MEDICAL ASSOCIATION OF TANZANIA

Guiding Principles on Medical Ethics and Human Rights in Tanzania

CMA
Commonwealth Medical Association

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The principles set out in this booklet have been approved by the National Council of the Medical Association of Tanzania. They are based on the Guiding Principles on Medical Ethics and Human Rights issued by the Commonwealth Medical Association with amendments to take into account the conditions of medical practice in Tanzania.

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Respect for the patient

Principle 1: Physicians must pay full respect at all times and in all circumstances to persons they are attending[1]

Commentary:

This principle applies irrespective of the age, race, colour, gender, sexual orientation, lifestyle, religion, educational level, socio-economic position or political affinities of the persons they are attending; as well as of the status, eg whether they be refugees, prisoners or visitors, and of the diseases or disabilities from which they are suffering.[2]

Patient's right to information

Principle 2: Patients have a right to receive relevant information about their own medical condition and its management

Commentary:

Refusal to impart such information, when requested, diminishes the trust which is fundamental to the physician/patient relationship.

The development of good communication and rapport with the patient should make it unnecessary to withhold information other than on a temporary basis in order that a suitable time can be found to provide a full explanation of the facts. Physicians must always inform patients promptly of any significant errors that may have occurred in the course of investigation or treatment.

Consent to medical procedures

Principle 3: Treatment and other forms of medical intervention to patients who have the capacity to consent should not be undertaken without their informed consent

Commentary:

Patients must always be given sufficient information to enable them to decide whether or not to accept treatment, including the relevant risks of the proposed treatment as well as its expected benefits.[3] Wherever possible available alternative treatments should be offered if the patient objects. A change of mind by the patient at any stage of treatment must always be respected.[4]

Physicians should be careful not to exert undue pressure on patients to accept treatment,[5] and should refrain from adopting diagnostic or therapeutic procedures that have not been endorsed by contemporary competent medical authority.

They should take care not to associate themselves with unacceptably coercive health policies such as those which have been introduced for population management reasons.

Physicians should be aware that the reluctance of patients to accept treatment, especially if it involves hospital admission, may often result from anxiety, particularly in women, about the consequences for other members of their family.[6] Physicians should do what they can to alleviate such anxiety eg by allowing members of the family to stay in hospital with the patient, by arranging early discharge, or by offering alternative arrangements or procedures.[7]

Physicians must also bear in mind that influence may be exerted on patients by other persons, eg it is customary in some societies for the male head of the family to take decisions about medical treatment for other members of the family.

Patients should be encouraged to make their own choices about medical treatment, even if they are unaccustomed to do so and are content that others should express an opinion and take the final decision for them. This is particularly important in societies where it is usual for marriage to occur at an early age, when it is in the interests of the health of the woman and her children that she has access to services such as family planning.

Where the patient has the ability to understand the proposed treatment and its likely consequences, his (or her) wishes should be respected irrespective of age or any other factor that might be regarded as affecting the right to consent.[8]

Where a patient does not have the ability to understand the nature of proposed medical treatment and its consequences, the decision whether to proceed should be taken in the interests of the patient,[9] irrespective of the views expressed by others, such as those caring for the patient, as they may not necessarily be in the patient's best interests. In cases where the proposed treatment infringes human rights, such as reproductive rights, a second opinion and/or an application to a court of law may be necessary before the procedure can be carried out.

Confidentiality

Principle 4: Information obtained in the physician/patient relationship must be regarded as strictly confidential

Commentary:

Besides being a right to which patients are entitled, confidentiality is essential to the physician/patient relationship. Physicians need to be aware of all relevant aspects of the patient's personal and family medical history in order to give safe and effective treatment. This will often include sensitive information that is unlikely to be disclosed by the patient unless confidentiality is assured.

When seeking the patient's consent to disclosure of confidential information, the physician must ensure that the patient understands the reasons for disclosure and its likely consequences.

Apart from situations where disclosure is required by law, such as the notification of infectious diseases, there must always be the most compelling reasons before a physician discloses confidential information without the consent of the patient,[10] eg an immediate and serious threat to the life or health of other persons. In such cases the physician must notify the patient of the intention to divulge the information whenever it is possible to do so.

Physicians should ensure that their supporting staff should be instructed to observe confidentiality.

Competence to practice

Principle 5: Physicians in active practise must maintain competence to practice at all times and must ensure that they never expose patients to unnecessary risks

Commentary:

Physicians must take steps to ensure that they keep up-to-date with relevant developments in their fields of practice,[11] and remain competent to provide patients with reliable advice about measures necessary to promote their good health. Patients must not be subjected to risk of avoidable harm from unnecessary procedures, nor must they be placed at risk as a result of the physician's own health status,[12] eg dependence on alcohol or other drugs.

Physicians must be able to recognise clinical situations in which their own professional skills and experience are inadequate and must be willing to refer patients to such suitably qualified and experienced colleagues as may be available.

Medical emergencies

Principle 6: Physicians must do all they can to assist at medical emergencies

Commentary:

Physicians must accept that their primary obligation is to save life and to relieve pain and suffering, eg conscientious objection to abortion,[13] does not absolve physicians from taking immediate steps in a life-threatening emergency to ensure that the necessary treatment is given without delay and before any avoidable damage can result to the patient.[14]

Physicians must recognise and react to situations where their ability to provide emergency treatment could be compromised, eg employment in hospitals which place unreasonable restrictions on emergency admissions, such as delaying or refusing treatment until it has been established that the patient is able to pay,

or participation in industrial action in circumstances where inadequate arrangements have been made to ensure that emergency treatment continues to be available.

Medical care for disadvantaged and vulnerable groups

Principle 7: The obligation of a physician to provide medical care for disadvantaged and vulnerable groups must be upheld. Physicians should endeavour to identify the causes of ill health in such groups and should draw attention to the need to alleviate them.

Commentary:

All sick or disabled persons are vulnerable insofar as they are likely to be unduly susceptible to suggestions which offer them relief from pain and suffering and a cure of their condition. Physicians must constantly bear this in mind[15] and be careful not to take unreasonable advantage of it. Physicians must also be aware of the special needs of those members of the community who are deprived of adequate access to health care or who have difficulty in making their requirements known. These groups should be given greater privacy to enable them to communicate directly with the physician.

They are at risk of exploitation, violence and abuse, and the risk is greatest for the following groups:

Children: Physicians must constantly bear in mind that violence suffered by children is by no means always accidental[16] and that sexual abuse of children may remain undetected for long periods of time.

Whenever they become aware of violence to children, from whatever source, physicians should enlist the aid of the social or other supporting services to deal with the problem. In many countries girl children are likely to be undernourished as a result of the discrimination which exists in favour of male children in the family. This may result in delayed physical development and difficulties with future childbearing.

As the HIV/AIDS pandemic spreads among the heterosexual population in developing countries, increasing numbers of children will lose their parents, and become orphans.

Child labour eg in the fields, is a common hazard to the health of children in such countries[17] even though it is usually proscribed by law.

The girl child is also less likely to receive adequate schooling and may often be required to carry out an unfair share of heavy physical work in the family home which can further damage her health.

Other hazards to the health of the girl child include adverse traditional practices such as genital mutilation.[18]

Physicians should endeavour to expose the dangers of such practices with the aim of changing the beliefs and attitudes which support them.

Adolescents: Adolescent girls are exposed to special health risks in developing countries as a result of gender (sex) discrimination and of being forced into marriage at too young an age.[19] Where additional earning power is needed for the family, or where their parents become sick, eg from AIDS, the girls in the family, rather than boys, will be the first to be taken away from school.

They may be forced to leave school prematurely as a result of becoming pregnant, following which they will have to earn money from available sources, which may be limited to commercial sex, drug peddling or other occupations hazardous to their health.

Too often their only recourse in pregnancy is to unsafe abortion. Physicians should try to help girls to avoid these adverse consequences by providing them with family planning counselling and services whenever necessary,[20] and with safe termination of pregnancy whenever it is appropriate and permitted by law.

In addition to HIV infection and others STDs, adolescent boys are also at special risk from substance abuse, including alcohol.

Women: Women in developing countries suffer disproportionately from ill health including many illnesses that are life-threatening. They are often denied access to means of controlling their fertility.[21]

Reliable information about the prevention of disease may never reach them because of the high incidence of functional illiteracy. The high maternal mortality rate in such countries is largely avoidable.

The associated morbidity from pregnancy-related causes includes fistula formation which will often lead to the affected woman being evicted from her home and left with no means of support. Physicians should do all they can to promote the services that can help women avoid these adverse consequences to their health, whilst taking care not to expose them to non-essential intrusive procedures.

Elderly: The dependence of the elderly on others for their care renders them susceptible to exploitation. The capacity of the extended family to care for the elderly has been seriously compromised in many developing countries by the effects of the HIV/AIDS pandemic which has reduced the number of family members available to look after them.

Physicians must be alert to the signs of violence and neglect in the elderly and do all that is possible to provide them with the support which is necessary to protect their health.

Other high risk groups: Physicians should be aware of the special needs of refugees,[22] asylum seekers, minority ethnic groups,[23] persons living in poverty, etc and should recognise that their access to health care is often limited. Refugee status is not conducive to health and refugee women are often subjected to sexual abuse.

Persons suffering from severe physical or mental incapacity[24] are often at risk of abuse, maltreatment or neglect by their families or by the institutions in which they have been placed. Physicians attending these vulnerable and disadvantaged groups must be vigilant in detecting any suspicious signs of violence or neglect, and must be sure to alert the appropriate authorities promptly.

Medical attendance upon persons held in detention

Principle 8: Attendance by physicians on persons held in detention must always be conducted in the best interests of their health[25]

Commentary:

Prison conditions in many countries are damaging to both physical and mental health as a result of overcrowding, inadequate nutrition, bad sanitation, prolonged detention, abuse of various kinds and the many other disadvantages of having to live in a dehumanising environment.

Physicians working in prisons must draw the attention of the prison authorities to unhealthy environmental conditions that must be remedied. If prison authorities refuse to take the necessary action the appropriate higher authority should be informed.

Physicians attending prisoners should take all possible steps to preserve the dignity of detainees eg by insisting wherever possible that medical examinations are carried out in private, that the ethical requirements of consent and confidentiality are respected, and that treatment is carried out in a humane manner.

They should ensure that the United Nations human rights instruments relevant to the care of prisoners and other detainees, particularly those concerned with juvenile detainees, are complied with.

Body searches: When law enforcement, prison or other detaining authorities decide that an intimate body search should be carried out on a detained person eg where there is reason to believe that dangerous substances may be concealed in body cavities, consent should always be sought by the examining physician from the prisoner before the examination is carried out. If consent is withheld it should be made clear to the prisoner that the examination may have to be carried out by someone without medical qualifications and experience, eg a prison officer.

Signs of violence: Physicians must be vigilant for signs of violence, particularly those resulting from torture or other degrading and inhuman practices. They must report the matter immediately to the prison or other detaining authorities, and make a comprehensive note of their findings at the time.

Any failure of the authorities to take appropriate action should be reported to the national medical licensing or registration body and to the national medical association.

Physicians must never falsify their medical reports on prisoners at the request of prison authorities nor must they acquiesce in the concealment of any signs of violence that may be disclosed at post-mortem examinations of prisoners. Drugs or medicaments (including psychoactive drugs) should never be prescribed or administered to prisoners other than for purposes of medical treatment.

Hunger strikes: Physicians requested to attend hunger strikers must first determine whether the prisoner is capable of forming the necessary intent to refuse food and/or whether there is coercion by others. This will include informing the prisoner of the injurious effects on health if food is refused beyond a certain stage. Prisoners who fully understand the implications of their choice should not be forcibly fed. Physicians should insist that only they, and not the prison or other detaining authorities, must decide whether compulsory feeding is appropriate eg where the prisoner's demands have been met, but he or she no longer has the mental capacity to take a decision.

Monitoring judicial punishments: In many countries,it is a legal requirement that corporal and/or capital punishment be overseen by a physician.

This presents an ethical dilemma for physicians. On the one hand, they recognise that participation in such activities (which can range from a flogging chosen by the convicted prisoner in lieu of imprisonment, to life-long mutilation and disability following judicially authorised amputations) lends a spurious respectability to such punishments which is contrary to the accepted goals of medical practice.

On the other hand the mandated presence of a physician may allow humane intervention eg if the flogging is excessively harsh.

It may also permit less pain, less mutilation and less disability following judicial amputations - an outcome often desired by victims faced with the inevitability of the sentence. If physicians refuse to participate their active civil disobedience may jeopardize their own lives and the prisoner's suffering may be increased. If physicians do participate, even under protest, they may be identified with, and help to perpetuate, an oppressive and inhuman practice. Neither option is satisfactory.

Whatever are the circumstances under which physicians attend or participate in punishments it is essential that they are appropriately qualified and are made fully aware of their rights and obligations.

NMAs, both nationally and internationally, should exercise their influence to try to abolish inhumane punishments. Individual physicians opposed to such activities should be supported and encouraged, and those who participate in them should be sensitized to the implications of their participation,

in the international quest for the elimination of degrading punishment and coercive forms of control as defined in the International Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.[26]

Medical examinations,reports, and procedures requested by third parties

Principle 9: Care must be taken not to compromise the interests of patients when carrying out examinations or supplying reports at the request of third parties

Commentary:

It is important that physicians should observe the guiding principles especially those concerned with consent and confidentiality, whenever medical examinations or reports are requested by third parties. Detailed medical information should never be passed to a third party without the specific consent of the person concerned, eg pre-employment medical reports should be limited as far as possible to a simple statement of fitness or unfitness for the post concerned.

Where detailed medical information is required by a third party it is important to ensure that the person to whom it relates understands the possible consequences before consenting to disclosure or to any medical examination or test being carried out in order to provide it, eg HIV testing. A warning must always be given to the patient in advance if it is impossible to guarantee confidentiality.

The same considerations apply to medical examinations and reports carried out for life or health insurance, and for any other purposes involving the interests of third parties.

Physicians must never acquiesce in the wrongful use of sex selection procedures for purposes of discrimination. Whilst gender selection may be acceptable for the purpose of avoiding the transmission of genetic disease, it should be employed only selectively and sparingly for this purpose, and its use for sex discrimination must be condemned.

Responsibility to the community

Principle 10: **Physicians, by reason of their training, expertise and status should actively promote the provision of effective health services and should notify health and other relevant authorities whenever they become aware of hazards to the health of the community[27]**

Commentary:

The community is exposed to a wide and increasing number of hazards to health in many countries. Physicians, as a result of their training in public health, and their status in the community, are in a unique position to draw attention to inadequate or improperly managed health services and institutions as well as to environmental hazards, whether they be industrial, domestic or therapeutic. Examples include water pollution, bad sanitation, toxic emissions, the improper disposal of toxic waste, and drug dumping by international companies.

The provisions of the World Medical Association's Declaration of Helsinki (Annex G) should be observed.

Health promotion and preventive medicine

Principle 11: The role of physicians in active practice should include the promotion of healthy life styles and education of the community in disease prevention[28]

Commentary:

Health promotion and preventive medicine are especially important in developing countries where preventable diseases and disabilities are the main causes of ill health. Accordingly, physicians should take every opportunity to educate their patients in healthy living[29] and in the avoidance of disease and disability. Patients should always be given the necessary information to enable them to improve their health and to prevent further illness.

Physicians should call attention to the adverse consequences of traditional practices which are harmful to health. They should seek, through community participation, to modify adverse social and cultural patterns of behaviour, such as early marriage, female genital mutilation, that have a deleterious effect on women's health, and they should advocate the elimination of prejudicial stereotyped roles for the sexes with which they are associated.

Relationships with medical colleagues

Principle 12: Physicians have a responsibility to co-operate fully with their medical colleagues in the interests of providing the best possible health care for the community

Commentary:

Shared health care between physicians is becoming increasingly common. It is in the best interests of patients that physicians should co-operate fully with each other and avoid undermining the reputation of their colleagues by criticising them unjustifiably. There should always be mutual respect among medical colleagues.

On the other hand, where it is apparent that patients are in danger as a result of deterioration in the professional ability and skills of a colleague, eg as a result of mental illness or the abuse of alcohol or other drugs, the situation should be reported without delay to the appropriate authority, using whatever special procedures exist for the purpose. Wherever practicable it is advisable to discuss the matter with a senior colleague before such action is taken, and it must always be taken in good faith.

Relationships with other health workers

Principle 13: Physicians should recognise and respect the expertise of other health workers,and collaborate with them in the interests of providing the best possible holistic health care

Commentary:

The contribution of other health professionals and health and social workers is becoming increasingly important in all countries. It is in the best interests of patients that the expertise of such workers should be acknowledged by physicians who should reinforce the contribution they can make to health care, by involving them fully in case management. Care must be taken to ensure that they are not asked to carry out procedures which they are not competent to undertake.

Relationships with traditional practitioners

Principle 14: Physicians should endeavour to influence traditional healers and birth attendants to adopt safe practices

Commentary:

In many societies patients rely partly or wholly on traditional healers for their health care, and they may consult both orthodox practitioners and traditional healers at the same time. Physicians should inform patients if they have good reason to believe that the traditional treatment they are receiving is detrimental to their health. [30] But care should be taken not to exaggerate the proven benefits of orthodox medicine, and the patient should be helped to make an informed choice. Physicians should take interest in the activities of traditional healers and birth attendants and encourage them to adopt adequate hygienic and infection control measures.

Transplantation

Principle 15: Physicians must safeguard the rights and interests of potential donors and recipients by observing the internationally accepted rules and procedures for transplantation

Commentary:

In some countries potential live donors are at particular risk from financial or other inducements to donate their organs. Physicians involved in transplantation have an obligation to explain fully to potential donors the risks associated with removal of organs or tissues and the possible consequences to health, and to ensure that the decision to donate has been entirely voluntary, ie it has not been influenced by coercion, financial inducement, or undue pressure from other sources, such as by the family of a potential recipient. The selection of recipients for available organs should be made on the basis of their medical suitability for the procedure.

Where the donor's organ is to be removed after death, the fact that death has occurred must be confirmed by a physician who is not directly involved with the team carrying out the transplant procedure, and wherever possible by the physician who was responsible for treatment of the donor's terminal condition. There are serious objections to the use of cadaveric organs from executed prisoners as judicial decisions and the timings of executions could be influenced by the most convenient time for the transplant to take place.

Medical Research

Principle 16: Physicians should not participate in medical research that does not conform with i nternationally accepted guidelines

Commentary:

Research subjects are at risk in some countries where internationally accepted guidelines may not be applied. It is essential that the free and informed consent of research subjects is obtained, and that those who are unable, for whatever reason, to consent to participation are not included in the research projects without the specific approval of the research protocol by a properly constituted ethical review committee. The provisions of the World Medical Association's Declaration of Helsinki (Annex G) should be observed.

REFERENCES

1. *Universal Declaration of Human Rights* (1948) Art 1
2. *ibid* Art 2; *International Covenant on Civil and Political Rights (1966)* Art 26
3. *Universal Declaration of Human Rights* Art 19
4. *ibid* Art 18; *International Covenant on Civil and Political Rights* Art 18
5. *Universal Declaration of Human Rights* Art 3
6. *Convention on the Elimination of All Forms of Discrimination against Women (1979)* Arts 12 & 14(2)(b)
7. *Universal Declaration of Human Rights* Art 16(3); *International Covenant on Civil and Political Rights* Art 23(1); *International Covenant on Economic, Social and Cultural Rights (1966)* Art 10(1)
8. *Universal Declaration of Human Rights* Art 3; *International Covenant on Civil and Political Rights* Art 6
9. *Convention on the Rights of the Child (1989)* Art 12(1)
10. *Universal Declaration of Human Rights* Art 12; *International Covenant on Civil and Political Rights* Art 17
11. *International Covenant on Economic, Social and Cultural Rights* Arts 12(d) & 15(1)(b)
12. *Universal Declaration of Human Rights* Art 29

13. *ibid* Art 18
14. *ibid* Art 3
15. See eg *Hippocratic Oath,* the Kindu code *Caraka Samhita* (1st century AD) and the *Islamic Declaration of Kuwait*
16. *International Covenant on Economic, Social and Cultural Rights* Art 10(3); *Convention on the Rights of the Child* Arts 3(2), 9, & 32-37
17. *Convention on the Rights of the Child* Art 32
18. *ibid* Art 24(3); *Convention on the Elimination of All Forms of Discrimination against Women* Art 5(a)
19. *Convention on the Elimination of All Forms of Discrimination against Women Art 16(2)*
20. *Convention on the Rights of the Child Art 16(1)(e) & (f); Convention on the Elimination of All Forms of Discrimination against Women ARt 16(1)(e)*
21. *Convention on the Elimination of All Forms of Discrimination against Women Arts 12, 14(2)(b) & 16(1)(e)*
22. *Declaration on the rights of persons belonging to national or ethic, religious and linguistic minorities (UN General Assembly resolution 47/135 of 18 December 1992)*
23. *Convention on the Rights of the Child Art 22(1); International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (1990) Art 28*

24. *UN principles for the protection of persons with mental illness and for the improvement of mental health care: (UN General Assembly resolution 47/135 of 17 December 1991)*
25. *UN Economic and Social Council (ECOSOC) Resolutions 663 (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977 (Standard minimum rules for the treatment of prisoners);*

Principles of medical ethics relevant to the role of health personnel, particularly physicians, in the protection of prisoners and detainees against torture and other cruel, in human or degrading treatment or punishment (UN General Assembly Resolution 37/194 of 18 December 1982);
Basic principles for the treatment of prisoners (UN General Assembly Resolution 45/111 of 14 December 1990);

Body of principles for the protection of all persons under any form of detention or imprisonment (UN General Assembly Resolution 43/173 of 9 December 1988);

UN rules for the protection of juveniles deprived of their liberty (UN General Assembly Resolution 45/113 of 14 December 1990);
UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (General Assembly Resolution 39/46 of 10 December 1984)

ECOSOC Resolution 1984/50 of 25 May 1984 (safeguards guaranteeing protection of the rights of those facing the death penalty)

26. *International Covenant on Economic, Social and Cultural Rights* Art 10(3); *Convention on the Rights of the Child* Arts 3(2), 9 and 32-37
27. *International Covenant on Economic, Social and Cultural Rights* Art 12
28. *Universal Declaration of Human Rights* Art 23; *International Covenant on Economic, Social and Cultural Rights* Art 12

29. *Universal Declaration of Human Rights* Art 19; *International Covenant on Civil and Political Rights* Art 19

30. *Convention on the Rights of the Child* Art 24(3)