Introduction to Medical Ethics

Chief Assistant Professor Kostadin Kostadinov, MD, PhD

Academic Year 2026/2027

Social Medicine and Medical Ethics - Part I

Department of Social Medicine and Public Health

Registration

Welcome!

- **15 practical classes:** 7 in medical ethics and 8 in biostatistics (90 minutes each)
- **15 lectures:** 7 in medical ethics and 8 in biostatistics (90 minutes each)
- **Two progress tests** offering bonus points; January examination and a resit
- **Lecturers:**
  - Prof. Nina Musurlieva, MD, PhD - Medical Ethics
  - Prof. Georgi Iskrov, PhD - Biostatistics
- **Final state examination:** Social Medicine and Medical Ethics, Year 6

Learning resources

- Examination syllabus (English)
- Compendium for the final state examination
- Lecture slides
- Lecturer's website
- **Biostatistics:** textbook (PDF) and practical study guide
- **Medical ethics:** textbook (University bookshop) and practical study guide and case studies

Outline

1. Key terms and definitions
2. Historical development
3. Major ethical approaches
4. Ethical principles
5. Perspectives on justice
6. Analysing an ethical case

Key terms and definitions

Key concepts

Ethics is the systematic study of the norms, principles and values that guide human conduct: critical reflection on morality.

Morality is the set of beliefs, rules and standards through which people judge right and wrong.

Moral conduct is morality expressed in practice: how we actually behave.

Law is a system of enforceable rules, including written laws arranged in a hierarchy.

Ethics and law

What they share: both guide behaviour and shape life in society.

How they differ:

- Law is enforced through formal institutions; ethics also relies on conscience and professional judgement.
- Laws are formally established; moral norms may be written or unwritten.
- Legal breaches can bring formal penalties; ethical failures can bring moral criticism and professional consequences.

In medicine: ethical obligations may go beyond legal requirements.

Medical ethics

Medical ethics applies ethical reasoning to the moral problems encountered in healthcare practice.

Its scope includes:

- Relationships between clinicians and patients
- Professional responsibilities
- Clinical decisions

Its distinctive task: bringing scientific knowledge and moral principles together in patient care.

Bioethics

Bioethics examines moral questions arising in medicine and the life sciences, particularly as knowledge and technology advance.

Areas of application:

- Genetic engineering
- Reproductive technologies
- Organ transplantation
- Research involving human participants
- Artificial intelligence in medicine
- Ethics during pandemics

Key features: an interdisciplinary approach and a global perspective.

Medical ethics and bioethics

Medical ethics:

- Focuses on moral questions in healthcare practice
- Places the clinician-patient relationship at its centre
- Has deep roots in the Hippocratic tradition

Bioethics:

- Extends to the life sciences, research and wider social questions
- Draws on several disciplines
- Gives a prominent role to human rights

The two fields overlap; medical ethics extends beyond individual consultations.

Historical development

A historical overview

1. **Early civilisations** - before the 5th century BCE
2. **Classical antiquity** - 5th century BCE to 5th century CE
3. **The Middle Ages** - 5th to 15th centuries
4. **The Renaissance and early modern period** - 15th to 18th centuries
5. **The modern period** - 19th and 20th centuries
6. **Contemporary developments** - the 21st century

Each period brought different expectations of physicians and different ideas about ethical care.

Early civilisations

Mesopotamia: the Code of Hammurabi (c. 1750 BCE)

The code linked surgical fees and penalties to outcomes and the patient's social status. Some provisions rewarded successful surgery with silver and punished fatal errors by amputating the surgeon's hands.

Ancient Egypt:

- The Edwin Smith Papyrus (c. 1600 BCE)
- Expectations governing physicians' conduct
- Specialisation in different areas of medicine

The Hippocratic tradition

The Hippocratic Oath, traditionally dated to the 4th century BCE, is an early and influential statement of professional ethics.

Key elements:

- An oath invoking the gods
- Respect for teachers
- Benefiting patients and avoiding harm
- Confidentiality and professional conduct
- Prohibitions on giving a deadly drug or an abortive pessary

Legacy: a lasting reference point for medical ethics.

Ideas associated with Hippocratic medicine

1. **Primum non nocere** - First, do no harm
2. **Vis medicatrix naturae** - The healing power of nature
3. **Ars longa, vita brevis** - The art is long, life is short
4. Attention to the whole patient
5. Careful observation and documentation
6. Professional integrity

These ideas remain influential. The Latin maxims are later expressions of the tradition, not verbatim wording from the Greek Oath.

Hellenistic and Roman medicine

Developments in Greco-Roman medicine:

- **Galen (129-c. 216 CE):** organised and extended medical knowledge
- Growth of medical education
- Roman military hospitals: **valetudinaria**
- Development of military medicine

Ethically relevant developments:

- Care for gladiators
- Public health measures
- Medical documentation

The Middle Ages: Christian influences

Key changes:

- Christian beliefs shaped understandings of illness and care.
- Illness could be interpreted as divine punishment or a spiritual trial; caring for the sick was a Christian duty.
- Monastic institutions provided care for the sick.

Important figures:

- Basil the Great - an early charitable care complex in the 4th century
- John Chrysostom - advocacy for the care of the poor

Ethical emphasis: compassion, charity and spiritual care.

Byzantine and Islamic medicine

The Byzantine Empire:

- Preserved medical knowledge from antiquity
- Produced medical encyclopaedias

The Islamic world:

- Developed medical teaching
- Established hospitals with specialised departments
- Al-Ruhawi's **Ethics of the Physician** (9th-10th century)
- Provided charitable treatment for poor patients

Contribution: more systematic accounts of physicians' ethical responsibilities.

The Renaissance and humanism

Key changes:

- Renewed engagement with classical learning
- Greater attention to human experience and dignity
- Expansion of university-based medical education

Ethical themes:

- Compassion and patience as professional virtues
- Medical learning as a moral responsibility
- Critical enquiry in medicine

A transition: increasing attention to human agency alongside religious perspectives.

The Enlightenment and the 19th century

Thomas Percival's Medical Ethics (1803):

- A systematic account of physicians' duties
- Responsibilities to patients, colleagues and society
- An influence on the AMA Code of Medical Ethics (1847)
- An emphasis on professionalism and competence

Related developments:

- Growth of public health
- Hospital and nursing reforms associated with Florence Nightingale
- Increasingly formal professional standards and oversight

The 20th century: a turning point

Before the Second World War:

- Growing professional debate about medical ethics
- Development of medical specialties
- Eugenic movements and abuses of medical authority

After the war:

- The Doctors' Trial (1946-1947) exposed medical atrocities.
- The **Nuremberg Code (1947)** set out principles for research involving people.
- Voluntary consent became a central ethical requirement.
- International declarations and conventions followed.

International declarations and conventions

- **Declaration of Geneva (1948):** a modern physician's pledge in the tradition of the Hippocratic Oath
- **Declaration of Helsinki (1964):** ethical principles for medical research involving human participants
- **Declaration of Tokyo (1975):** physicians' responsibilities concerning torture and cruel, inhuman or degrading treatment
- **Oviedo Convention (1997):** human rights and biomedicine

Significance: shared international reference points for medical ethics.

Dates refer to initial adoption. WMA: Declaration of Tokyo.

The 21st century: emerging challenges

Areas of ethical debate:

- Genetics and gene editing
- Regenerative medicine
- Artificial intelligence in healthcare
- Telemedicine and digital health
- Pandemic ethics, including COVID-19
- Climate change and health

The central question: how can technological progress serve human values?

Major ethical approaches

Three approaches to ethical reasoning

1. **Utilitarianism:** judge actions by their consequences, seeking the greatest overall benefit.
2. **Deontology:** judge actions by duties and moral rules, rather than consequences alone; closely associated with Kant.
3. **Principlism:** a widely used framework that weighs autonomy, beneficence, non-maleficence and justice.

Kant’s categorical imperative

Respect each person as an end in themselves, never merely as a tool for someone else’s purposes.

Paraphrase of the humanity formulation. Kant’s moral philosophy.

Ethical principles

Respect for autonomy

Meaning: respecting a person's ability and freedom to make decisions about their own life.

Word roots: Greek **autos** (self) and **nomos** (rule or law).

Autonomous decision-making requires:

- Freedom from coercion or controlling pressure
- Understanding relevant information
- The ability to consider options and form intentions
- The ability to communicate a choice

Support people in making their own decisions.

What can limit autonomy?

Factors affecting decision-making:

- Cognitive abilities and decision-making capacity
- Developmental stage
- Illness or severe distress
- Altered consciousness

External constraints:

- An unfamiliar or restrictive hospital environment
- Too little information, overload or poor communication
- Financial barriers

Age or diagnosis alone does not determine capacity.

Beneficence: promote the patient's welfare

Core idea: act to benefit others.

In clinical practice:

- Promote the patient's health and wellbeing.
- Take positive steps to help, rather than simply avoid harm.
- Weigh the likely benefits against the risks and burdens.

Key question: what would benefit this patient, taking their own goals and values into account?

Non-maleficence: avoid unnecessary harm

Core idea: do no harm - **primum non nocere**.

Responsibilities:

- Avoid causing preventable harm.
- Minimise risks and avoid disproportionate burdens.

Harm can include:

- Physical injury: pain, disability or death
- Violations of rights and interests
- Damage to reputation

Treatment is rarely risk-free; the risks must be justified.

Justice: what makes an allocation fair?

Meaning: fairness in how healthcare resources, opportunities and burdens are distributed.

The underlying question: how should we correct the gap between existing arrangements and a defensible standard of fairness?

The following slides consider **five perspectives** on justice and the distribution of care.

Perspectives on justice

Status-based proportionality

A historical view: access to care reflects a person's social position.

- Classical accounts distinguished care for enslaved people from care for free citizens.
- Enslaved people received care from slave physicians.
- Wealthy people had greater access to care.
- Christian charity helped develop institutions for poor patients.

This illustrates how ideas of fairness have changed over time.

Social justice

Basic social goods for everyone:

- Work and livelihood
- Basic education
- Healthcare

Questions of responsibility:

- Which obligations are unconditional?
- Which benefits may depend on contributions or other conditions?

Health becomes a political concern, giving rise to health policy.

The utilitarian approach

- Defining how much healthcare is needed is difficult.
- Limited resources make **priority setting** unavoidable.
- Cost-effectiveness asks how much health benefit resources can produce.
- The aim is to achieve the **greatest overall benefit**.

The ethical challenge: maximising total benefit may conflict with protecting those who are worst off.

A basic minimum, then allocation by contribution

Combining fairness with economic contribution:

- For **basic social goods**, ensuring a fair minimum takes priority.
- For **additional goods**, allocation may reflect productivity or contribution.
- Everyone receives a minimum level of provision.

This approach combines a social safety net with rewards linked to contribution.

Perfect justice as an ideal

The practical reality:

- Perfect justice is an **ideal**.
- Our responsibility is to narrow the gap between that ideal and existing conditions.

The practical approach: keep identifying and reducing avoidable unfairness in society and healthcare.

Analysing an ethical case

Three steps in ethical analysis

1. **Define the ethical problem.**
   - State the dilemma clearly.
   - Separate factual questions from questions about values.
2. **Identify the stakeholders.**
   - Who is affected?
   - What are their roles, interests and perspectives?
3. **Analyse the competing considerations.**
   - Map stakeholders in rows and ethical principles in columns.
   - Weigh conflicts between principles and justify a course of action.

Worked example: refusing a blood transfusion

Case: An adult patient with decision-making capacity refuses a potentially life-saving blood transfusion on religious grounds.

Stakeholders: the patient, the treating physician and the family.

Stakeholder	Autonomy	Beneficence	Non-maleficence	Justice
Patient	Makes an informed, voluntary choice	Seeks care consistent with personal values	Understands the risk of death	Deserves the same respect and care as others
Physician	Checks understanding and respects the choice	Seeks a beneficial, acceptable treatment	Explores safer alternatives and explains risks	Provides equally attentive care
Family	Respects the patient's decision	Wants the patient to survive	Fears losing a loved one	Receives a fair hearing without overriding the patient

Thank you for your attention!