics In Health Care", Macmillan Press, Basingstoke, UK, pp. 19-20.
3. Krause, F., & Boldt, J. (2018). „Understanding Care: Introductory Remarks" in Krause, F.; Boldt, J. (eds): „Care in Healthcare - Reflections on Theory and Practice", Palgrave Macmillan, Springer International Publishing AG, Cham, Switzerland, pp. 1-2.
4. Agich, G. J. (2003). „Dependence and Autonomy in Old Age - An Ethical Framework for Long-term Care", Cambridge University Press, Cambridge, UK, pp. 71.
5. Fritz, Z. (2019). „End of Life" in Sturgess, J.; Duane, D.; Ley, R. (eds): „A Medic's Guide to Essential Legal Matters", Oxford University Press, Oxford, UK, pp. 77-84.

6. Gisondi, M. A. (2005). „Ethics and end-of-life issues" in Mahadevan, S. V., Garmel, G. M. (eds): „An Introduction to Clinical Emergency Medicine", Cambridge University Press, Cambridge, UK, pp. 653.
7. Bowling, A. (2014). „Quality of life in healthcare decisions" in Rai, G. S. (ed): „Medical Ethics and the Elderly, Fourth Edition", Radcliffe Publishing Ltd, London, UK, pp. 179.
8. Miller, F. G., & Truog, R. D. (2012). „Death, Dying, and Organ Transplantation - Reconstructing Medical Ethics at the End of Life", Oxford University Press, New York, USA, pp. 20-21.
9. Farrell, A. M. (2017). „Organ and Tissue Donation and Transplantation" in Farrell, A. M., Devereux, J., Karpin, I., Weller, P. (eds): „Health Law - Frameworks and Context", Cambridge University Press, Cambridge, UK, pp. 228.
10. Cotler, M. P. (2013). „Clinical Bioethics and Its Interface with Legal Medicine" in Beran, R. G. (ed): „Legal and Forensic Medicine", Springer-Verlag Berlin Heidelberg, Berlin, Germany, pp. 4.
11. Brazier, M., & Cave, E. (2016). „Medicine, Patients and the Law, Sixth Edition", Manchester University Press, Manhester, UK, pp. 64.
12. Smith, R. C. (2013). „Body Integrity Identity Disorder: a problem of perception?" in Alghrani, A., Bennett, R., Ost, S. (eds): „ Bioethics, Medicine and the Criminal Law - Volume 1, The Criminal Law and Bioethical Conflict Walking the Tightrope", Cambridge University Press, Cambridge, UK, pp. 76.