THE CONSEQUENCE OF CONFIDENTIALITY IN MEDICAL PRACTICE

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BEING A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF PHILOSOPHY, FACULTY OF ARTS, UNIVERSITY OF BENIN, BENIN CITY, EDO STATE.

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF BACHELOR OF ARTS (B.A HON) DEGREE IN PHILOSOPHY

MAY, 2021

DECLARATION

I hereby declare that this work entitled "The Consequence of Confidentiality in Medical Practice" is a research carried out by me. All sources consulted are acknowledged and properly documented. Therefore, I attest that the record of this work is the effort of my research and I would be accounted to all information provided therein.

Fadairo Anthony Adewunmi	**……..……**	**…….**
Student	**Signature**	**Date**

CERTIFICATION

This project has been read and approved as meeting the requirements and regulations of the Department of Philosophy, Faculty of Arts, University of Benin, Benin City.

Prof. P. F. Omonzejele	----------	----------
Supervisor	Signature	Date

Dr. S.I. Odia	----------	----------
(Ag) Head of Department	Signature	Date

…….
External Examiner

DEDICATION

This project is dedicated to God Almighty whose infinite love, mercy and grace saw me throughout the course of this study. I therefore return all glory to Him for all His countless grace.

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Abstract

This study is a philosophical examination into the problems and challenges of the consequence of confidentiality medical practice. Historically, particularly, with the time of Hippocrates, medical practice began to be seen as an organized profession guided by some ethical rules and norms. Certain conditions were set and required to be met or sustained in the practice of medicine. One of such principles and rules was/is the importance of confidentiality of doctor-patient's relationship. The principle of confidentiality admonishes physicians to adhere and maintain the right of keeping patient's health record(s) secret and that only the patient is expected or allowed to be disclosed with the true nature or status of his or her health situation. In other words, the principle of confidentiality in medical practice argues that doctors are obligated never to disclose the health status of his or her patient to a third party but must always respect the ethical law of confidentiality by ensuring that the health result or report of the patient is been disclose to another person neither to be made available to the general public or to the community. Ironically, keeping to the tenet of this principle or this ethical law appears to be elusive today as there evidences of the violations of this ethical law. There are debates today among ethicists as to whether should this ethical norm be continually adhered to at all course and in all situations. Some medical practitioners have argued that such ethical norm be abolished; others continued to argue in support of keeping to this norm. In order to argue against or in defense of the practice of confidentiality in medical practice, different moral theories have been employed by different moral philosopher in defense for and against it. Such theories may include Deontologism, Consequentialism, Emotivism, Situationism, and many others. In this study however, the moral theory of situationism was adopted and the study posits that while the ethical norm of confidentiality is plausible, it is however, not without some challenges. Thus, the study concludes that in keeping to the consequence of confidentiality in medical practice, certain situations much be given considerations.

CHAPTER ONE

1.0 GENERAL INTRODUCTION

1.1 Background to the Study

In recent times, one of the most perplexing puzzles in the study of ethics is the problems and challenges of the principle of confidentiality in biomedical ethics. While ethics, on the broad-based can be viewed as the study of actions taken by moral agents, to determine if they are good (praiseworthy) or bad (blameworthy), bioethics on the other hand, specifically focuses on the rightness and wrongness of actions in the attitude of experts and professionals in their relationship with their patients, especially within the medical profession and practice. Broadly speaking, bioethics is a branch of 'applied ethics' which requires the expertise of people working in a wide range of disciplines including law, philosophy, theology, medicine, the life sciences, nursing and social science. It is the interdisciplinary study of problems created by biological and medical progress and its impact in society and value system, both for now and for the future. According to Daniel "The word is made up of two parts: 'bio' (from the Greek word for life) and 'ethics', so it is the study of ethics as it relates to living things. It includes the study of values relating to primary care and other branches of medicine."[1] To further substantiate the nature and thrust of bioethics as a branch in the study of ethics, Daniel opines that:

> Bioethics includes the study of what is right and wrong in new discoveries and techniques in biology, such as genetic engineering and the transplantation of organs. It is concerned with questions about basic human values such as the rights to life and health, the rightness or wrongness of certain developments in healthcare institutions, life technology, medicine, the health professions and about society's responsibility for the life and health of its members.[2]

Bioethics is a study of philosophy as well as a study of biology. Bioethics deals with the ethical implications of biological research and applications especially in medicine. Bioethics has an impact on every level of human community from the local nursing home to the huge international conferences on issues like the Human Genome. It is concerned with what ought to be done when dealing with or taking care of people and other living creatures. It enquires into the questions about values and what matters in medicine, biological research and care of people who cannot speak up for themselves; such as the mentally ill, small children or prisoners. This project however does not intend to consider all of the ethical actions within the various disciplines under bioethics. It is the thrust of this study however to pay attention on the problems of confidentiality within the practice of medicine.

Historically, until 1803 there was no particular reference to medical ethics as an acceptable or official sphere in the study of ethics. Although medical ethics and practice has long been in existence and is said to be traced to Hippocrates, it was however, an English physician Thomas Percival in 1803 who actually first published a document describing the requirements and expectations of medical professionals within medical

practices. For anyone to be qualified to undertake the practice of medicine, certain requirements were set to be met. One of these requirements and expectations was/is the establishment of the principle of confidentiality between the medical professionals and their patients. It is in this area that the trust of this project was spurred. Jonsen Siegler and Winslade contend that; "Traditionally, medical ethics has viewed the duty of confidentiality as a relatively non-negotiable tenet of medical practice. Among the medical professionals, confidentiality is an important issue in primary care ethics, where physicians care for many patients from the same family and community, and where third parties often request information from the considerable medical database typically gathered in primary health care."[3] Confidentiality is one of the core duties of medical practice. It requires health care providers to keep a patient's personal health information private unless consent to release the information is provided by the patient. It can further be expressed that the idea of confidentiality in medical practice is commonly applied to conversations between doctors and patients. This concept is commonly known as patient-physician privilege. Legal protections prevent physicians from revealing their discussions with patients, even under oath in court. According to Jonsen Siegler and Winslade "The obligation of confidentiality prohibits the health care provider from disclosing information about the patient's case to others without permission and encourages the providers and health care systems to take precautions to ensure that only authorized access occurs."[4]

Jonsen Siegler and Winslade further reported that as contained in the Health Information Portability and Accountability Act of 1997 (HIPAA), it is stressed that; "institutions are required to have policies to protect the privacy of patients' electronic information, including procedures for computer access and security."[5] It is specifically spelt out in the Medical Oath Taking that all medical practitioners shall respect the autonomy of their patient; observe the principle of non-maleficence, take into cognizance the principle of beneficence and do justice to all patients who come for medical examination and diagnosis without fear or favour.

Unfortunately, these rules and maxims seem to have been neglected and no longer adhered to by medical experts. This particular rule of medical ethics seems to be totally adhered to within the medical practice. Most of the medical doctors or physicians no longer treat none still adhere to these core values and tenets of medical ethics, especially as it pertains to the principle of maintaining confidentiality between himself and the patient at all times and course.

1.2 Statement of the Problem

In bioethics, one of the fundamental problems that has continued to generate mix feelings and reactions is the issue of doctors' quest to maintain and keep the information of their patients private from a third (party); otherwise known as the rule of confidentiality. Basically, fundamentals to the study of bioethics are the adherence to four basic principles which serve as guide to all medical health care providers (doctors) in the discharge of their duty to their patients. As earlier stated in the background to the study,

early founders of bioethics put forth four principles which form the framework for moral reasoning. These principles attempt to describe a set of minimum moral conditions on the behaviour of health care professionals. These principles as enshrined in the traditional medical book of oath of code of conduct. These principles include; The Principle of Respect for Autonomy, The Principle of Non-maleficence, The Principle of Beneficence and The Principle of Justice.

Ironically, these principles are hardly observed without some contradictions and criticisms. Most medical experts today, no longer keep to these basic fundamental principles of medical ethics which emphasized on confidentiality as its prima facie. Doctors are by this oath of confidentiality obligated and duty bound at all times to keeping information about their patients private. In most cases, either one or all of these principles have been violated by physicians. The principle of respect for the autonomy of the patient, non-maleficence, beneficence and justice has been severally violated as medical professionals have deviated from the core value of these principles. Also, there are reported cases of deliberate cause of harms inflicted on the patients by their medical consultants and there are instances or cases where the doctors no longer relate fairly with their patients but rather increase their burdens and pains. These violations of ethical norms and rules within the medical practice are major problems in the study of bioethics, hence the need to undertake this project.

1.3 Aim and Objectives of the Study

The main aim of this study is to evaluate the consequence of confidentiality in medical practice. The specific objectives of the study are to:

i. Fill the gap in the literature review of scholarly works to be reviewed on the problems of confidentiality in bioethics.

ii. Trace and discuss the historical development, nature and meaning as well as the various theories of ethics.

iii. Expose the strengths and weaknesses in the debate for and against the practice of confidentiality in medical profession.

iv. Establish and make recommendations on the relevance of bioethics to the study of ethics as a disciplines or field of study.

1.4 Method of the Study

To undertake a proper investigation into the aforementioned problems and objective of the study, the method of critical analysis and evaluation would be adopted. In a more clear term, the researcher will adopt textual analysis and expository methods as its precedence. With these methods, the entire edifice of the research problems is to be x-rayed and diagnosed.

1.5 Scope and Limitations of the Study

One of the ways to situate a given research in its proper perspective lies in its scope. The scope(s) of any study, no doubt, is/are deduced based on the research topic and problem. This study, no doubt, revolves around many branches of philosophy such as

ethics, political philosophy, epistemology and philosophy of law. An investigation into the study of confidentiality in medical practice falls within the purview of bioethics. Bioethics is a branch of ethics concerned with the study of life. Again, the scope of the study also encompasses the areas of socio-political philosophy and epistemology. This is because its scope of operation and investigation has it relevance in the area of politics and its contributions to the area of epistemology. Apart from its related areas of covering, the scope of this study therefore is specifically limited to moral philosophy.

For coherence and systematic presentation of thoughts, this work is organized into Chapter's based-order. Each Chapter has its theme and subthemes. Thus, for the success of this study, the entire structure of the work is arranged into Four Chapters. Chapter One covers the general introduction. Here, we looked at the background of the study, statements of the problem, aim and objective of the study, significance of the study, the ongoing scope and limitation of the study, method of the study, definition of terms and the literature review. Chapter Two, is on the Development, Nature and Theories of Ethics. It subthemes include The Nature, Scope and Meaning of Ethics, Historical Development to the Study of Ethics, Ethics and Morality: The Nexus, Some Theories of Ethics, Deontology, Virtue Ethics, Normative Ethics, Utilitarianism and Consequentialism

Chapter Three examines the Consequence of Confidentiality in Medical Practice. To undertake as well as to successfully achieve this thrust, the researcher further divided this Chapter with the following subtitles; Historical Antecedents to Medical Ethics, Approaches to the Study of Medical Ethical Ethics, Principles of Bio-Medical Ethics,

Challenges and Problems of Confidentiality in Bio-Medical Ethics and The Ethical Implications of Confidentiality in Medical Practice. Finally, Chapter Four focuses on the Evaluation, Conclusion and Recommendations.

1.6 Significance of the Study

No academic exercise worth its value without its contribution(s) to knowledge. However, significant of a given study depends on its areas of research problem and the nature of solution its proffer. This work, no doubt shall be significant in the following ways:

- The discussions and findings of this study will enable us ascertain the importance of confidentiality; not just in medical practice but in almost all areas of human endeavours.
- Again, the study shall be significant as it would expose its readers with some general knowledge, principles and practices in medical profession.
- The study will supply the general public with the awareness of the weaknesses and strengths associated with the practice of medicine.
- Through its historical exposition, the researcher will be able to have a good comparison between the practice of medicine in the past and the present.
- Finally, the study will immensely be of great contribution to academia and researchers, especially, subsequent researchers in the Department of Philosophy and related disciplines who may embark on the same or related topics in the nearest future. Thus, it will add to other relevant materials in the library on

medical ethics, and it will serve as reference materials to subsequent researcher (s).

1.7 Literature Review

This section focuses on review of relevant literature which generally bothers on the issues and the studies of bioethics, as well as the problems of confidentiality in medical practice. The thrust and the intention of this review is to enable the researcher have broader knowledge and understanding of the subject matter under investigation. The second expectation of this review is to enable the researcher fill the gap in previous studies which will serve as the contribution and significance of this project. Having said this, let us avail ourselves with the thought by Beauchamp. In his study, Beauchamp begins with a quest into the history of the development of bioethics. In his opening remark, Beauchamp opines; "The term medical ethics first dates back to 1803, when English author and physician Thomas Percival published a document describing the requirements and expectations of medical professionals within medical facilities. The Code of Ethics was then adapted in 1847, relying heavily on Percival's words. Over the years in 1903, 1912, and 1947, revisions have been made to the original document."[6] As Beauchamp posited above, the actual official date of the development of medical ethics dates back to 1803. It is revealed according to Beauchamp above that Thomas Percival was the first English physicians to have coined and published an articulated document on medical ethics. However, in a separate research, Fabrice observed that the history of

Western medical ethics is traced to the aphilosopher and physician, Hippocrates. In his assertion, Fabrice writes thus:

> Historically, Western medical ethics may be traced to guidelines on the duty of physicians in antiquity, such as the Hippocratic Oath, and early Christian teachings. The first code of medical ethics, *Formula Comitis Archiatrorum*, was published in the 5th century; during the reign of the Ostrogothic King Theodoric the Great.[7]

Central to the above quotation is the fact that Hippocrates is actually known and accepted as the father of medicine. Among medical profession, the oath that they take is named and linked to Hippocrates; the Hippocratic Oath. In addition, the first medical code of ethics is contained in a document entitled; *Formula Comitis Archiatrorum.* This medical document as stated by Fabrice above was first published in the 5th century during the reign of King Theodoric the Great. Thereafter, especially from the modern period through the contemporary period, medical ethics has taken a new dimension and emerged with a different consciousness and orientation. In with this opinion, Fabrice further traces that; "By the 18th and 19th centuries, medical ethics emerged as a more self-conscious discourse. In England, Thomas Percival, a physician and author, crafted the first modern code of medical ethics. He drew up a pamphlet with the code in 1794 and wrote an expanded version in 1803, in which he coined the expressions "medical ethics" and "medical jurisprudence."[8]

In a study conducted, Beauchamp and Childress opine that; "Medical professionals are obligated to protect the confidentiality of their patients. The duty to

ensure discretion and confidentiality in the medical profession is morally justified based on the rights arising from relationships, and medical practice involves trust relationships with both patients and society."[9] This duty of confidentiality provides a fundamental basis for the existence of some level of trust in the doctor-patient relationship. These ebullient scholars further explained that; "From the ethical point of view, respect for the principles of beneficence, non-maleficence and also autonomy is recognized as a major justification for maintaining patient confidentiality, based upon a fundamental consideration for persons."[10] As evident from the above, within the medical profession, it is a duty and an obligation for the doctors to protect the confidentiality of their patients. The physicians therefore owe it a duty to maintain this obligation. On the importance of maintaining this right to confidentiality, Beauchamp and Childress went on to argue that:

> Respect for confidentiality is important to safeguard the well-being of patients and ensure the confidence of society in the doctor-patient relationship. Health information is not only based on objective observations, diagnoses, and test results, but also subjective impressions about the patient, their lifestyle, habits, and recreational activities. The improper disclosure of such highly sensitive information could harm patients' reputation or result in lost opportunities, financial commitments, and even personal humiliation. This obligation is stringent but not unlimited.[11]

Unfortunately, the important of this obligation seems to have been neglected or overlooked by most of the contemporary medical practitioners. There are some who see Percival's guidelines that relate to physician consultations as being excessively protective of the home physician's reputation. Jeffrey Berlant is one such critic who considers

Percival's codes of physician consultations as being an early example of the anti-competitive, 'guild'-like nature of the physician community. According to Beauchamp and Childress; "since the mid-19th century up to the 20th century, physician-patient relationships that once were more familiar became less prominent and less intimate, sometimes leading to malpractice, which resulted in less public trust and a shift in decision making power from the paternalistic physician model to today's emphasis on patient autonomy and self-determination."[12] hese scholars observed that as at today, the rules of engagement has changed. This is because amongst the medical physicians today, there both the student or doctors and those who have not actually attained all satisfactory requirements for practicing medicine. In his submission, McNamee avers:

> Medicine today is practiced by healthcare teams formed not only by physicians, residents, and nursing staff, but also nursing assistants, orderlies, administrative personnel, and even students. Patients should be aware of the large number of people in hospitals who need to access their medical records to provide the best possible health care , which consists in obtaining an accurate diagnosis, providing the appropriate treatment, as well as receiving the necessary training to do so. It is for this reason that hospital personnel are required to protect patient confidentiality.[13]

They conclude by asserting that breaches of confidentiality in clinical practice due to carelessness, indiscretion, or sometimes even maliciously, jeopardize a duty inherent in the doctor-patient relationship. Careless behavior, such as speaking about patients in public spaces like elevators and cafeterias, during telephone conversations, or even when accessing electronic data, can result in breaches of patient confidentiality.

McNamee observes that today; “Bioethicists come from a wide variety of the backgrounds and have training in the diverse array of disciplines. The field contains individuals trained in philosophy and other disciplines of studies.”[14] Biomedical ethics was in the past dominated by moral thinks within the discipline of philosophy but with times, it eventually becomes an interesting area of research among those in the sciences, social sciences, psychology, sociology and other field of studies. Sharing common ground on this idea with McNamee, Waller maintains inter alia; “The field, formerly dominated by formally trained philosophers, has become increasingly interdisciplinary, with some critics even claiming that the methods of analytic philosophy have had a negative effect on the field's development.”[15] There are several books, Journals and articles on bioethics today. According to Waller; “Bioethics has also benefited from the process philosophy developed by Alfred North Whitehead. Another discipline that discusses bioethics is the field of feminism; The International Journal of Feminist Approaches to Bioethics has played an important role in organizing and legitimizing feminist work in bioethics.”[16] The recognition and adoption of bioethical ethics and its penal codes gradually became enshrine in the United Kingdom and United States of America in 1847 and 1815, respectively. Waller captures this thought as he puts it thus:

> In 1815, the Apothecaries Act was passed by the Parliament of the United Kingdom. It introduced compulsory apprenticeship and formal qualifications for the apothecaries of the day under the license of the Society of Apothecaries. This was the beginning of regulation of the medical profession in the UK. In 1847, the American Medical Association adopted its first code of ethics, with

> this being based in large part upon Percival's work. While the secularized field borrowed largely from Catholic medical ethics, in the 20th century a distinctively liberal Protestant approach was articulated by thinkers such as Joseph Fletcher. In the 1960s and 1970s, building upon liberal theory and procedural justice, much of the discourse of medical ethics went through a dramatic shift and largely reconfigured itself into bioethics.[17]

Furthermore, Confidentiality is mandated in the United States by the Health Insurance Portability and Accountability Act of 1996. Specifically the Privacy Rule, and various state laws, some more rigorous than Health Insurance Portability Accountability Act. However, numerous exceptions to the rules have been carved out over the years. For example, many states require physicians to report gunshot wounds to the police and impaired drivers to the Department of Motor Vehicles. Confidentiality is also challenged in cases involving the diagnosis of a sexually transmitted disease in a patient who refuses to reveal the diagnosis to a spouse, and in the termination of a pregnancy in an underage patient, without the knowledge of the patient's parents. Many states in the U.S. have laws governing parental notification in underage abortion. Those working in mental health have a duty to warn those who they deem to be at risk from their patients in some countries.

Anthony in his study tells us that; “Patients have a right to privacy that should not be infringed without informed consent. Identifying information should not be published in written descriptions, photographs, and pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written

informed consent for publication. Informed consent for this purpose requires that the patient be shown the manuscript to be published."[18] He further insists that; "Identifying details should be omitted if they are not essential, but patient data should never be altered or falsified in an attempt to attain anonymity. Complete anonymity is difficult to achieve, and informed consent should be obtained if there is any doubt. For example, masking the eye region in photographs of patients is inadequate protection of anonymity."[19] The requirement for informed consent should be included in the journal's instructions for authors. When informed consent has been obtained it should be indicated in the published article. In line with this, Antony further raises a crucial observation by stating with question thus:

> If a patient is recognized or recognizes him or herself in a case study, what are the harms that may occur? The main harm is the experience of violation of privacy that comes from having information that was given in confidence disclosed in the public arena. However, it is not clear how this works in practice if there has been some anonymization so that an individual may recognize that this case is *like* their case, without being certain this is *indeed* their case. If the case is of a type that may be common to several unconnected people, and there is nothing to link it with a specific individual, then there may be no breach of confidentiality in the sense of having the *personal* details of the patient entering the public domain without consent.[20]

The central point to take cognizance of in view of the above quotation is that confidentiality as a maxim in medical practice emphasizes on keeping patient's information private and that there should be no patient's information to be made public without prior consent or knowledge of the said patient involved. Violations of patient's

medical right are said to occur when any physician or doctor under any circumstance published information about a particular patient without an informed consent of the patient. People may think they recognize themselves or someone they know, but it is not clear that the privacy objection holds if no one realizes, or can be certain, that the information is about a specific person. There are, however, difficulties with this reasoning. According to Antony:

> The first is that the biggest indicator that a case is about a particular individual is the geographical location of the author and their name. Anonymous authorship is unlikely to be attractive to many authors, as they belong to a system that largely measures the value of academics (and their institutions) by publication output. Second, what makes at least some of the cases so useful is that they are novel, and therefore the information might only match one individual.[21]

Perhaps more importantly, there are dangers if we think that the only harm from a breach of confidentiality is *experience* of violation of the privacy of specific individuals, as on this line of reasoning, no harm would be done if the person never found out, either through chance or because they are not capable of knowing. This would offer no protection to the incompetent, the deceased, and others. We need to find a balance between protecting privacy to the extent that no personal data; anonymous or otherwise, enters the public arena without consent and assessing violation of privacy only in terms of being able to recognize personal data. There is no doubt that patients routinely share personal information with health care providers. However, if the confidentiality of this information were not protected, trust in the physician-patient relationship would be

diminished. Patients would be less likely to share sensitive information, which could negatively impact their care. On the importance of confidentiality in medical ethics, Anniok argues that; "Creates a trusting environment by respecting patient privacy, encourages the patient to seek care and to be as honest as possible during the course of a health care visit. It may also increase the patient's willingness to seek care."[22] For conditions that might be stigmatizing, such as reproductive, sexual, public health, and psychiatric health concerns, confidentiality assures that private information will not be disclosed to family or employers without their consent. While keeping of confidentiality at all times and course is recommended, there are instances or situations where a physician is however permitted to share the information about a particular patient. This is done most times to avert further harms to other sin the society or within the community. Thought is collaborated by Anniok as follows:

> In situations where you believe an ethical or legal exception to confidentiality exists, ask yourself the following question: will lack of this specific patient information put another person or group you can identify at high risk of serious harm? If the answer to this question is no, it is unlikely that an exception to confidentiality is ethically or legally warranted. The permissibility of breaching confidentiality depends on the details of each case. If a breach is being contemplated, it is advisable to seek legal advice before disclosure.[23]

We may agree about our substantive moral commitments and our prima facie moral obligations of respect for autonomy, beneficence, non-maleficence, and justice, yet we may still disagree about their scope of application-that is, we may disagree radically about to what or to whom we owe these moral obligations. Interesting and important

theoretical issues surround the scope of each of the four principles. We clearly do not owe a duty of beneficence to everyone and everything; so whom or what do we have a moral duty to help and how much should we help them? While we clearly have a prima facie obligation to avoid harming everyone, who and what count as everyone? Similarly, even if we agree that the scope of the principle of respect for autonomy is universal, encompassing all autonomous agents, who or what counts as an autonomous agent? Who or what falls within the scope of our obligation to distribute scarce resources fairly according to the principle of justice? These are other countless questions bother on the discussion into the law of confidentiality in medical practice.

Again, Emmanuel in his study argues that there cases or situations where information about a patient can be revealed or relates to another. One of such situations is when the patient grants his or her consent to the physician or the doctor to do so. This can be clearly read in the following passages as Emmanuel writes; "Allowances are made in medical practice. When a patient agrees to the disclosure of confidential information viz. informed consent, and when the transfer of medical records is medically justified such as conveying information that is relevant to a patient's continuity of care to medical colleagues, such occasions constitute exceptions to the duty of confidentiality in professional practice."[24] However, there are other instances in which the release of medical information is justified both ethically and legally. Emmanuel however recognizes that respect for patient's privacy and confidentiality is a duty that doctors must adhere to. He also traced that this obligation has long been in existence. In support

of his thought, like most notable scholars reviewed above, Rogers and Clinton submit inter alia:

> Respect for patient confidentiality, as well as privacy, have long been recognized as basic tenets of medical practice. In the famous Oath credited to Hippocrates (4th century BCE), his followers swore confidentiality, 'all that may come to my knowledge in the exercise of my profession, or outside of my profession, or in daily commerce with men, which ought not to be spread abroad, I will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot'. [25]

Hippocratic physicians also pledged to maintain patient privacy: "Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private. Continuing the tradition of respecting patient privacy, the 2006 revision of the World Medical Association's Declaration of Geneva contains the statement: 'I will respect the secrets which are confided in me, even after the patient has died. If doctors do not keep patient confidences, then patients will not trust doctors with their personal information. Without personal information, a doctor cannot effectively practice the science and art of medicine.

To sum up Rogers and Clinton concludes that; "Some patient records contain an abundant amount of intimate personal information, and most of it may be greatly detailed. While the amount of information may differ to some degree, information of any type that relates to a patient should be regarded as confidential."[26] It is vital to keep in mind that

identifiable personal data, as well as medical information, is recorded. This information could severely harm patients in the wrong hands. As we have shown, medical confidentiality remains a vital part of ethical professional practice and it is likely that it will remain so. However, the desired to keep to these rules of ethical practice has been a controversial challenge. Maintaining patient's confidentiality has been a difficult task to fulfill in contemporary medical practice. In Chapter Three we shall look into the consequences of confidentiality in medical practice. But before we arrive at this, in the immediate Chapter (Chapter Two), we shall continue with a broad study and exposition of the development, nature and theories of ethics. This will also enable us to appreciate as well see which of these theories can be applied to the study of confidentiality in medical ethics.

Endnotes

1. D. Daniel. Practical Medical Ethics. New Jersey: John Wiley Publications, 1992), pp.67.

2. Ibid. pp. 68-69.

3. A. Jonsen M. Siegler and W. Winslade *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine. 7*th ed. (New York: McGraw-Hill; 2010), p.302.

4. Ibid. p. 304.

5. Ibid. ibid. 305.

6. Beauchamp, L. Tom. *Philosophical Ethics: An Introduction to Moral Philosophy*, 2nd Ed. (New York: McGraw Hill, 1991), p. 171.

7. J. Fabrice. "The Hippocratic Oath and Contemporary Medicine: Dialectic Between Past Ideals and Present Reality." In: *The Journal of Medicine and Philosophy*. Vol. 30, No. 33, 2005, 234-245.

8. Ibid. p. 246.

9. T. Beauchamp, J. Childress. *Principles of Biomedical Ethics*. (New York: Oxford University Press, 1979), pp. 80-81.

10. Ibid. p.83.

11. Ibid. pp.83-84.

12. Ibid. p.84.

13. T. McNamee. "Time for a Unified Approach to Medical Ethics." In: L. Gideon (ed.) Philosophy, Ethics, and Humanities in Medicine. (Australia: Giant Academic Inc., 2009), pp. 60-61.

14. Ibid. p.63.

15. Waller, N. Bruce. *Consider Ethics: Theory, Readings, and Contemporary Issues*. (New York: Pearson Longman, 2005), p. 23.

16. Ibid. pp. 23-24.

17. Ibid. p.27.

18. Flew, Antony. "Consequentialism." In: S. Martins (ed.) *A Dictionary of Philosophy*. (New York: Brace and Orbit, 2003), p. 73.

19. Ibid. p.74.

20. Ibid. pp.74-75.

21. Ibid. p. 77.

22. P. Anniok. *Ethics: Dilemmas for Medical Students and Doctors in Training*. (Cambridge: Cambridge University Press, 2001), p. 50.

23. Ibid. p. 53.

24. E. Emmanuel. "Critical Issues in Contemporary Ethics." In: Ted Honderich, (ed.), *The Oxford Companion to Philosophy*. (Oxford: Oxford University Press, 1995), pp. 187-188.

25. D. Rogers and S. Clinton. "The Patients and the Doctocs." In; L. Samuel ed. *Contemporary Discourse in Professional Ethics*. (New York: Pearson Longman, 2013), p. 55.

26. Ibid. p. 57.

CHAPTER TWO

2.0 THE DEVELOPMENT, NATURE AND THEORIES OF ETHICS

2.1 The Nature, Scope and Meaning of Ethics

The word Ethics is derived from the Greek word 'ethos' which means character or conduct. Ethics is also called as moral philosophy or philosophical thinking about morality. This morality has been further elaborated as action and behaviour which is concerned with 'good' or 'evil', of particular traditions, groups or individual. Ethics is the philosophical study of morality. It is one of the main branches of philosophy which corresponds to the traditional division of philosophy into formal, natural and moral philosophy. It can be turned into a general study of goodness, right action, applied ethics, meta-ethics, moral psychology and metaphysics of moral responsibility. The general study of the rightness and wrongness of human actions is the main task of ethics. It has correlatively its substantive questions such as; what is morality? How do we determine the rightness and wrongness of our human actions? Who determines when an action is morally right or wrong? Are we rational beings and what moral principles should govern our choice and pursuit? These questions are ethical concerns and are fundamental to the study of morality.

According to Carlin; "Ethics is that science which is concerned with moral behaviour or with right or wrong and good or evil of human behaviour. It propounds those principles which make our conduct moral. It becomes clear when we explain the derivation of the words right and good. The word right is derived from Latin word

'rectus', which literally means straight or according to rule."[1] This further implies that we are concerned with those principles which make our conduct right or straight. The scope of ethics includes its own subject-matter. Ethics is a normative science that deals with moral ideals or good in the nature of our conduct. Harrison and Williams in their study advances that ethics; "As a science of morality it does not enquire into the origin of human conduct but emphasizes on the contents and various problems of moral consciousness like motives, intentions, voluntary actions and so on. Every science and subject has got a fixed area of study. It moves within the ambit of that subject matter."[2] Ethics has also an area of study. The problem of ethics is related to our daily life. It is one of the important fields of study in modern times and without morality no human institution can progress. Ethics is a study of those cherished ideals and values which is vital for the growth, development and progress of human society. It is a matter of regret that people have forgotten the higher values of life and are hankering after power and money.

As briefly explained above, the nature of ethics encompasses its fundamental thrust for the rightness of the conduct of human actions. Ethics tries to guide us to avoid all actions that are harmful to the individual and the society at large. It sets certain standards for our actions. It promotes good actions for the benefit of all and discourages wrong actions for the interest of the society at large. It generally examines and investigates all actions performed by human beings. Its (ethical) scope is circumvents around the study of morality. And as defined above; it is the study of human conducts. It

is the science of human actions. Hence, having briefly stated this, let us avail ourselves with a historical study into the development of ethics. We proceed on this.

2.2 Ethics and Morality: The Nexus

Within the intellectual circle, especially in everyday language, the distinction between the terms 'ethics' and 'morality' is not always clear. Even in some philosophical texts both are used synonymously, while others seem to draw a clear distinction between them. Historically, the term 'ethics' comes from Greek ethos which means the customs, habits and mores of people. 'Morality' is derived from Latin mos, moris which denotes basically the same; it was introduced by Cicero as an equivalent to the Greek ethos. For the sake of clarity we assume as a standard definition that morality means the customs, the special do-s and don't-s that are shared and widely accepted as standard in a society or community of people accepted as a basis of life that doesn't have to be rationally questioned. Ethics on the other hand is the philosophical reflection upon these rules and ways of living together, the customs and habits of individuals, groups or mankind as such.

In no doubt, the study of the questions of rightness and wrongness, good and bad, ought and ought not are of utmost important and cannot be over emphasized. These issues are both questions of morality and ethics. This interplay between morality and ethics makes some individuals to mistake one for the other. In this sense, Dipo Irele clarifies that "the words, ethics and morality are used interchangeably but there is a subtle difference between the words. Ethics is the study of what constitutes good and bad human conduct, including related actions and values."[3] Furthermore, Dipo continues by

saying that “ethics and morality are usually used to refer to human conduct itself. Ethics has its root in the Greek word Ethos which means character. Morality comes from the Latin word Moralis which means customs or manners.”[4] Again, it is important to note that ethics refers to an objective inquiry into morality which is concerned with human conduct. To further buttress the relationship between ethics and morality, Joseph Omoregbe says; “Ethics presupposes that we already have a sense of morality, and it is the systematic study of the fundamental principles underlying our morality. Hence morality is the basis of ethics; the latter is the explicit reflection on and the systematic study of the former.” [5] Ethics grapples with moral questions and moral codes; both are concerned with the rightness of human conduct, they are all preoccupied with the questions and issues that bother on human social behavior while morality laid the foundations, ethics polishes us with how we can put this moral code into practice.

Ethics can be said therefore to be concerned with individual human character while morality is concerned with the relationship between human beings. In a nutshell, the relationship or similarity between ethics and morality can be likened to the one between logic and thinking or better still the similarity between theology and religion. Each of this instances or example can be understood that the latter is the basis for the former. That is if we can say logic is the basis 0of thinking, in the same view we can infer that theology is the basis for religion. Following this illustrations, morality therefore is the basis for ethics.

2.3 Historical Development to the Study of Ethics

One of the fundamental problems of studying ethics has been the problem of establishing or arriving at a consensus view as to when the history of ethics actually began. Philosophers have taken to divergence views and positions about this debate. While some thinkers have believed that the history of ethics as a branch of study within the discipline of philosophy dates back to the times of the Socratic tradition, on the contrary, there are other indications and arguments that the actual historical development of ethics predates ancient period. The study of ethics is as old as the origin of philosophy. In the pre-ancient period or pre-critical state, the questions and problems of morality were already issues of concerned. Pre-history of philosophy shows that Homer was one of these pre-ancient thinkers that contributed to the study and development of ethics. It in line with this historical development that led Assas to posit that:

> For the ancient Greeks, the code of moral correctness was represented by the epics. Writers like Homer sang the praises of virtuous men, holding such characters up as paradigms of virtuous action. It is evident in the *Odyssey* that these heroes looked to the pantheon of Greek gods as their resource for right living. Regardless of true belief in the existence of such beings, the characteristics of the various deities, as outlined in myth, informed the actions of heroes like Odysseus.[6]

Assas also buttresses that; "It is clear that Homer invokes the gods in order to account for the observation that a central form of human excellence must be drawn from without. A god, in Homer's terminology, is a mood that attunes us to what matters most in a situation, allowing us to respond appropriately without thinking." [7] In addition to this, studies have pointed out that central to the study of moral philosophy is the question of

how ought one live? This question has been said to be one of the fundamental quests of moral agents. Antony therefore remarkably argues in this regard as he aptly observes; "How ought one live? This question represents the foundation of centuries of debate concerning the philosophy of ethics, a subject that writers from every country across every generation have discussed, dispelled, and posited their thoughts on without yet reaching a consensus."[8] In response to this very all-important question, each philosopher takes their distinct stance on morality. The idea of good and evil has been filtered through multitudinous perspectives, allowing for questions not only on the goodness of actions but the use, rightness, morality, and justness of actions. In this way, the Greeks had a model to inform their own behavior and by which to judge others. Since the fall of ancient Greece, other philosophers have taken an opposing stand, insisting that morality is a relative feature of the individual which no preset code applies to all people in all circumstances. Meanwhile, Hawkins notes that:

> The changes in ethical philosophy over the years reflect sociological shifts that, in responding to contemporaneous events, intellectually summarize the social understandings and reactions to socio-political changes. Despite the constant flux of thought, at a very base level, ethics strives for a cohesive society. Philosophers describe their ideal; the most functional and productive structure of society, thus laying out their best plan to achieve such an end. Whether the source of ideal cohesion rests in the individual or the community at large has yet to be determined, but the debate continues. [9]

It is to be specifically situated that at the initial stage of the development of ethics, ethics was more concentrated on the "ideal". In other words, it has little to do with daily

practical experiences. The study of ethics in these traditional days was seen as that which speculates into only that which is not in actual stage of existence but the one yearned for. However, with times, there was a paradigm-shift. A new turning point began. With the arrival of the Sophist and the Socratic traditions, ethics was no longer merely seen as the ideal but towards more practical reflections of our daily life encounters. On this note, commenting on the prevailing attitude and the Sophists' view on the nature of ethics, Hawkins observes thus; "The foundation of Western philosophy can be traced to the Grecian empire, culminating in the Athenian philosophers of the 5th century BCE. As was true of China, a socio-political shift was the catalyst for novel ethical theory. During this time there was a shift away from disparate agrarian monarchies to a more centralized industrial democracy. Athens became the hub of commerce and intellect in the ancient world."[10] Fabrice also buttresses that:

> A group of teachers known as the Sophists capitalized on this newly realized need for education by providing fee-based courses on a variety of subjects. At the core of this movement was the rejection of dependence upon traditional custom as a justification for behavior. The philosopher Protagoras epitomized the group's attitude of relativism in his dictum the "man is the measure of all things" and so there can be no objective truth. Cultural customs, then, are useful only in that they represent agreed upon laws established from experience, but have no inherent truth and may be challenged. What is right and wrong is subjective, based on personal or social beliefs rather than inherent fact. [11]

In further development and on the contrary, Socrates rejected the Sophist's argument of moral relativism and advancing the transition of Greek philosophy to one of self-

awareness by which moral absolutes could be objectively identified. Unlike the Sophists, he believed that ethical verities were not only universal, but were able to be identified, learned, and improved upon within the individual. For this reason, life needed to be examined in minute detail in order to be lived well. This comes close to Aristotle's conception of ethics. In the words by Fabrice:

> In ancient Greek philosophy the question was to find how to act well and rightly and what personal/individual qualities are necessary to be able to do this. Ethics therefore encompasses the whole range of human action including personal preconditions. This is still true today, but for e.g. Aristotle ethics focused mainly on the pursuit of the 'good life', the *eudaimonia*. The aim was to identify and to practically realize 'the highest good' in life which means that you have to evaluate what is 'good' as regards content: what life is a good life and what is not? [12]

What can be deduced from the above quotation is the fact that in early stage of the development of ethics, especially among the Greeks, ethics was primarily concerned with the thrust of how humans can act rightly and avoid those actions that are wrongs. From this time, ethics was said to be concern with a whole range of how human being can rightly conduct himself. Ethics from the time of Aristotle goes beyond mere having the knowledge of morality but to strive toward how to put these moral codes into practice. As opinions concerning the question what makes a good life differed more and more in modern times, ethics had and has to face the question how the resulting conflicts of interests and values could be solved peacefully and justly without taking the part of one side or the other. And this leads to the question of what is morally right; moral rightness

and ‘good life’ become separate issues. Whereas questions of ‘good life’ are tied to an evaluation of what is good and are answered in the form of recommendations how to achieve that goal, norms or principles of moral rightness generate imperatives. From the time of Aristotle through the various epochs in the history of philosophy, rather than focusing on moral ought, ethics was shifted to practical life. Today it is common to separate ethics into three sub-branches, namely; descriptive ethics, meta-ethics and normative ethics. However, we are not interested in the discussion what each of these sub-branches of ethics entailed. We shall however not explain each of these sub-branches but to proceed with a discussion on some of the theories of ethics.

2.4 Some Theories of Ethics

Since the time that the study of ethics began, plethora of moral philosophers has strived to explain issues and ideas bothering on ethics. In their bid to explain the nature and the operation of ethics, philosophers took to different views and positions as to what constitute morality and how it can be studied. It is in line with this desired that philosophers have developed variegated theories of ethics as ways to explain the central quest of ethics; the problem of how human beings can act rightly and avoid acting wrongly. Thus, in this section, we tried to unravel and briefly explain the central ideas of each of these theories and what they stand for. In other words, while there are many theories of ethics, we however only attempt to discuss few or some of these theories, not all of them.

2.4.1 Deontology

The word deontology derives from the Greek words for duty (*deon*) and science (or study) of (*logos*). In contemporary moral philosophy, deontology is one of those kinds of normative theories regarding which choices are morally required, forbidden, or permitted. In other words, deontology falls within the domain of moral theories that guide and assess our choices of what we ought to do (deontic theories), in contrast to those that guide and assess what kind of person we are and should be. Deontological theories of morality stand in opposition to consequentialists. It holds that we must not harm people in various ways. We should not lie, kill innocent people, or torture anyone. These prohibitions constrain us in what we may do, even in pursuit of good ends. Commenting on deontology as a theory of ethics, Benson opines:

> Deontologists differ in how stringent these constraints are. Some think them absolute. Roman Catholic moral theology has traditionally held that one may never intentionally kill an innocent person. Kant infamously argued that it would be wrong to lie, even to prevent murder. Other deontologists have held that, though constraints are always a significant consideration, they may be overridden, especially if that is the only way to avoid catastrophe. Either way, deontology sometimes requires agents not to maximize the good. [13]

Deontology can be described as duty ethics. As evident above, Immanuel Kant is known as one of the proponents of this theory of ethics. Deontological ethics or deontology as a Greek derivative simply implies 'obligation' or 'duty'. It is an approach to ethics that focuses on the rightness or wrongness of actions themselves, as opposed to the rightness or wrongness of the consequences of those actions. Benson in further explanation avers

that; “It is sometimes described as ‘duty’ or ‘obligation’ based ethics, because deontologists believe that ethical rules bind you to your duty.”[14] Beside the popular writings that Kant is the proponent of this theory of ethics, some studies have revealed the term first exist in the year 1930. , Roger captures this idea in the following passages:

> The term 'deontological' was first used in this way in 1930, in C. D. Broad's book, Five Types of Ethical Theory. Deontological ethics is commonly contrasted with consequentialist or teleological ethical theories, according to which the rightness of an action is determined by its consequences. However, it is also important to note that there is a difference between deontological ethics and moral absolutism. Deontologists who are also moral absolutists believe that some actions are wrong no matter what consequences follow from them. Immanuel Kant, for example, famously argued that it is always wrong to lie even if a murderer is asking for the location of a potential victim. [15]

Deontologists who are not moral absolutists, such as W.D. Ross, hold that the consequences of an action such as lying may sometimes make lies the right thing to do. When Broad first used the term 'deontological' in the way that is relevant here, he contrasted the term with 'teleological', where ‘teleological’ theories are those that are concerned with outcomes or consequences. Broad's main concern was distinguishing the positions that different ethical theories took on the relationship between values and right action. Broad writes; “Theories which hold that there is some special connexion between moral obligation and moral value might take the following forms. The concepts of obligation are fundamental and the concepts of value are definable in terms of them.”[16] Thus it might be held that the notion of fittingness is fundamental, and that ‘X is

intrinsically good' means that it is fitting for every rational being to desire X. Such theories might be called Deontological. The concepts of value are fundamental, and the concepts of obligation are definable in terms of them. Such theories may be called Teleological. E.g., it might be held that 'X is a right action' means that X is likely to produce at least as good consequences as any action open to the agent at the time.

Thus, according to Waller Bruce "the term 'deontological' picked out the set of ethical theories that are based on the idea that an action's being right or wrong is basic, and whether a situation is good or bad depends on whether the action that brought it about was right or wrong." [17] On the other hand, Broad writes; "Immanuel Kant's theory of ethics is considered deontological for several different reasons. First, Kant argues that to act in the morally right way, people must act according to duty (deon). Second, Kant argued that it was not the consequences of actions that make them right or wrong but the motives of the person who carries out the action." [18]

Kant's argument that to act in the morally right way, one must act from duty, begins with an argument that the highest good must be both good in itself, and good without qualification. Something is 'good in itself' when it is intrinsically good and 'good without qualification when the addition of that thing never makes a situation ethically worse. Kant then argues that those things that are usually thought to be good, such as intelligence, perseverance and pleasure, fail to be either intrinsically good or good without qualification. Pleasure, for example, appears to not be good without qualification, because when people take pleasure in watching someone suffering; this seems to make

the situation ethically worse. He concludes that there is only one thing that is truly good: Nothing in the world indeed nothing even beyond the world can possibly be conceived which could be called good without qualification except a good will. Kant then argues that the consequences of an act of willing cannot be used to determine that the person has a good will; good consequences could arise by accident from an action that was motivated by a desire to cause harm to an innocent person, and bad consequences could arise from an action that was well-motivated. Instead, he claims, a person has a good will when he or she 'acts out of respect for the moral law'. People 'act out of respect for the moral law' when they act in some way because they have a duty to do so. So, the only thing that is truly good in itself is a good will, and a good will is only good when the willer chooses to do something because it is that person's duty. Thus, according to Kant, goodness depends on rightness. [19]

2.4.2 Virtue Ethics

In 1958, the philosopher Elizabeth Anscombe published a paper that was to change the shape of modern moral philosophy. Until that time, the main debate in moral theory concerning normative theories was between proponents of, broadly conceived, deontological theories and proponents of, broadly conceived, consequentialist theories. As a very general definition, normative theories try to provide some account of what is morally good and right. One of the ways of classifying different normative theories is to divide them between those that give an account of what is right in terms of producing good consequences (broadly speaking, consequentialist theories) and are therefore

outcome-based, and those that give an account of what is right in terms of the agent's motives and intentions and are therefore agent-based broadly speaking, deontological theories.[20] So if you think about an act as a whole including motives, choices, acting/omitting, results, consequentialists will focus on an assessment of the results, the consequences of what was done, whereas deontologists will focus on an assessment on what was intended, for example, whether the agent acted from duty. This means that consequentialists and deontologists may come up with entirely different accounts of what we ought to do and whether we should hold people responsible or not for what they have done.

The virtuous agent, then, does the right thing, undividedly, for the right reason he understands, that is, that this is the right thing to do. What is this understanding? In classical virtue ethics, we start our moral education by learning from others, both in making particular judgments about right and wrong, and in adopting some people as role models or teachers or following certain rules. At first, as pupils, we adopt these views because we were told to, or they seemed obvious, and we acquire a collection of moral views that are fragmented and accepted on the authority of others. [21] For virtue ethics, the purpose of good moral education is to get the pupil to think for himself about the reasons on which he acts, and so the content of what he has been taught. Ideally, then, the learner will begin to reflect for himself on what he has accepted, will detect and deal with inconsistencies, and will try to make his judgments and practice coherent in terms of a wider understanding which enables him to unify, explain and justify the particular

decisions he makes. This is a process that requires the agent at every stage to use his mind, to think about what he is doing and to try to achieve understanding of it.

The classical account has also been criticized because of the notions of disposition and character that are central to it. Some modern theories object to making character basic to ethical discourse, as opposed to single actions; this reflects a difference between types of ethical theory that focus on actions in isolation and types that emphasize the importance of the agent's life as a whole, and, relatedly, the importance of moral education and development. Recently, virtue ethics of the classical kind has been attacked on the ground that its notion of a disposition is unrealistic. These attacks rely on some work in 'situationist' social psychology that claims that unobvious aspects of particular situations have a large role in explaining our actions. According to Roger; "Some philosophers have claimed from this that we are not justified in thinking that people have robust character traits; for, if they did, these would explain their actions reliably and across a wide variety of types of situation, excluding this kind of influence."[22]

2.4.3 Normative Ethics

Normative ethics is that branch of moral philosophy, or ethics that is concerned with criteria of what is morally right and wrong. It includes the formulation of moral rules that have direct implications for what human actions, institutions, and ways of life should be like. It is typically contrasted with theoretical ethics, or meta-ethics, which is concerned with the nature rather than the content of ethical theories and moral judgments, and applied ethics, or the application of normative ethics to practical problems.

Normative ethics has in its main thrust the desired to determine the extent at which moral norms can be justified. Putting this idea in a similar line of thought, Harrison and Williams opine inter alia:

> The central question of normative ethics is determining how basic moral standards are arrived at and justified. The answers to this question fall into two broad categories deontological and teleological, or consequentialist. The principal difference between them is that deontological theories do not appeal to value considerations in establishing ethical standards, while teleological theories do. Deontological theories use the concept of their inherent rightness in establishing such standards, while teleological theories consider the goodness or value brought into being by actions as the principal criterion of their ethical value. [23]

In other words, a deontological approach calls for doing certain things on principle or because they are inherently right, whereas a teleological approach advocates that certain kinds of actions are right because of the goodness of their consequences. Deontological theories thus stress the concepts of obligation, ought, duty, and right and wrong, while teleological theories lay stress on the good, the valuable, and the desirable. Waller and Bruce.in their own writing assert that; "Deontological theories set forth formal or relational criteria such as equality or impartiality; teleological theories, by contrast, provide material or substantive criteria, as, for example, happiness or pleasure. The application of normative theories and standards to practical moral problems is the concern of applied ethics." [24]

2.4.4 Utilitarianism

Suffice to state that the history of Utilitarianism as an ethical theory first began with Epicurus in what he described as ethical hedonism. However, Utilitarian ethics was officially been launched by Jeremy Bentham and was popularized by John Stuart Mill. Narrating how the development of Utilitarian ethics originated, Daniel explained by contending that; "The notion of maximizing pleasure, or avoiding pain, seems an intuitive raison d'être, and indeed forms the basis of a body of moral philosophies dating from antiquity. Ethical hedonism was first described by Epicurus in 341 BC – 270 BC. Epicurus posits that the good life is one spent in pursuit of pleasure, defined simply as the avoidance of pain." [25] As evident from the above assertion, central to Utilitarian ethics is the quest for the maximization of pleasure and minimization of pain. Utilitarian are regarded as pleasure seekers. Charles goes on to submit:

> The original utilitarian ideas come from Jeremy Bentham (1748- 1832), who constructed a hedonistic view of utilitarianism. To Bentham, man was at the mercy of 'the pleasures' and it was therefore preferable to be 'a contented pig' than 'unhappy human'. Bentham did not valorize the 'higher pleasures', arguing that happiness arising from the mindless game of "pushpin" was as good as that from reading poetry. John Stuart Mill (1806-1873), by contrast, argued that cultural, intellectual, and spiritual pleasures are of greater value than the physical pleasures in the eyes of a competent judge. [26]

Mill viewed the maximization of some form of eudemonic happiness as the source of the good. In an assertion slightly undermining the secular humanism of his project, Mill sought to endorse his utilitarianism by proclaiming, John Stuart Mill further supported his position by arguing that the golden rule of Jesus of Nazareth, and we read the complete

spirit of the ethics of utility. Mill's utilitarianism does not necessarily avoid the same difficulties as Bentham's version, particularly the so-called 'quantification problem'; that is, how to measure overall pleasure. Also, Charles further contended that; "G. E. Moore averred that no true conception of the good could be formulated, and that an intuitive view of maximizing 'ideals', like aestheticism, may be the ultimate goal of maximizing good (Moore, 1903/1988). Later, economist-driven formulations of the ultimate good of utilitarianism involved the satisfaction of preferences, allowing people to choose for themselves what has intrinsic value." [27]

Over time, there have been a number of cogent criticisms of utilitarianism as a moral philosophy. The more practical critiques have focused upon the simple issue of the measurement of outcome of a utilitarian choice. Whilst this problem is more difficult with the Benthamite version of utilitarianism, the matter of how robustly one can measure gratification of preferences is problematic. The issue of adaptive preferences, whereby people accept less because of low expectations such as the 'contented slave, is one such area. The issues of inexperienced preferences, that is, ones we will never know existed and granting harmful preferences are also challenges to preference utilitarianism. Some have argued that this potential limitation can be overcome by only applying preference utilitarianism to goods which are universally desired or provide basic necessity, or for some form of utilitarian elite, like that described by Sidgwick.

2.4.5 Consequentialism

Consequentialism as an ethical theory holds that an action can be said to be morally right or wrong based on the consequent it brought on the individual. Terry and Williams agree with this idea when he posits that; “A consequentialist philosophy holds that the rightness or wrongness of an action is determined solely by reference to the ‘goodness’ or ‘badness’ of the consequences of that action. Consequentialist ethicist would make decision based on the consequence of the outcome of an action.” [28] As an ethical theory, consequentialism is one of the normative ethics theories that try to answer the ethical questions about right or wrong and how we arrive at this answer. Consequentialist theory determines whether to do or not do something based on the expected result of the action. If the expected result is good then it's ethically right to do, if it's bad then it is wrong. Collaborating and conceptualizing this thought, Chambers maintains that:

> Consequentialists try to accommodate such constraints by finessing their axiologies. Previously, the value of the consequences of all actions was assessed from a universal perspective. Thus, an outcome was taken always to be better, for instance, the more it contained general well-being. However, the new consequentialists propose that we should rank states of affairs according to how good they are relative to agents. This means that the same states of affairs can be very good-relative-to-x whilst less good-relative-to-y. [29]

In all, the Consequentialist ethicist makes decision in dilemmas based on the consequentialist theory analysis of the outcome brought by different actions. However, the evaluation of outcome of various actions differs depending on a person's valuation.

For some, five lives are more important than one life, for others, a healthy person is more valuable than a sick person, and for some others, a young person is more valuable than an old person. So killing five sick persons instead of one healthy person is a better decision according to a person's valuation. Therefore, when applying the Consequentialist theory, one can reach different answer based his or her valuation system. In summary, it can be seen that in the desired to explain the issues and problems bothering on ethics and morality, philosophers have divided themselves over what they thought and perceived to be the right approach and method in solving the problem. It is in line of this, that they further divided on the very theory that can best explain the problem of morality. In the next chapter therefore, we shall proceed with a more critical discussion and evaluation of major issues regarding the problem of confidentiality in medical practice.

Endnotes

1. Crisp, Roger. 1995. "Deontological Ethics." In: Ted Honderich, (ed.), *The Oxford Companion to Philosophy*. (Oxford: Oxford University Press, 1995), pp. 187-188.

2. C. Harrison and K. Williams. *Philosophy and other Disciplines* (United Kingdom: Ever-Rich Communications, 2011), p.45.

3. I. Dipo, "The Nature and Meaning of Ethics". In: F.A, Adeigbo, I. Dipo and A. Udefia (ed.) *Ethics and Public Affairs*. (Ibadan: Ibadan University Press, 2014), p.1

4. Ibid. p. 3.

5. J.I. Omoregbe, *Ethics: A Systematic and Historical Study.* (Lagos: Joja Publishers, 2006), p. 5.

6. J. Assas. *Ethical Issues in Modern Period*. (United Kingdom: Mayfield Publication, 2007), p.87.

7. Ibid. p.88.

8. Flew, Antony. "Consequentialism." In: S. Martins (ed.) *A Dictionary of Philosophy*. (New York: Brace and Orbit, 2003), p. 73.

9. A. Hawkins. *Ethics: Issues in Philosophy of Science*. (London: Freedom Press, 2017), p.190.

10. Ibid. p.191.

11. J. Fabrice. "The Hippocratic Oath and Contemporary Medicine: Dialectic Between Past Ideals and Present Reality." In: *The Journal of Medicine and Philosophy*. Vol. 30, No. 33, 2005, 234-245.

12. Ibid. p. 246.

13. R. Benson. *An Introduction to Ethics*: *Problems and Prospect.* 2nd Ed. (New York: McGraw Hill, 2001), p. 120.

14. Ibid. p. 121.
.

15. C. D. Broad. *Five Types of Ethical Theory*. (New York: Harcourt, Brace and Co, 2010), p. 277.

16. Ibid. pp. 277-278.

17. Ibid. p. 278.

18. J. Terry, P. Williams. *Ethical Theories: A Comparative Study*. New York: Oxford University Press, 1999), p. 87.

19. Ibid. p. 89.

20. N. Carlin. *Ethics: Critical Thinking in Philosophy of Arts*. (London: Pearson Longman, 2008), pp.34-35.

21. Ibid. p. 35.

22. Crisp, Roger. 1995. "Deontological Ethics." In: Ted Honderich, (ed.), *The Oxford Companion to Philosophy*. (Oxford: Oxford University Press, 1995), pp. 187-188.

23. C. Harrison and K. Williams. *Philosophy and other Disciplines. Optcit.*

24. Waller, N. Bruce. *Consider Ethics: Theory, Readings, and Contemporary Issues*. (New York: Pearson Longman, 2005), p. 23.

25. J. Cole and B. Carson. *Medical Humanities: An Introduction*. (New York: Cambridge University Press; 2015), p. 202.

26. Charles, Timothy. *Ethical Problems: Contemporary Quests.*(London: White House Internationals, 2009), p.8.

27. Ibid. p. 9.

28. Anderson, S. Daniel. *Ethics: History and Problems*. (Cambridge: The Queen Press, 2005), p. 270.

29. T. Chambers. *Major Issues and Debates in Contemporary Ethics*. (Nova York: Routledge, 1999), pp. 234-235.

CHAPTER THREE

3.0 THE CONSEQUENCE OF CONFIDENTIALITY IN MEDICAL PRACTICE

3.1 A Historical Antecedents to Confidentiality in Medical Practice

Suffice to say that the history of medical ethics dates back to antiquity. However, a more focus and attention was later given its priority in the late 19th and earlier 20th centuries. This thought is given scholarly backing in the following passages by Brody. He writes; "Since the beginning of human history, concern for medical ethics has been expressed in the form of laws, decrees, assumptions and 'oaths' prepared for or by physicians. Among the oldest of these are the Code of Hammurabi in Babylonia (approximately 1750 BCE), Egyptian papyri, Indian and Chinese writings, and early Greek writers, most notably Hippocrates (lived between 460 and 377 BCE)."[1]

Traditionally, the practice of oath taken by medical practitioners is traced to the ancient Greek philosopher and scientist named Hippocrates. This oath is usually refers to as Hypocritical Oath. The essence of the oath was/is to ensure that medical practitioners keep to some of the ethical norms that governed the profession, especially as it concerns confidentiality and respect of the dignity of human person. However, with times, there was a new paradigm-shift, as a new approach and attitude was given towards the importance of medical ethics. Buttressing this view further, Brody observes inter alia:

> Early medical ethical codes were written by individuals or by small groups of people, usually physicians. The Oath of Hippocrates is considered historically to be the first such code written in an organized and logical way which describes the proper relationships between physician and patient. During the middle ages, other medical codes were written. In recent times, Thomas Precival's writings, disseminated in 1803, represent one of the first ethical codes in the United States and the Western world. [2]

Beginning in the second half of the nineteenth century medical organizations began writing codes of medical ethics. The first ethics code of the American Medical Association was published in 1847. This was the first ethical code of a professional organization which outlined the rights of patients and caregivers. Over the years many revisions and additions to this original code have been made. The latest edition of the American Medical Association Code of Medical Ethics (1997) contains four parts, which include general principles, opinions on specific issues and special reports. Commenting on this development, Hunt and Assas maintain that; "The American Medical Association established the Council on Ethical and Judicial Affairs to advise it on legal and ethical issues and to prepare position papers on these issues for the American Medical Association." [3]

In recent time, a more concentration is given to the practice of medical ethical by attempting to modify the traditional standard and to set a more novel model for medical practitioners. This modern lens of looking at medical practices from an ethical point of view began from around the year 1950's. Summarizing on this thought, Hunt and Assas aver that; "The Modern medical ethics as a separate field began to develop in the 1950's. One of the major innovations of modern Western medical ethics involves the physician-patient relationship with the dramatic change from paternalism to autonomy and its resultant requirement for informing the patient, obtaining informed consent, and relating to the patient as an active partner in decision-making." [4] From thence henceforth, different ethical theories, and principles have been developed and propounded as panacea in

studying the many faceted problems bedeviling the practice of medicine. To take us further, we therefore make a leap toward a discussion of some of these ethical approaches into the study and examination of medical practices.

3.2 Approaches to the Study of Medical Ethics

Today, to undertake a study into medical ethics, some approaches have been developed. We are however not interested in undertaken a comprehensive discussion into all of these approaches. We shall therefore only to explain two or three of these approaches. While there are however mix understandings as to what these approaches entailed, it has been widely accepted that the principlism approach is the most widely known approach. As a starting point, it is helpful to understand the basic ethical theories of deontology, consequentialism, and virtue theory and the advantages and disadvantages of each. Beyond that, it is important to have a basic understanding of principlism, the most widely accepted approach to ethical analysis in modern medicine. Finally, it is helpful to understand some of the alternative approaches to medical ethics, as they each provide unique insights into ethical dilemmas and also highlight the limitations of principlism. Putting this thought into a unified intellectual basket, Duncan opines thus:

> The principlism perspective of Beauchamp and Childress has become the predominant approach to medical ethics over the past decades. Most introductory ethics courses and much bedside ethical analysis emphasize the four principles as the generally accepted approach to doing ethics. However, many ethicists have argued that this perspective is inadequate and restricts our moral vision in important, and sometimes destructive, ways. They argue that other

> perspectives provide insights that allow us a broader and more realistic perspective on ethical questions. [5]

The second approach to be discussed here is what has been termed as the 'Care-based Approach. The Care-based approach was developed by Carol Gilligabn and Nel Noddings in the years 1982. To explain further on the Care-Based as an approach to the study of medical ethics, Duncan further buttresses inter alia; "One of the most important challenges to the principlism approach comes from the work of Carol Gilligan (1982) and Nel Noddings (1982), who argue that the principlism approach excessively values traditionally male perspectives and devalues traditionally feminine perspectives, reflecting historic male domination of academics and medicine." [6]

Gilligan's work was based on studies exploring the differing development of the moral perspectives of boys and girls. Similarly, Lawrence Kohlberg had studied moral development in children and concluded that they evolve through six universal stages; from the lowest stage of punishment and obedience orientation, through stages of good boy–good girl orientation. The next stage is law and order orientation. Those who develop the highest moral stage develop a universal ethical principle orientation. This analysis supports the principlism approach as representing the highest level of moral development.

However, according to Beachump and Walters "Gilligan was troubled by the fact that Kohlberg's experimental data suggested that males were much more likely than girls

to develop the highest levels of moral insight and wondered if these stages were truly universal or whether, instead, they were biased toward a male perspective." [7]

Another approach to the study of medical ethics is the 'Narrative Ethics Perspective.' Narrative ethics is the perspective that in the act of abstracting the "essential" elements of a clinical case, we lose the most essential elements of the case, that is, that each case is unique and happens to a single identifiable person who is the protagonist in his or her own unique life story. Of course clinical medicine always starts with a narrative of the patient's illness. We abstract details to help us understand the illness, make a diagnosis, and determine treatment options. But ultimately, to appreciate the impact of the illness and treatments on the patient, we need to return to the patient in the context of his or her life. Narrative ethics is thus, in some ways, the expression of the bio-psychosocial model of medicine. It emphasizes the larger narrative or story of the patient's life as the central reality in the medical situation. A more conceptualization of the Narrative approach of medical ethics is captures thus by Campbell:

> It also locates the medical condition and the medical encounter as only a chapter in a larger narrative. That chapter may be a very important chapter, it may even be the final chapter, but it is never the entire story. Furthermore, each individual's story is almost always intertwined with the stories of other individuals and groups. And if the medical encounter in question is the final chapter of the protagonist's story, it typically becomes a particularly important and powerful chapter in the lives of the patient's family and friends. [8]

Narrative ethics incorporates many of the same ideas as emphasized in care-based ethics. Both emphasize the importance of family, friends, and relationships in the context of

medical illness. Both remind physicians that their role in the medical encounter, though very important, is always subsidiary to that of the patient and family. Narrative ethics may present a broader framework from which to understand this, even as it reminds us of the centrality of narrative in medicine.

Lastly here, the next approach to be briefly discussed is the Feminist ethics. Feminist ethics incorporates the ideas of 'feminine' ethics in that it tends to note the gender-based differences in perspectives on caring and relationships. But it goes further in emphasizing the importance of power and control in medical relationships. From the feminist perspective, the primacy of principlism in medical ethics is mostly a result of the relative power differential of males and females in medicine. Historically, physicians have mostly been male; whereas nurses and family caregivers have traditionally been predominantly female one may note that nursing ethics has traditionally been more care-based than physician ethics. Thus the assertion that an ethic which reflects a traditionally male perspective is actually a universal ethical perspective serves the interest of a male-dominated enterprise, that is, medicine while serving to maintain a gender-based imbalance of power. It is worth noting that the care-based perspective was proposed by women and has gained traction as women have gained parity in medicine.

3.3 Principles of Medical Ethics

The most commonly employed approach to clinical ethical analysis is the principle approach, popularized by Beauchamp and Childress (2008) in their book,

Principles of Biomedical Ethics. It is noteworthy that Beauchamp and Childress assert that these principles are operative whether one is inclined toward a deontologic perspective or a consequentialist perspective. They assert that the four principles represent fundamental values that are equal in importance and therefore, ideally, should always be honoured. However, in practice, as situations inevitably arise in which two or more of the principles come into conflict, it will be necessary to prioritize them. Such prioritization must occur on a case by- case basis. The priority given to a particular principle in a particular case will depend on the facts of the case as well as the values of those involved. The four principles are: (1) respect for patient autonomy; (2) beneficence; (3) non-maleficence; and (4) justice. These principles applied to all branches of medical ethics. Thus, in light of the above, we shall proceed with a separate conceptualization, discussion and analysis of each of these principles.

Principle 1: Respect for Autonomy: The principle of respect for autonomy is basically refers to as the first fundamental principle in the study of medical ethics. It is known as the first moral principle in medical practice. This first moral principle reflects the ethical norm of 'respecting the decision-making capacities of autonomous individuals.' According to Engelhardt "This norm mirrors self-governance, privacy, freedom of will, individual choice, and self-rule free from control. Its antonym is the state of being controlled by others, or being incapable of acting on the basis of one's own intentions and goals."[9] Autonomy rests on at least two essential conditions. These include liberty; that is a person's independence from controlling influences and second one is the agency; that is,

a person's physical and mental capacity to act. In order to experience liberty, a patient needs to have full access to all information related to his/her health and medical care. Thus, a provider's obligation to respect patient autonomy implies that the provider must disclose all objective information related to close calls and adverse events to the patient and/or (if the patient is incapacitated) the patient's family.

Although several patient safety advocates like American Medical Association code of ethics and Joint Commission on Accreditation of Healthcare Organizations have adopted this rule, discussions around this moral obligation are controversial. However, the core practical concern does not seem to be the disclosure decision but rather the way in which the disclosure is conducted."[10] On the other hand, Charles continues; "The agency condition of patient autonomy implies that patients need to understand the content of the disclosure fully in order to make informed decisions about their health and ongoing medical care." [11] Thus, the notion of agency suggests that disclosure is crucial, and particularly that it is important how a disclosure is communicated. For example, a provider's disclosure of an error would not be effective and thus not ethical if it is delivered in a language just as in the case of medical jargon that the patient cannot understand. In addition, Gilson would emphasize:

> An ethical disclosure needs to compensate for the discrepancy in medical knowledge between physicians and patients. In order to optimize such efforts, the physician needs to have the knowledge to translate the information into a language that is understood by the particular patient, the motivation to translate the medical information, and the skills to conduct the disclosure accordingly. In the event of

> a medical error, patients want to be informed about their care. [12]

Patients are unable to understand their health situation and make competent judgments about corrective treatments and their continuing medical care unless they are informed about the events that led up to the incident, the consequences of the error on their health, and the treatments and side effects that are available to repair them. This notion defeats the therapeutic privilege argument, which solely focuses on the provider-perceived appropriateness of disclosure given the patient's condition. Instead, it takes into account the outcomes of the disclosure as a crucial criterion.

From an autonomy standpoint, a physician should not decide to withhold information related to a critical incident from a patient in an attempt to save the patient from additional harm. Nondisclosure is a defensive and passive approach to prevent further potential harm, a link that has not yet been empirically established. Rather, the provider must focus on disclosing all reliable information related to the critical event competently. Competent disclosure reflects an active effort that can promote healing. It is an approach that is both effective and appropriate and therefore reflects the most ethical way to respond to critical events. It mirrors the term 'patient-centered care', that is, listening to patients and respecting their views, giving patients' information in a way that they can understand, and respecting the rights of patients to be fully involved in the decision-making process. Patients have a right to know and must understand when errors

have occurred in their care, even if they have not been harmed by them, in order to consent properly to necessary follow-up treatments and future medical care.

Unfortunately, this autonomy-based ethical rationale for disclosure goes beyond what the law currently requires providers to do. Compliance with the Joint Commission on Accreditation of Healthcare Organizations code of ethics, for example, compromises the moral right of patient autonomy because it only requires disclosure of harmful events. This concealment reinforces substandard care and implies a contractual violation of the fiduciary doctor–patient relationship. Patients should be able to trust their physician about anything related to their care and welfare, and they cannot make informed autonomous decisions about their subsequent care and medical treatments with incomplete or deceptive information. Competent error disclosure respects patient autonomy and enhances informed decision-making. Therefore, the decision to disclose and competent disclosure conduct should be ethical priorities for all providers.

Principle 2: Non-Maleficence: Non-maleficence refers to the ethical norm of avoiding causation of harm. It rests on the *dictum* of *primum non nocere*. This implies that the doctor's obligation not to injure or harm patients and to refrain from actions that would harm them. This norm captures the complexities of medical practice. The term "actions that would harm" highlights the fallibility of medicine, where harm is not always a predictable outcome but based on the probabilities of side effects and complications. Gillon further explained that "Non-maleficence as a principle in the study of medical practice exposes challenging tensions between killing versus allowing to die, intending

and foreseeing harmful outcomes, withholding and withdrawing life-sustaining treatments, and choosing between ordinary and extraordinary treatments." [13]

There are indications that adverse events imply maleficent conduct because harm was not prevented. However, subsequent nondisclosure or incompetent disclosure conduct can be maleficent as well. Doctors may decide to exercise their largely discredited therapeutic privilege and choose not to disclose an error for the patient's benefit. Such nondisclosure might cause serious additional harm to a patient if it impedes or delays necessary medical intervention. Gelfand remarks that; "A patient may incur complications, for example, because s/he lacked information that would have allowed him or her to receive appropriate treatment on time. Withholding error-related information also commonly causes patients to lose confidence and faith in their physician's ability to help them." [14]

Furthermore, it undermines public trust in medicine and damages the therapeutic relationship between providers and patients. From a systems perspective, nondisclosure can also prolong recovery and undermine institutional efforts to improve patient safety, constituting a breach of providers' ethical duty to learn from past errors in order to protect future patients who might be harmed by a repetition of the same error. The conduct of error disclosure can also be a harmful act if it is performed incompetently. In response to an error, patients want to hear an empathic disclosure and a sincere apology from their provider. According to Abrams and Buckner:

> A nonverbally detached disclosure, even if it is complete and truthful, can lead to decreased patient satisfaction, trust, forgiveness, and relational closeness to the physician. It is associated with higher patient distress, avoidance of the provider, and perceived severity of the health consequences of the mistake. Nonverbally uninvolved disclosures also lead to higher likelihood of doctor-switching, lower likelihood of continued medical care, and lower adherence with treatment recommendations. [15]

In sum, error disclosures that accommodate the ethical principle of non-maleficence have to facilitate transparent reporting to the institution, as well as verbally and nonverbally effective and appropriate communication with the patient and/or the patient's family in order to prevent and intervene with the causation of additional avoidable harm which would constitute an additional error in the chain of mistakes. Thus, the ethical dictum 'do not injure' implies 'do not abstain from disclosure', and 'refraining from harmful actions' mandates medical practitioners to disclose errors in a competent, effective and appropriate manner.

Principle 3: Beneficence: The third principle of medical ethics states that one ought to help others. This norm entails actions such as preventing evil or harm, removing evil or harm, and doing or promoting good. Thus, beneficent acts require doctors to balance benefits against risks and costs. In addition, they entail active contributions to patient welfare rather than merely refraining from doing harm. Keywords that illustrate this principle include mercy, kindness, charity, altruism, love, and humanity. Therefore, according to Abrams and Buckner "Thus, beneficence encompasses active Samaritan-like acts that are conducted to benefit others, such as protecting and defending the rights of

others, preventing harm from occurring to others, removing conditions that will cause harm to others, helping persons with disabilities, and rescuing persons in danger." [16] On protecting and defending rights of patients, Abrams and Buckner aver that:

> Patients have the right to know what happens in their medical care, and beneficence ethically mandates providers to protect and defend this right. In the context of medical errors, the principle of beneficence clearly mandates disclosure of critical events as proper ethical conduct. Thus, the right to know is closely associated with the liberty condition of patient autonomy. That is, knowledge contributes to liberty. However, beneficence has paternalistic connotations and therefore can also work against patient autonomy. [17]

For example, a physician may decide not to disclose an error or deceive in order to protect a patient. This peculiar tension between therapeutic privilege and the patient's right to know is alleviated with an overarching standard that respect for autonomy should triumph over beneficence. This standard defeats arguments that rely on therapeutic privilege and benevolent deception, which are commonly used to justify nondisclosure and deception as acts being in the patient's best interests. In this light, Daniel argues that; "The only reason to conceal an error or deceive a patient would be to protect the professional's own interest, unethically positioning the welfare of the doctor over the welfare of the patient." [18] However, the patient's best interest in the case of a critical event is clearly facilitated by the doctor's ethical adherence to truthful disclosure. Patients also have a right for dignity. This standard has direct implications for the conduct of error disclosure. A beneficent disclosure requires an empathic perspective, or

a “view from below”, on behalf of the provider. It requires providers to demonstrate that the patient’s experience has been treated seriously and that measures have been taken to prevent recurrence of the event.

Again, Culver and Gert suggest that; “Doctors should provide fair compensation for the injury that their error caused to the patient. They should offer access to counseling services and invite patients to contribute to the institution’s quality improvement processes by sharing their experiences. Such empathic expressions can diminish patient anger and desire for revenge that often motivates litigation.” [19] In a similar line of opinion, Dunstan and Shineborne maintain that:

> Doctors should make it possible for patients to forgive the provider and create opportunities for patients to become part of quality improvement efforts that enhance patient outcomes. As long as the physician cannot see that the patient’s suffering, and not her own suffering, constitutes the view from below as long as she cannot admit that she is not the victim of this incident due to its perceived impact upon her career, income or self-image; as long as she fears what the injured patient might do to her rather than recognizing the disclosure as part of the narrative of caregiving, she will not be able to understand and embrace full disclosure as ethical norm.[20]

The second notion under the principle of beneficence is preventing harm from occurring to others. This implies that nondisclosure would be immoral. As mentioned above, nondisclosure can cause additional avoidable harm to patients, commonly undermines public trust in medicine, and may keep patients from seeking crucial follow-up treatments and continued medical care. Thus, removing conditions that will cause harm to patients

implies that disclosures need to be conducted. We must understand that an apology of acknowledged responsibility followed by an empathic disclosure might cause patients to continue trusting their physicians and to be less likely to change physicians, which is a condition necessary for intervention to prevent additional harm

In sum, the second notion of beneficence also promotes disclosure and competent disclosure performance as ethical conduct. Next is the notion of helping the patient. Doctors are obliged to help patients who have been harmed by an error, like in the case of adverse events. Such help needs to occur on multiple levels. For example, doctors may offer emotional support such as caring and empathy and tangible support such as financial help, or assistance in completing tasks, affectionate support , like expression of positive emotions, and supportive social interaction like to convey a sense of social companionship and integration.

Principle 4: Justice: This principle emphasizes that doctors should be fair and transparent to all patients. Doctor by this principle are obligated to be justified with all honesty in their dealings with their patients. According to Dunstan and Shineborne explained; “neglecting the justice principle in this particular context compromises other ethical principles, particularly respect for patient autonomy. Justice reflects the moral obligation of fairness, a norm that demands equal distribution of benefits, risks, and costs among all involved groups.” [21] Doctors and patients need information to understand the events that led up to an error and to prevent it from happening again. They also rely on

medical expertise to understand the health consequences and make competent decisions about continued care. Dunstan and Shineborne buttress that:

> According to the principle of justice, these scarce resources need to be distributed fairly among patients and doctors. Thus, all reliable informational content that is available should be shared, the most competent medical expertise should be applied collaboratively in presence of the patient, and the privacy of patients and doctorrs needs to be reinstituted and maintained. In terms of the disclosure decision and content, these ethical standards clearly mandate full disclosure and respectful disclosure conduct with optimized translational efforts. [22]

In summary, it can be deduced that the various principles of medical ethics is not free from one challenge or the other. There are issues and problems facing doctors in keeping to the fate and feat of these principles. Hence, in the immediate phase, we shall be considering in a more clear discussion these challenges and problems of confidentiality within the practice of medical profession.

3.4 Challenges and Problems of Confidentiality in Medical Ethics

Respecting patients confidentiality and privacy are considered as patients' rights. Confidentiality is the key virtue for trust building in physician-patient relationship. While law considers confidentiality as absolute except for legal situations, despite efforts to maintaining confidentiality, sometimes breaching confidentiality is unavoidable but not necessarily unethical. Till today, among the various medical practitioners across the globe, there is no unified ethical guideline to define clear approaches to patient

confidentiality in clinical setting. This lack of unified standard, no doubt, is a very fundamental challenge to the practice of doctor's and patient's confidentiality.

` Furthermore, the principle of truth telling or telling the truth always has been another ambivalent ethical maxims faced by researchers in defending the argument for and against the morality of confidentiality in medical practice. One may ask; should the doctor maintain telling the truth at times even when saying a lie sometimes may safe life or lives? This principle, fundamentally, has been a serious challenge to the practice of medicine. Peter and Daniel capture that; "Truth-telling is a vital component in a physician-patient relationship; without this component, the physician loses the trust of the patient. An autonomous patient has not only the right to know (disclosure) of his/her diagnosis and prognosis, but also has the option to forgo this disclosure. However, the physician must know which of these two options the patient prefers." [23]

Broadly speaking, it is to be stated that respect to confidentiality as an important consideration in medical practices has over the years not been maintained and upheld with serious attention among physicians. In spite of efforts toward maintaining confidentiality, sometimes breaching confidentiality is unavoidable but not necessarily unethical. Among the medical professionals, there are reported cases of frequent violations and breaches of patient's rights by their physicians. A significant number of breaches occur by health professionals who are aware of confidentiality but do not know the way of avoiding breaches. In short, it is sad to note that medical practitioners do not

share a common universal standard. There are no unified approach toward curbing the problems and challenges of doctors' to patients' ethical norms of confidentiality. This lack of unity and consensus led Peter and Daniel to eloquently decry thus:

> Breaching confidentiality based on the third parity's benefit is a major ethical challenge in respecting patients' confidentiality and it is managed differently in different countries; however, in our country, there is no clear guideline in this regard. Both United States and the UK have similar policy on this issue. The Code of Medical Ethics of American Medical Association indicates: "The obligation to safeguard patient confidences is subject to certain exceptions ethically and legally justified because of overriding social considerations. [24]

Here in most cases, the rights of patient's confidentiality are often violated and breached. For instance, as stated above, when a patient is subconscious and unable to speak for him or herself the ethical norms of confidentiality are usually breached. In most of these cases third party are invited into a health case that would and should have been handled strictly between the physician and his or her patient. In such situation, one cannot uphold the principle and the practice of confidentiality.

The case of a little child is no typical example where the practice of confidentiality seems to be mostly breached. The child who cannot communicate are been assisted by parents or one outside the parental coverage. With this, vital health information about a particular child which were supposed to be kept secret between the doctor and the child are most often leaked to public domains. To step further, in most countries, governments' legal system mandates physicians and other hospital staff to

report child abuse and every other type of abuse as well as contagious diseases. However, according to Beachump and Childress "Sometimes this legal duty is in conflict with patients' confidentiality, therefore a proper guideline or ethical framework would be of great help."[25] They buttressed further:

> Child abuse or sexual violence causes physical and mental distress in short and long-term. The victims will suffer stigmatization, discrimination and get more sensitive to violation and sometimes become a subject of more violations. In this situation, the victim regardless of age may seek real protection of health care system especially the physicians.[26]

Reporting any case of abuse and disregarding confidentiality in report may diminish the trust and sensitizes the victim to more violations. Accordingly, the child abuse report should be based on an appropriate guideline while the patient or his/her surrogates' consent should not be ignored. In the draft, we differentiate between different types of consents drawn from patients according to the severity of their diseases, for example, consents obtained from incapacitated patients. There is a need, however, to make further investigation into compilation of an ethical guideline for reporting child abuse adapted to our local condition, cultural and religious principles.

Adolescents have the right to confidentiality the same as adults. Privacy has an impact on adolescents-physicians relationship and lack of confidentiality could be their major obstacle to seek for healthcare. Some constitutions, like that of Nigeria consider children of 18 years and above as able to give consent without their parents' stewardship.

Accordingly, their information should be kept confidential in clinical settings. For children of less than 18 years, there would be a challenge as we do not know their degree of maturity consistent with their autonomy and ability to decision making, so keeping their information confidential, putting them responsible, and not informing their parents about their health-related issues would be problematic. To sum up, it is pertinent to further stress that the obligation to respecting the rights of the patient and keeping patient's information confidential has been severally violated in recent times. On this note, Gorovitz decries thus:

> Accordingly, all health care providers ought to protect patients' information whether saved as paper print or electronic health records. Ironically and unfortunately, these principles appear to be neglected by physicians. In short, there appears to be no respect for confidentiality anymore. This scenario, no doubt, has many effects on the medical profession and this by extension affects the society and its community of people. [27]

From the above discussion, it can be established that some of the challenges highlighted above are multidimensional and need more investigations from ethical, legal and social aspects. While there are other areas of human professions that also requires for upholding the principle of confidentiality, it is to be submit here that these other areas of confidentiality were not looked into or considered. For instance, confidentiality in relationship with social media, confidentiality in child abuse, designation of system audit, confidentiality in detention setting, and confidentiality after death have not been included in our section. In fact, this section specifically looks into the ethical guideline to

confidentiality in clinical settings to address the most common ethical challenges and the scope of confidentiality. Having said this, in the next section, we tried to examine the ethical implications of the principle of confidentiality within the practice of medicine.

3.5 The Ethical Implications of Confidentiality in Medical Practice

As we try to reflect on the ethical implications of confidentiality in medical practice, it would not be out of place to briefly state some of the most fundamental considerations. No doubt, the requirements of an informed consent for a medical or surgical procedure, or for research, are paramount and fundamental in medical practice. These requirements insist that the patient or subject must be competent to understand and decide, receives a full disclosure, comprehends the disclosure, acts voluntarily, and consents to the proposed action. These standing rules and norms are to be examined to ascertain its ethical implications. According to Gorovitz ; "The universal applicability of these requirements, rooted and developed in western culture, has met with some resistance and a suggestion to craft a set of requirements that accommodate the cultural mores of other countries." [28] These norms are seen to be universal. In other words, they are applicable and can be applied to all parts of the human society.

In response and in vigorous defense of the 5 requirements of informed consent, Angell writes, "There must be a core of human rights that we would wish to see honored universally, despite variations in their superficial aspects. The forces of local custom or local law cannot justify abuses of certain fundamental rights, and the right of self-

determination on which the doctrine of informed consent is based, is one of them." As competence is the first of the requirements for informed consent, one should know how to detect incompetence. Standards (used singly or in combination) that are generally accepted for determining incompetence are based on the patient's inability to state a preference or choice, inability to understand one's situation and its consequences, and inability to reason through a consequential life decision.

To further elucidate this argument, within the medical practice, it would be unethical for a patient to be administered medication by a quack physician or doctor. It would be morally wrong for an incompetence doctor to prescribe or conduct surgery on a patient. Another important aspect of moral consideration is the principle of telling the truth. Ethically speaking is recommended. But there are some cases where this can be violated. Another very important ethical implication of the principle of confidentiality in medical practice is how to maintain the ethics of truth telling in relation to keeping patient's information confidential. Chambers saw this problem as fundamental and more challenging, hence, he writes:

> Importantly, surveys in medical studies show that patients with cancer and other diseases wish to have been fully informed of their diagnoses and prognoses. Providing full information, with tact and sensitivity, to patients who want to know should be the standard. The sad consequences of not telling the truth regarding a cancer include depriving the patient of an opportunity for completion of important life-tasks: giving advice to, and taking leave of loved ones, putting financial affairs in order, including division of assets, reconciling with estranged family members and

> friends, attaining spiritual order by reflection, prayer, rituals, and religious sacraments. [29]

It can be said that by the standard of confidentiality, information is said to be confidential once it lies within the individual person alone. Once any piece of information is shared between two parties, it is no longer to be seen as confidential. An obvious exception (with implied patient authorization) is the sharing necessary of medical information for the care of the patient from the primary physician to consultants and other health-care teams.

In the present-day modern hospitals with multiple points of tests and consultants, and the use of electronic medical records, there has been an erosion of confidentiality. However, individual physicians must exercise discipline in not discussing patient specifics with their family members or in social gatherings and social media. By the very oath of confidentiality, all medical reports and information are required to be kept secret and private. But today, doctors have severally argued that such principle should be applied in all cases. For instance, some physicians would argue that information on diseases such as HIV and other epidemics infectious diseases should not be kept hidden but are to be disclosed to save the health of others. On this note, Chambers argues; "There are some noteworthy exceptions to patient confidentiality. These include, among others, legally required reporting of gunshot wounds and sexually transmitted diseases and exceptional situations that may cause major harm to another e.g., epidemics of

infectious diseases, partner notification in HIV disease, relative notification of certain genetic risks." [30]

Lastly, let us examine the case of Covid-19 patient. If we are to go by or maintain always the ethical rules of confidentiality, how do we justify the case of Covid-19 patient? Are Covid-19 patients to be kept private or confidential? Should we make public those infected with the various to isolate from them? If doctors are to maintain the rule of keeping their information confidential, would do by doing good or harm to the general public or the patient concerned; if the patient's right to confidentiality is to be upheld in this case, what becomes the fate of the general public? These are ethical questions that the different ethical theories read in previous chapter would offer variegated answers to them. For instance, Kantian ethics would argue that the private right of doctor-patient's confidentiality must be adhered to at all courses and in all situations. On the contrary, Fletcher's *New Morality* would disagree with Kant's duty ethics. Situation Ethics would rather insist that in certain situation or medical case like the case of covid-19 patient, doctors should overlook the principle of confidentiality of the patient and give information about their patient to the public to safe others. This debate can continue *ad infinitum*

From the above discussion, it is observed that the philosophical exploration into the principle of confidentiality and through its ethical lens is one of the most recent topics of discussion in bioethics. While there are other important themes or principles that are ethically studies under medical practice, the thrust of this study however was focused and

channeled on the principle of confidentiality. In the previous chapters, we have been able to evaluate these issues. Thus, in the last chapter of this research, we shall proceed with recommendations and conclusion of the study.

Endnotes

1. H. Brody. *Ethical Decisions in Medicine, 2nd ed*, (Boston: Little, Brown and Com, 2007), p. 89.

2. Ibid. pp. 90-91.

3. R. Hunt J. Assas. Ethical Issues in Modern Medicine. (Nova York: Mayfield Pub Com, 1999), p. 45.

4. Ibid. p. 47.

5. A.S. Duncan. (eds.) *Dictionary of Medical Ethics*. (New York: Crossroad, 2009), p. 34.

6. Ibid. pp.39-40.

7. T.L. Beachump, and L. Walters (eds.) *Contemporary Issues in Bioethics, 2nd ed*. (Belmont: Wadsworth, 1993), pp. 67-68.

8. A.V. Campbell. *Moral Dilemmas in Medicine*. (Edinburgh: Churchill Livingstone, 1972). p. 66.

9. H.T. Engelhardt. *The Foundations of Bioethics*. (Cambridge: The Queen Press, 2013), p. 29.

10. Charles, Timothy. *Ethical Problems: Contemporary Quests.*(London: White House Internationals, 2009), p. 8.

11. Ibid. p. 11.

12. R. Gillon. (ed). *Principles of Health Care Ethics.* (Chichester: John Wiley and Sons, 1994), p. 676.

13. Ibid. p. 676.

14. M. Gelfand. *Philosophy and Ethics of Medicine*. (Edinburgh: Churchill Livingstone, 2003), pp. 44-45.

15. N. Abrams and M.D. Buckner. (eds): Medical Ethics, Cambridge: MIT Press, (New York: Oxford University Press, 1997), p. 59.

16. Ibid. p. 60.

17. Ibid. pp. 61-62.

18. Anderson, S. Daniel. *Ethics: History and Problems*. (Cambridge: The Queen Press, 2005), p. 200.

19. C.M. Culver and B. Gert. *Philosophy in Medicine*. (New York: Oxford University Press, 2018), pp. 109-110.

20. G. R. Dunstan and E.A. Shineborne. (eds) *Doctors' Decisions: Ethical Conflicts in Medical Practice*. (New York: McGraw Hill, 2006), p. 301.

21. Ibid. pp. 302-303.

22. Ibid. p. 305.

23. K. Peter and D. Daniel. *Bioethics and Secular Humanism: The Search for a Common Morality*. (Cliffs: Prentice-Hall, 1991), p. 23.

24. Ibid. p. 27.

25. T.L. Beachump and J.F. Childress. *Principles of Biomedical Ethics, 4th ed,* (New York: Oxford University Press, 1994), P.302.

26. Ibid. p. 303.

27. S. Gorovitz. *Doctor's Dilemmas: Moral Conflict and Medical Care.* (New York: McGraw Hill, 2017), PP. 121-122.

28. S. Gorovitz. (eds) *Moral Problems in Medicine*. (Engelwood : Prentice-Hall, 1995), p. 65.

29. T. Chambers. *Major Issues and Debates in Contemporary Ethics*. (Nova York: Routledge, 1999), p. 239.

30. Ibid. p. 240.

CHAPTER FOUR

4.0 RECOMMENDATIONS AND CONCLUSION

4.1 Recommendations

To make recommendations which will serve as the suggestions for possible research on this topic and to provide the research's contributions to knowledge, it is imperative to summarize that generally speaking, philosophically, and particularly, within the domain of Biomedical Ethics, medical ethics is a conscious effort to determine what clinicians should do in complex clinical and research situations. It is not a hypothetic exercise, because physicians and other healthcare providers must act to provide care for patients. Although usually what we should do is obvious, situations invariably arise in which what we should do is not immediately self-evident. Some understanding of the bases for ethical analysis is essential if we are to act correctly in most situations.

Furthermore, as evident from the discussion of the research problem in the previous chapters, respect to confidentiality goes back to respect for autonomy and human dignity. According to medical ethicists, ethics and law breaching confidentiality is forbidden while in some occasions in medical practice it is unavoidable. Therefore and based on our analysis and evaluation done in previous chapters of this study, we therefore attempt to make some recommendations as guideline to shape ethical decision making when facing with ethical challenges in practice. These recommendations, no doubt will earnestly guideline and help medical professionals, researchers, law makers, the individual or group of individuals to be ethically conscious in keeping with the ethics that

guide the profession. However the multidimensional nature of the challenges of confidentiality in medical practice necessitates further investigations from ethical, legal and social aspects. Based on these, the following recommendations are made:

1. Medical professionals are obligated to protect the confidentiality of their patients. Therefore, this ethical standard must be adhered, kept and maintained by all medical doctors irrespective their positions within the medical practice.
2. The duty to ensure discretion and confidentiality in the medical profession is morally justified based on the rights arising from relationships. Thus, all medical students are encouraged to take the study of philosophy, especially ethics serious to enable them be trained and have a more knowledge of the usefulness and relevant of medical ethics within the medical practice.
3. Medical practice involves trust relationships with both patients and their physicians. Thus, the study recommends that there should be more synergy and trust between Doctors-patients relationship.
4. The ethics of confidentiality should be given legal backing in all society of the world; for instance, like in the case of Nigeria, there should be more laws to back this medical rules and norms to equate the Nigerian Medical practice with those of the other nations of the world.
5. Finally, the study recommends that more studies should be undertaken by students in the Department of philosophy in order to come up with more solutions to the challenges of medical ethics within the medical practice.

4.2 Conclusion

To conclude this study, suffice to reiterate that from the ethical point of view, respect for the principles of beneficence, non-maleficence and also autonomy is recognized as some of the major justifications for maintaining patient confidentiality, based upon a fundamental consideration for persons. Respect for confidentiality is important to safeguard the well-being of patients and ensure the confidence of society in the doctor-patient relationship. Health information is not only based on objective observations, diagnoses, and test results, but also subjective impressions about the patient, their lifestyle, habits, and recreational activities. The improper disclosure of such highly sensitive information could harm patients' reputation or result in lost opportunities, financial commitments, and even personal humiliation. This obligation is stringent but not unlimited. In fact, there are two general exceptions where it is necessary to question whether or not to maintain confidentiality: when the safety of others or public health is threatened.

In addition, it is to be established that ethical conduct can be displeasing and difficult, particularly in the context of disclosure of medical errors. However, it can also promote a learning experience. It is important to note that ethical disclosure standards come with certain limitations. First, the literature suggests that patients prefer a sincere apology. Thus, providers may face an ethical conflict if their apology is not genuine. Future research is needed to elaborate this tension. Second, a causal link between the apology element and positive error disclosure outcomes has not been empirically

established. In light of the legal controversy on this disclosure element, future studies need to provide a more novel and critical analysis to further assist in the study of medical ethics.

Confidentiality protects information given in confidence. It is a vital component of the doctor-patient relationship protected in equity, common law and statutory regulation, as well as through professional discipline. Without the assurance that a doctor or other health professional will not disclose confidential information given by a patient, some people may withhold important information about their medical conditions which they find embarrassing (for example, an abortion or sexually transmitted disease), or lifestyle habits that may impact on their health, for example, smoking or drug-taking. The duty of confidentiality is not absolute and there are exceptions, such as when public health or safety is threatened.

Finally, it is to be established that the ethical quest for confidentiality in medical practice protect a person's health records from disclosure to others. Whether, and in what circumstances, a person can access his or her own records is covered by medical ethics. Based on the above exposition, discussion, analysis and recommendations, the study concludes that the applications of ethical studies into medical practice are plausible and therefore should be encouraged for further studies. Physicians or medical practitioners are advised to adhered or take all rules of medical ethics with almost considerations. However, given its deficiency in human knowledge, we submit that the yearning calls for

the application of medical ethics in medical practices are good but not quite perfect as it also has its shortcomings.

Bibliography

Abrams, N and Buckner, M.D. eds. Medical Ethics, Cambridge: MIT Press, 1997.

Anderson, S. Daniel. *Ethics: History and Problems*. Cambridge: The Queen Press, 2005.

Anniok, P. *Ethics: Dilemmas for Medical Students and Doctors in Training*. Cambridge: Cambridge University Press, 2001.

Antony, Flew. "Consequentialism." In: S. Martins *ionary of Philosophy*. New York: Brace and Orbit, 2003.

Assas, J. *Ethical Issues in Modern Period*. United Kingdom: Mayfield Publication, 2007.

Beachump, T.L and Childress, J.F. *Principles of Biomedical Ethics, 4th ed,* New York: Oxford University Press, 1994.

Beauchamp, L. Tom. *Philosophical Ethics: An Introduction to Moral Philosophy*, 2nd Ed. New York: McGraw Hill, 1991.

Beachump, T.L. *Contemporary Issues in Bioethics, 2nd ed*. Belmont: Wadsworth, 1993.

Benson, R. *An Introduction to Ethics*: *Problems and Prospect.* 2nd

Ed. New York: McGraw Hill, 2001.

Broad, C. D. *Five Types of Ethical Theory*. New York: Harcourt, Brace and Co, 2010.

Brody, H. *Ethical Decisions in Medicine, 2nd ed*, Boston: Little, Brown and Com, 2007.

Bruce, N. Waller. *Consider Ethics: Theory, Readings, and Contemporary Issues*. New York: Pearson Longman, 2005.

Chambers, T. *Major Issues and Debates in Contemporary Ethics*. Nova York: Routledge, 1999.

Charles, Timothy. *Ethical Problems: Contemporary Quests.* London: White House Internationals, 2009.

Carlin, N. *Ethics: Critical Thinking in Philosophy of Arts*. London: Pearson Longman, 2008.

Cole, J and Carson, B. *Medical Humanities: An Introduction*. New York: Cambridge University Press, 2015.

Campbell, A.V. *Moral Dilemmas in Medicine*. Edinburgh: Churchill Livingstone, 1972.

Culver, C.M and Gert, B. *Philosophy in Medicine*. New York: Oxford University Press, 2018.

Daniel, D. *Practical Medical Ethics.* New Jersey: John Wiley Publications, 1992.

Dipo , I. "The Nature and Meaning of Ethics". In: F.A, Adeigbo, I. Dipo and A. Udefia (ed.) *Ethics and Public Affairs*. Ibadan: Ibadan University Press, 2014.

Duncan, A.S. eds. *Dictionary of Medical Ethics*. New York: Crossroad, 2009.

Dunstan, G. R. and Shineborne, E.A. eds. *Doctors' Decisions: Ethical Conflicts in Medical Practice*. New York: McGraw Hill, 2006.

Emmanuel, E. "Critical Issues in Contemporary Ethics." In: Ted Honderich, (ed.), *The Oxford Companion to Philosophy*. Oxford: Oxford University Press, 1995.

Engelhardt, H.T. *The Foundations of Bioethics*. Cambridge: The Queen Press, 2013.

Fabrice, J. "The Hippocratic Oath and Contemporary Medicine: Dialectic Between Past Ideals and Present Reality." In: *The Journal of Medicine and Philosophy*. Vol. 30, No. 33, 2005, 234-245.

Flew, Antony. "Consequentialism." In: S. Martins (ed.) *A Dictionary of*

Philosophy. New York: Brace and Orbit, 2003.

Gillon, R. ed. *Principles of Health Care Ethics.* Chichester: John Wiley and Sons, 1994.

Gelfand, M. *Philosophy and Ethics of Medicine*. Edinburgh: Churchill Livingstone, 2003.

Gorovitz, S. *Doctor's Dilemmas: Moral Conflict and Medical Care.* New York: McGraw Hill, 2017.

Gorovitz, S. (eds. *Moral Problems in Medicine*. Engelwood: Prentice-Hall, 1995.

Hunt, R. Assas, J. Ethical Issues in Modern Medicine. Nova York: Mayfield Pub Com, 1999.

Harrison, C and Williams, K. *Philosophy and other Disciplines* United Kingdom: Ever-Rich Communications, 2011.

Hawkins, A. *Ethics: Issues in Philosophy of Science*. London: Freedom Press, 2017.

Jonsen, A Siegler, M. and Winslade, W. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine. 7*th ed. New York: McGraw-Hill; 2010.

McNamee, T. "Time for a Unified Approach to Medical Ethics." In: L. Gideon (ed.) Philosophy, Ethics, and Humanities in Medicine. Australia: Giant Academic Inc., 2009.

Omoregbe, J.I. *Ethics: A Systematic and Historical Study.* Lagos: Joja Publishers, 2006.

Peter, K and Daniel, D. *Bioethics and Secular Humanism: The Search for a Common Morality*. Cliffs: Prentice-Hall, 1991.

Rogers, D and Clinton, S. "The Patients and the Doctors." In; L. Samuel ed. *Contemporary Discourse in Professional Ethics*. New York: Pearson Longman, 2013.

Roger, Crisp. "Deontological Ethics." In: Ted Honderich, (ed.), *The Oxford Companion to Philosophy*. Oxford: Oxford University Press, 1995.

Terry, J and Williams, P. *Ethical Theories: A Comparative Study*. New York: Oxford University Press, 1999.

Timothy, Charles. *Ethical Problems: Contemporary Quests.* London: White House Internationals, 2009.

Waller, N. Bruce. *Consider Ethics: Theory, Readings, and Contemporary Issues*. New York: Pearson Longman, 2005.