MEDICAL ETHICS LECTURE SERIES

Lecture 1

Definition and Fundamentals of Medical Ethics

Department of Psychiatry • Jordan University Hospital
Psychiatry Residency Training Program

Duration: 40 minutes

LECTURE OVERVIEW

Learning Objectives

- Define medical ethics and distinguish it from morality, law, and etiquette
- Explain what makes the physician–patient relationship ethically distinct
- Trace the historical foundations that shaped modern medical ethics
- Describe the four-principles framework and apply it to a clinical scenario
- Discuss whether, and how, medical ethics changes across time and cultures

LET'S BEGIN WITH A SCENARIO

Case Study

CASE VIGNETTE

A 68-year-old man with newly diagnosed pancreatic cancer is admitted under your team. His adult children ask the resident, in the corridor, not to tell their father the diagnosis — arguing that “in our culture, this news will destroy his hope.” The patient has already asked you, directly and clearly, “Doctor, please tell me exactly what is wrong with me.”

Discussion: Whose voice should guide disclosure — the family, the patient, or the physician’s own judgment? Hold this question; we will return to it.

This single scenario touches autonomy, beneficence, confidentiality, and cultural context — the exact themes of today’s lecture.

What Is Medical Ethics?

> *"The study of the moral, or ethical, aspects of medicine, including the moral values that should inform individual physician conduct and the goals and structures of the healthcare system as a whole."*
>
> — WMA Medical Ethics Manual, 3rd ed.[1]

Medical ethics asks, and tries to answer, the practical question: "What should I do, and why?" — in the specific context of caring for patients.

Three things medical ethics is NOT:

Not just "being a good person"

It requires specific professional knowledge — of consent, confidentiality, competing obligations.

Not the same as law

Something can be legal but unethical, or ethical but not (yet) codified in law.

Not fixed for all time

It evolves as medicine, society, and technology change — explored later in this lecture.

WHY ETHICS MATTERS HERE

What's Special About Medicine?

Vulnerability	Patients are sick, frightened, or in pain — rarely on equal footing with the physician.
Power asymmetry	Physicians hold specialised knowledge, access to the body, and influence patients rarely have.
Trust as currency	Patients must disclose intimate information and permit examination — medicine cannot function without trust.
High-stakes decisions	Choices affect health, autonomy, and sometimes life itself — errors are rarely fully reversible.

HOW WE GOT HERE

A Brief History

c. 400 BCE

Hippocratic Oath

First articulation of physician duty: benefit the patient, do no harm.

1947

Nuremberg Code

Ten principles for research ethics, written after Nazi medical atrocities.[2]

1948

Declaration of Geneva

WMA's modern restatement of physician commitment; revised repeatedly since.[3]

1964–2013

Declaration of Helsinki

WMA's global standard for ethical research on human subjects.[4]

1979

Belmont Report

Established respect for persons, beneficence, and justice in research ethics.[5]

CLEARING UP CONFUSION

Ethics, Morality, Law, and Etiquette

Law

What society enforces through courts and penalties. Legal ≠ ethical (e.g., some legal acts remain unethical).

Morality

An individual's or community's broader beliefs about right and wrong — shaped by religion, culture, upbringing.

Ethics

Reasoned, justifiable standards of conduct — in medicine, grounded in professional duty and codified guidance.

Etiquette

Rules of professional courtesy (e.g., how physicians address colleagues) — matters of custom, not moral weight.

BEAUCHAMP & CHILDRESS[6]

The Four Principles Framework

Autonomy

Respect a patient's right to decide for themselves

Beneficence

Act in ways that benefit the patient

Non-maleficence

Above all, do no harm

Justice

Treat patients fairly and allocate resources equitably

Principle 1: Autonomy

“Respect for the patient's right to hold views, make choices, and take actions based on personal values and beliefs.”[7]

In practice, this means:

- Obtaining valid informed consent before any intervention
- Disclosing diagnosis and prognosis honestly, even when news is difficult
- Respecting a competent patient's refusal of treatment
- Protecting confidentiality unless overridden by a clear, justified exception

[7] *WMA Medical Ethics Manual, 3rd ed., Chapter Two.*

Principle 2: Beneficence

“The duty to act for the benefit of the patient — promoting their welfare and best interests.”[8]

In practice, this means:

- Recommending treatments on the basis of best available evidence
- Considering the patient's own values when defining what “benefit” means
- Balancing beneficence against the patient's autonomy — benefit is not imposed
- Extending beyond the individual: contributing to public health and community welfare

[8] *AMA Code of Medical Ethics, Principles of Medical Ethics.*

Principle 3: Non-maleficence

“Primum non nocere — above all, do no harm. Avoid interventions where risk clearly outweighs benefit.”[9]

In practice, this means:

- Weighing risk versus benefit before every intervention, test, or medication
- Avoiding futile or unnecessarily burdensome treatment
- Recognising that inaction can itself cause harm — non-maleficence is not passive
- Applies to psychological and emotional harm, not only physical harm

[9] *Beauchamp TL, Childress JF. Principles of Biomedical Ethics, 8th ed., 2019.*

Principle 4: Justice

"The fair, equitable, and appropriate distribution of benefits, risks, and resources among patients."[10]

In practice, this means:

- Allocating scarce resources (beds, medications, specialist time) without discrimination
- Treating patients equally regardless of background, diagnosis, or ability to pay
- Recognising structural barriers to equitable care — not just individual decisions
- Balancing individual patient advocacy against fairness to the wider patient population

[10] *UNESCO Universal Declaration on Bioethics and Human Rights, Art. 10–11.*

BACK TO OUR CASE STUDY

Applying the Four Principles

Autonomy	The patient explicitly asked for the truth — this is a direct, competent request that carries strong ethical weight.
Beneficence	Truthful disclosure, delivered with compassion, generally serves the patient's best interest and preserves trust.
Non-maleficence	Withholding the diagnosis risks harm too: loss of trust, inability to plan, and exclusion from his own care.
Justice	The family's cultural concern deserves respect and a compassionate conversation — not automatic authority over the patient's own information.

SOURCES OF ETHICAL GUIDANCE

Who Decides What Is Ethical?

The individual physician

Personal conscience, reasoning, and professional judgement in the moment of decision.

Professional bodies

Codes of ethics (WMA, AMA, national medical councils) set shared professional standards.

Law and regulation

Statutes and health-ministry regulations set enforceable minimums — a floor, not a ceiling.

Society and culture

Public expectations and cultural norms shape what patients and communities consider acceptable.

YES — IT EVOLVES

Does Medical Ethics Change?

Ethical standards shift as medicine, evidence, and society change:

From paternalism to shared decision-making

Mid-20th century medicine often withheld information “for the patient's own good.” Today, informed, shared decision-making is the expected standard.[11]

Removal of homosexuality as a disorder

Reclassified by the American Psychiatric Association in 1973, reflecting evolving scientific understanding and social values.[12]

Research ethics after historical abuses

The Nuremberg Code and Belmont Report emerged directly from documented research atrocities — ethics was rebuilt in response.[25]

A UNIVERSAL CORE, LOCAL APPLICATION

Does Medical Ethics Differ by Culture?

Universal core

International instruments — the WMA Declarations and the UNESCO Universal Declaration on Bioethics and Human Rights — articulate principles intended to apply everywhere: dignity, consent, non-maleficence, justice.[13]

Local application

How principles are applied varies: family involvement in decisions, disclosure norms, and end-of-life practices differ across Jordan, Europe, and North America — without abandoning the shared underlying principles.

A GLOBAL ANCHOR

The Role of the World Medical Association

International Code of Medical Ethics

Codifies the duties of physicians to patients, colleagues, and society — most recently revised in 2022.[14]

Declaration of Geneva

The modern physician's pledge, restated for each generation since 1948; most recent revision 2017.[3]

Declaration of Helsinki

The global reference standard for the ethical conduct of research involving human participants.[4]

A PRACTICAL REASONING PROCESS

How Do Individuals Decide?

This is the same reasoning loop we will use for every case in this lecture series.

1 — Identify the facts

Clinical situation, patient wishes, family context, prognosis.

2 — Identify the principles at stake

Which of autonomy, beneficence, non-maleficence, or justice apply — and where they conflict.

3 — Consult guidance

Professional codes, institutional policy, and — where needed — an ethics consultation.

4 — Decide and act

Choose the most justifiable course, and be able to explain the reasoning behind it.

5 — Reflect afterward

Review the outcome and reasonin — ethical skill improves through reflective practice.

RESOLUTION

Back to the Case Study

A competent patient's clear request for the truth generally takes precedence over family preference. The ethically sound path is not to choose sides, but to engage both: acknowledge the family's cultural concern with genuine respect, and gently confirm with the patient how much detail, and in what manner, he wants information delivered.

Principles in tension, and how they resolved:

- Autonomy (patient's explicit request) carried the greatest ethical weight here
- Beneficence was served by honest, compassionate communication — not by silence
- The family's concern was addressed through dialogue, not by overriding the patient

KEY TAKEAWAYS

Definition and Fundamentals of Medical Ethics

- Medical ethics is the reasoned, justifiable standard of conduct guiding physician behaviour — distinct from law, morality, and etiquette
- Medicine is ethically distinctive because of patient vulnerability, power asymmetry, and the centrality of trust
- The four-principles framework — autonomy, beneficence, non-maleficence, justice — offers a practical, shared vocabulary for ethical reasoning
- Medical ethics has evolved historically and continues to evolve, guided by international instruments such as the WMA Declarations
- A universal ethical core is applied with sensitivity to local culture — not replaced by it

References

1. World Medical Association. Medical Ethics Manual. 3rd ed. Ferney-Voltaire: WMA; 2015.

2. Nuremberg Military Tribunals. Trials of War Criminals Before the Nuremberg Military Tribunals: The Nuremberg Code. 1947.

3. World Medical Association. WMA Declaration of Geneva. Adopted 1948; revised 2017.

4. World Medical Association. WMA Declaration of Helsinki — Ethical Principles for Medical Research Involving Human Subjects. Adopted 1964; revised 2013.

5. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The Belmont Report. 1979.

6. Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 8th ed. New York: Oxford University Press; 2019.

7–8. American Medical Association. AMA Code of Medical Ethics. Available at: code-medical-ethics.ama-assn.org.

10–13. UNESCO. Universal Declaration on Bioethics and Human Rights. Paris: UNESCO; 2005.

12. American Psychiatric Association. Position Statement on Homosexuality and Civil Rights. 1973 (historical record of DSM reclassification).

14. World Medical Association. WMA International Code of Medical Ethics. Adopted 1949; revised 2022.