KING KHALID UNIVERSITY

Introduction to the Course and the History of Medical Ethics

Medical Ethics · MED 431 · Lecture 1

Introduction to the course, and where its rules came from

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Three decisions you will have to make

- A woman with metastatic cancer asks you what her scan showed. Her son has begged you to say nothing.
- A man on a ventilator left no written instructions. His family is divided about withdrawing support.
- Two patients arrive in septic shock. There is one ICU bed and their severity scores are identical.

None of these is a gap in medical knowledge.

So what are they?

- Situations where two or more legitimate values conflict, and no algorithm settles the answer
- **Recognising, analysing and navigating them is a core clinical competency**
  - As essential as reading an ECG or managing sepsis — not a soft skill at the margins of medicine

What this course will not give you

- A formula that produces the correct answer to every ethical question

- **What it will give you**
  - A structured way of thinking — principles, frameworks, and habits of moral reasoning for approaching hard cases with clarity, consistency and compassion

First tool

Is this even an ethical dilemma?

Not every difficult situation is one

- Some difficulties are clinical — what is the diagnosis?
- Some are organisational — how do we manage this with what we have?
- Some are emotional — this is painful for everyone
- **An ethical dilemma has a structure:**
  - A decision must be made — inaction is itself a choice
  - There are at least two morally defensible options
  - Each option violates some principle or causes moral harm
  - No option is clearly superior on every dimension

Apply it to the three cases

- Take each one and test it against the four conditions
  - Which principle does each option violate?
  - Is there an option that is better on every dimension?
- **If there is, the problem was never ethical — it was clinical, organisational or emotional**

A second distinction: ethics is not law

- Law sets a floor of minimally acceptable behaviour, enforced by sanction

- **Ethics often demands more than the law requires**
  - A physician who tells a patient the bare minimum needed for legal consent may be acting lawfully and not ethically
- Laws differ between countries; core ethical principles are far more stable

  - Active euthanasia is lawful in some countries. It is prohibited in Islam and unlawful in Saudi Arabia.

Six moments

that changed what a doctor is allowed to do

Six moments, at a glance

c. 1754 BCE	c. 420 BCE	9th century	1914	1939–1972	1979
Hammurabi	**the Oath**	**al-Rahawi**	**Schloendorff**	**the abuses**	**four principles**
accountability	the profession	a discipline	a right	consent	a language

Each one took something the doctor decided alone, and moved it.

1 · Babylon, c. 1754 BCE — the healer becomes accountable

- The Code of Hammurabi sets fees for surgery — and penalties for the physician whose patient dies or is harmed
- In Egypt, physicians are expected to follow the protocols written in the medical papyri
- **What changed**
  - Healing stops being a private art. Someone may now be answerable for it.

2 · Cos, c. 420 BCE — the profession binds itself

- Act in the patient’s best interest
- Avoid harm — primum non nocere
- Keep the patient’s confidence
- No sexual relations with patients

What changed

- Medicine becomes a profession — a vocation with internal moral standards, distinct from trade. The duties are owed by the doctor, and decided by him.

3 · Baghdad, 9th century — conduct becomes a discipline

- **Ishaq ibn Ali al-Rahawi, Adab al-Tabib — The Conduct of the Physician**
  - Twenty chapters; the first book in history devoted entirely to medical ethics
  - Physicians described as “guardians of souls and bodies”
- Ibn Sina (980–1037): the Canon taught for five centuries — treat body, mind and soul; the patient’s trust is part of the treatment
- Grounded in fiqh and maqasid al-shari’ah: life, intellect, progeny, wealth, religion

Medicine before the patient had a say

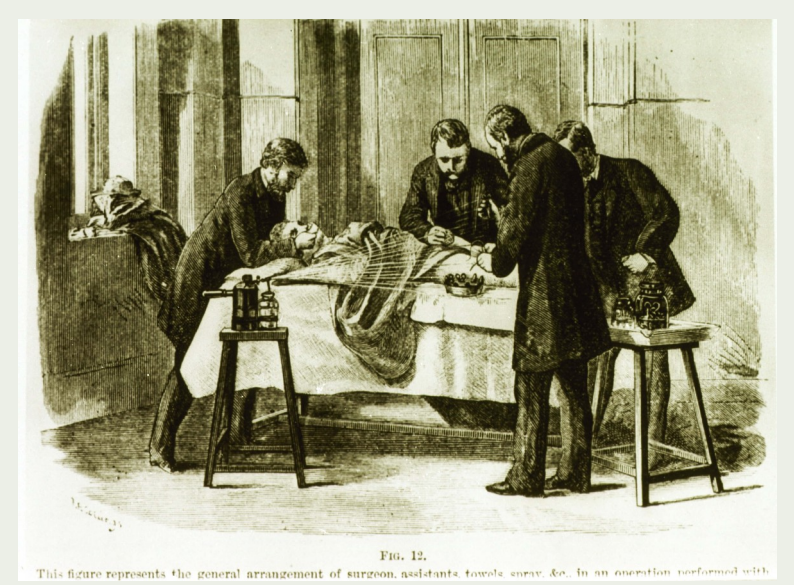


Fig. 12.

This figure represents the general arrangement of surgeon, assistants, towels, spray, &c., in an operation performed with

For most of its history medicine was practised on patients rather than with them. The doctor decided, and frequently did not tell.

READ Applied Medical Ethics §1.2 — A Brief History of Medical Ethics husainalkhaldy.site/books/applied-medical-ethics#h8

4 · New York, 1914 — the patient acquires a right

- Mary Schloendorff consented to an examination under anaesthesia, and expressly refused any operation
- A fibroid tumour was removed anyway. She developed gangrene of the left arm and lost fingers.
- She sued. Justice Benjamin Cardozo delivered the judgment of the New York Court of Appeals.

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body.”

— Justice Benjamin Cardozo, 1914

What changed in 1914

- Autonomy stops being a courtesy the doctor may extend, and becomes a right the patient holds
- **The first legal recognition of patient autonomy — and the beginning of informed consent as a requirement, not a formality**

5 The century of abuses

The modern field of bioethics was born out of moral horror

1939 to 1945

Nazi human experimentation

- Hypothermia, high-altitude depressurisation, forced infection, transplantation and surgery — performed on prisoners
- No consent was sought, and no limit was enforced by anyone
- **The physicians involved were qualified, published, and several held chairs of medicine.**

1932 to 1972

Tuskegee, Alabama

- 399 Black men with syphilis, enrolled without being told what they had
- Deceived about their condition for forty years
- **Penicillin became the standard treatment in 1947. They were still not treated.**
- The study ended in 1972, and only because a journalist published it.

1946 to 1948

Guatemala

- United States Public Health Service researchers deliberately infected prisoners, soldiers and psychiatric patients with syphilis and gonorrhoea
- Around 1,300 people were infected; several thousand more were subjected to study procedures
- **The record was found by a historian in 2010, and the United States apologised.**
- Sixty years passed before anyone outside the study knew.

1956 to 1970

Willowbrook

- Children with intellectual disability at a New York state school were deliberately infected with hepatitis
- The school was overcrowded, and admission became effectively conditional on enrolling in the study
- **Consent was obtained — from parents who had no other way in**
- Consent extracted from someone with no alternative is not consent.

Baltimore, 1951

Henrietta Lacks

Her tumour cells were taken during treatment, shared, and grown worldwide as the HeLa line. She never consented, and her family was not told for twenty-five years.



Two things these have in common

- **The subjects were people with the least power to refuse**
  - Prisoners, soldiers, orphans, psychiatric patients, the poor, the institutionalised, the segregated
- **Nobody involved thought of himself as a criminal**
  - Each study had a scientific rationale, an ethics-free approval, and a reasonable-sounding published paper

The answer: Nuremberg, 1947

Box 1. Nuremberg Code 1947

- Obtaining voluntary, informed consent is essential. The research participant must be fully informed of all aspects of the research to enable him or her to make a fully informed decision as to whether or not to take part
- The research should be to obtain results which are for the good of society, not unnecessary in nature and not obtainable by other means
- The research should be based upon a prior knowledge of the history of the disease or problem under study (including animal research) and the results should justify the research being undertaken
- The study should be conducted as to avoid all unnecessary physical or mental suffering and injury
- No experiment should be conducted, where there is an apriori reason to believe that death or disabling injury will occur
- The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by the experiment
- Proper preparations should be made and adequate facilities provided to protect the participant against risks of injury, disability, or death
- The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the research study
- The participant is able to withdraw from the study at any time
- During the course of the study, the scientist in charge must be prepared to terminate the research, if he has probable cause to believe that a continuation of the study is likely to result in injury, disability, or death to the experimental subject

Source: Nuernberg Military Tribunals, 1949

For the first time in international law, voluntary informed consent becomes an absolute requirement for human experimentation.

READ Applied Medical Ethics Ch. 13 — Research Ethics husainalkhaldy.site/books/applied-medical-ethics#h151

And then the instruments that followed

- Declaration of Helsinki, 1964 — the duties of the physician-researcher, revised repeatedly since
- Belmont Report, 1979 — written after Tuskegee was exposed
  - **Three principles: respect for persons, beneficence, justice**
- Note carefully: Belmont has three, not four. The four principles are a different framework, published the same year.

6 · 1979 — medicine acquires a common language

- **Beauchamp and Childress, Principles of Biomedical Ethics**
  - Four prima facie principles — binding unless overridden by stronger competing considerations
  - Offered as a framework that works across different moral traditions
- **What changed**
  - Doctors from different traditions acquire a shared vocabulary for disagreeing precisely.

The tools those six moments produced

The four principles

Autonomy

the right of a competent person to decide about their own body, free from coercion

Beneficence

acting in the patient’s best interest; actively doing good, not merely avoiding harm

Non-maleficence

that the benefit justify the risk. Not that the risk be zero.

Justice

fair allocation, equal rights, and the law

Prima facie: each is binding unless a stronger consideration overrides it. None automatically outranks the others.

Where they collide

- Autonomy against beneficence — the competent patient refuses what would save her
  - Overriding her “for her own good” is paternalism: once the default of medical practice, now indefensible in a competent adult
- Beneficence against justice — everything you do for this patient is a resource another patient does not get
- **Naming the pair in tension is most of the work. Do that before you decide.**

Three ways of arguing — and one more

- Deontology (Kant) — some acts are right or wrong in themselves, whatever follows. “She had a right to know.”
- Consequentialism (Bentham, Mill) — the right act is the one with the best overall outcome. This is how quarantine is defended.
- Virtue ethics (Aristotle) — not “what should I do?” but “what kind of person should I be?”

- **The same action can be reached by all three roads. Listen to the justification, not the act.**

Islamic ethical theory

- Theocentric — obligations derive from the Quran and Sunnah, interpreted through usul al-fiqh
- La darar wa la dirar — do no harm, and cause no harm to others
- Al-darurat tubih al-mahzurat — necessity permits the prohibited
- Al-maqasid al-shari’ah — preserving life, intellect, progeny, wealth and religion; hifz al-nafs comes first
- **These are tools with different jobs. Match the maxim to the work the case needs done.**

Paternalism gave way to autonomy. Has the pendulum swung too far?

Now work one

The case

- A 62-year-old woman is admitted with jaundice. Imaging and biopsy show metastatic pancreatic cancer.
- Her son, a pharmacist, meets you in the corridor before you see her. He asks you not to tell her, and says the family has decided.
- She asks you directly what the tests showed.
- **What do you do — and on what grounds?**

Work it in this order

- **Is it a dilemma? Two defensible options, each violating something?**
- **Which principles are in tension, and for whom?**
- **What does she actually want to know? Have you asked?**
- **What would each theory say — duty, outcome, character?**
- **What do the law and the SCFHS code require of you here?**
- We take this much further in Chapter 7 — Truth-Telling and Communication.

How this course works

Two tracks, both examined

- Medical ethics — in English, with me and guest lecturers from the College of Medicine, in person
- الفقه الطبي — in Arabic, with Dr. Yahya Alkhalayleh, عن بُعد
- **Neither track owns the other. Both carry marks.**
- Three periods a week: two for medical ethics, one for الفقه الطبي

Assessment

- Electronic assignments on Blackboard — 20%
- Midterm, Arabic part — 20% (week 9)
- Midterm, English part — 20% (week 12)
- Final examination — 40% (weeks 18–19)
  - MCQs on the English topics, short answers on the Arabic topics

What we will cover

- Professionalism — as a student, then as a doctor
- Patient rights, autonomy and informed consent
- Privacy, confidentiality, truth-telling
- Research ethics, publication ethics, AI in medicine and academia
- Specialty ethics — surgery, women’s and children’s health, end of life, organ donation, special needs
- الفقه الطبي alongside all of it

Your book — online, free, and the source for these slides

- **Applied Medical Ethics — the full edition, 18 chapters**
  - husainalkhaldy.site/books/applied-medical-ethics
- **Trainee Edition — shorter, written for the wards**
  - husainalkhaldy.site/books/applied-medical-ethics-trainee
- **Question Bank — 113 scenarios, answers explained**
  - husainalkhaldy.site/books/applied-medical-ethics-qbank
- It supports the lectures and the set textbooks. It does not replace them.

Recommended textbooks

RECOMMENDED TEXTBOOKS:

1. Saudi Commission for health specialties. Professionalism and ethics for medical resident,
2. الجمعية العلمية السعودية للدراسات الطبية الفقهية، الفقه الطبي، ٢٠١٠
3. الهيئة السعودية للتخصصات الصحية، أخلاقيات الممارس الصحية، ٢٠١١
4. اخلاقيات الطب، ٢٠٢١ جمال الجار الله،

N.B: all recommended textbooks will be made available to students as soft copies

All are supplied to you as soft copies.

Before every lecture — not only the next one

- Every lecture in this course has a chapter behind it
- **Read the chapter before the lecture, not after**
- **Then do the case vignettes at the end of that chapter**
  - Bring your answers. We argue about them in class, and you will be asked to defend yours.
- Today was Chapter 1. From next week the reading runs ahead of the lecture, not behind it.

Which chapter goes with which week

- Week 3 · Rules and regulation in study and training — Ch. 2 and Ch. 17
- Week 4 · Professionalism, student and doctor — Ch. 2 and Ch. 3
- Week 5 · Patient rights — Ch. 4
- Week 6 · Informed consent — Ch. 5
- Week 7 · Research and publication ethics — Ch. 13 and Ch. 14
- Week 8 · Academic integrity and copyrights — Ch. 2 and Ch. 14
- Week 10 · Public health · organ donation — Ch. 16 and Ch. 11
- Week 13 · Privacy and confidentiality · special needs — Ch. 6 and Ch. 12
- Week 14 · Surgery · women and children · end of life — Ch. 9, 8 and 10
- Week 15 · AI in medicine and academia — Ch. 15
- **Chapters 7 and 18 run underneath several of these. Read them when the topic reaches them.**

And one more thing

- **Write to me by email, and write it properly**
  - halkhaldy@kku.edu.sa
- Your section representative is the first point of contact for anything that concerns the whole class.

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