Appendix C

Medical ethics in context

Deontology is a branch of normative ethics that argues for the primacy of moral principles in human actions. Applied to medicine, deontology claims that all treatments must be based on good intentions. Some of the deontological tenets such as humility, respect for others, courtesy to strangers etc. have a long tradition and can be traced back to the early centuries of the Common Era; Tirrukural in Tamil literary heritage provides such an early example.

The principles of modern deontology can be traced back foremost to Immanuel Kant (1724-1804). The Kant's teaching is based on the key importance of the moral agent acting always based on the normative moral principles and in contrast to the consequentialist theories not on the expected outcomes. Subsequently, the imperative character of Kant's doctrine has been questioned and new deontological teachings such as those focusing on agent- and patient-relationships have been proposed.

Nevertheless, modern medical ethics in the Western cultural tradition subscribe to deontology as the guiding principle. Yet, in clinical practice other moral principles and ethical considerations may also apply. In Europe in 1987 [European Medical Ethics] in thirty-seven short articles the rules of conduct concerning wide range of medical activities have been spelled out. In this document the section ***the doctor's commitment*** reads as follows:

Article 2
In the practice of his or her profession, the doctor commits to giving priority to the patient's healthcare interests. The doctor must only use his or her professional knowledge to improve or maintain the health of those who entrust themselves to his or her care, at their request; the doctor may not, in any case, act to their detriment.
Article 3
The doctor is forbidden from imposing personal, philosophical, moral or political opinions on the patient in the practice of his or her profession.

In some contrast to this somewhat vague formulation the American College of Physicians Ethics Manual provides far more detailed information and guidance to medical practice. For example, the section *Medical risk to physicians and patients'* states:

Physicians take an oath to serve the sick. Traditionally, the ethical imperative for physicians to provide care has overridden the risk to the treating physician, even during epidemics. In recent decades, with better control of such risks, physicians have practiced medicine in the absence of risk as a prominent concern. However, potential occupational exposures, such as Ebola virus disease, Zika virus, HIV, multidrug-resistant tuberculosis, and severe acute respiratory syndrome necessitate reaffirmation of the ethical imperative.

Further below in the section *The Patient–Physician Relationship and Health Care System Catastrophes* it helpfully defines:

Large-scale health catastrophes from infectious causes (for example, Ebola, influenza, severe acute respiratory syndrome), natural disasters (for example, tsunamis, earthquakes, hurricanes), or terrorist attacks can overwhelm the capabilities of health care systems and have the potential to stress and even change the traditional norms of the patient–physician relationship. For example, physicians may unavoidably conduct triage. Furthermore, many state, national, and international bodies have issued reports on health catastrophes that include recommendations for unilateral physician decisions to withhold and withdraw mechanical ventilation from some patients who might still benefit from it, when the demand for ventilators exceeds supply. The guiding principles for health care delivery during catastrophes may shift from autonomy and beneficence to utility, fairness, and stewardship. One report notes that "[a] public health disaster such as an influenza pandemic, by virtue of severe resource scarcity, imposes harsh limits on decision-making autonomy for patients and health care providers". Physicians together with public and governmental organizations should participate in the development of guidelines for the just delivery of health care in times of catastrophe, being mindful of existing health disparities that may affect populations or regions.

With the multitude of issues concerning the Corona virus pandemic and growing global instability the critical importance of applied ethics as practice by individual doctors in their daily encounters with the patients has received new meaning. Within a short period of time physicians and other medical professionals, particularly those on the frontlines are put on the spot to make a wide range of professional and personal ethical decisions about prioritization of responsibilities not only towards patients but also other stakeholders participating in the delivery of health care, triaging in cases of limited supply, managing dwindling staff and own doubts. Thus, numerous reports from the early days of the pandemic bear witness to the scope of ethical conflicts arising in context of emergencies. Early reports on the emotional and physical demands on poorly prepared frontline workers facing "war-like conditions in a war without hinterland" provide important insights into the meaning of applied medical ethics real-life. With limited knowledge about the hazards to one's own health and the nature of risk to others, frontline workers, particularly during the early stages of pandemic in cluster centres, had to deal with difficult tasks assuring the patient care by making responsible decisions often on the spot. Ethics "under fire" at the frontlines is a showcase of the importance of personalized applied ethics. In such context Doctor Peabody's adage, *The secret of the care of the patient is in caring for the patient* becomes a challenge faced by all physicians. Here, no single answer will exist. Rather, personalized applied medical ethics comes to fore.

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