Mini Review

BIOMEDICAL Journal of Scientific & Technical Research

ISSN: 2574 -1241

DOI: 10.26717/BJSTR.2022.44.006981

Contract of Treatment Between Doctor and Patient: Based on Medical Ethics and Evidence-Based Medicine

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ARTICLE INFO

Received: April 24, 2022

Published: May 19, 2022

Citation: Duong Dieu, Nguyen Quoc Khoa, Duong Quoc Hien. Contract of Treatment Between Doctor and Patient: Based on Medical Ethics and Evidence-Based Medicine. Biomed J Sci & Tech Res 44(1)-2022. BJSTR. MS.ID.006981.

Abbreviations: REB: Research and Ethical Boards; EFGCP: The European Region with the European Forum for Good Clinical Practice; AHEC: Australia with the Australian Health Ethics Committee; AMA: The American Medical Association; EBM: Evidence-Based Medicine; EBCP: Evidence Based Clinical Practice; EBT: Evidence-Based Treatment

ABSTRACT

In economics, contract theory studies how economic agents can and do construct contractual agreements. The 2016 Nobel Prize in Economics was awarded to Oliver Hart and Bengt Holmström for their work on contract theory. Contracts develop a framework for understanding agreements such as insurance contracts, employer relationships, and property rights. Holmström's contract work explored how to balance risk and incentive - both in idealized theory and in real-life situations. Hart discovered a fundamental shortcoming of contracts - that no one can predict the future and there are too many variables in the future to code them all in one contract.

In the medical practice, doctors who treat patients also need a contract like in an economic contract, expressing the obligations and rights of the doctor and the patient. This contract outlines the effects and consequences of the risks with evidence-based medicine associated with medical ethics such as 3 rights: "Non-maleficence" to the patient; "Patient's beneficence": "Patient's justice": is provided by a physician and the patient has the right "Autonomy": refuse or choose the method of treatment based on medical ethics after understanding with what level of evidence-based medicine will be treated. The tighter the contract, the better the doctor-patient relationship is, and the disadvantages and complaints will be reduced.

Keywords: Contract; Economics; Medicine; Medical Ethics; Evidence-Based Medicine

Introduction

In economics, contract theory studies how economic agents can and do construct contractual agreements. The 2016 Nobel Prize in Economics was awarded to Oliver Hart and Bengt Holmström for their work on contract theory. Contracts develop a framework for understanding agreements such as insurance contracts, employer relationships, and property rights. Holmström's contract work explored how to balance risk and incentive - both in idealized theory and in real-life situations. Hart discovered a fundamental shortcoming of contracts - that no one can predict the future and there are too many variables in the future to code them all in one contract.

In the field of medicine, a doctor who treats a patient also needs a contract as in an economic contract that shows the obligations and rights of the doctor and the patient. This contract should be

performed on the basis of medical conditions. which department? Through this review we highlight the 2016 Nobel Prize in Economics on Contracts theory, medical ethics and implementation challenges, and evidence-based medicine. All of these can be the basis of medical contracts.

Nobel Prize in Economics 2016 in Contracts [1]

In economics, where contract theory studies how economic agents can and do construct contractual agreements, contract theory is often classified in an area known as Law and Economics. A standard practice in the microeconomics of contract theory is to represent the decision maker's behavior according to a given numerical utility structure, and then apply an optimization algorithm to determine the superior optimal decisions. The 2016 Nobel Prize in Economics was awarded to Oliver Hart and Bengt Holmström for their work on contract theory - developing a framework for understanding agreements such as insurance contracts, the relationship between employers and property rights. The new theoretical tools developed by Hart and Holmström are of great value in understanding contracts and organizations in practice, as well as potential pitfalls in contract design. Holmström's work explored how to balance risks and incentives - both in idealized theory and in real-world situations. An initial assessment, according to the Nobel committee, is that high-risk industries should have more fixed wages while stable industries should consider performance bonuses more often.

Hart, meanwhile, examines discovered a fundamental shortcoming of contracts - that no one can predict the future and there are too many variables in the future to code them all in one contract. So when the unforeseeable inevitably emerges, who decides how to deal with it? This is the realm of "incomplete contracts," and Hart wrote that contracts should define who has the power to make future decisions—an important kind of power. The theory of incomplete contracts provides a way of thinking about which government services could benefit from privatization and which services are better off under government control. The question marks raised in contract theory research are: should public services such as hospitals, schools, and prisons be owned by the government or privately? Or should teachers, health care workers, and prison officials get a fixed salary or pay for performance? Modern economies are bound together by countless contracts [1].

Treatment Contract Between Doctor-Patient: Based on Medical Ethics and Evidence-Based Medicine

Medical Ethics: Is an ethics in the practice of clinical medicine and scientific research based on a set of values that professionals can refer to in the event of any confusion or conflict. Tom Beauchamp and James Childress in their textbook Principles of Biomedical Ethics (Principles of Biomedical Ethics 1978) recognize four basic ethical principles: [2,3] Respect for autonomy: Patients have their right to refuse or choose their treatment. "Non-maleficence" to the patient harm to the patient: not a cause of harm. "Patient's beneficence" to promote the good over the harm; "Patient's justice" is patient equity: Involves the distribution of scarce medical resources and deciding who gets treatment in the spirit of "One for All, All for One". Medical ethics is particularly relevant in decisions regarding involuntary treatment and involuntary engagement. Development history: Some Codes of Conduct:

a) The Hippocratic Oath discusses basic principles for medical professionals.

b) The Declaration of Helsinki (1964) and the Nuremberg Code (1947) are both well-known and respected documents that contribute to the issue of medical ethics.

More recently, new techniques for gene editing aimed at the treatment, prevention and cure of disease using gene editing, are raising important ethical questions about their application in medicine and methods. treatment as well as the social impact on future generations remains controversial due to their connection to eugenics [4,5]. Medical ethics include rights, autonomy, and justice as they involve conflicts such as sense of death, patient confidentiality, informed consent, and conflicts of interest in healthcare. strong [6,7]. In addition, ethics and medical culture are linked as different cultures practice different ethical values, sometimes with more emphasis on those values. family and downplays the importance of autonomy. This has resulted in a growing need for culturally sensitive physicians and ethics committees in hospitals and other healthcare settings [8,9]. Since the 1970s, the growing influence of ethics in contemporary medicine can be seen in the increasing use of Institutional Review Boards to evaluate experiments on human subjects, the establishment of hospital ethics committees, the expansion of the role of clinician ethicists, and the integration of ethics into many medical school curricula [10].

Challenges of Medical Ethics in Practice

a) **Conflict**: Between autonomy and interest / does not cause bad consequences. Autonomy can conflict with interests when a patient disagrees with recommendations that healthcare professionals believe are in the patient's best interest.

b) **Informed Consent**: Ethical informed consent generally refers to the idea that a person should be well informed and understand the potential benefits and risks in choosing a method their treatment [11].

c) **Confidentiality**: Is an important issue in primary healthcare ethics, where physicians care for many patients from the same family and community, and where third parties often request information from Substantial medical databases are commonly collected in primary health care.

d) **Cultural Differences**: Can create ethical dilemmas.

e) **Ethics Committees**: In complex cases, a simple communication is not sufficient to resolve the conflict and the hospital ethics committee must convene to decide. For example, the United States proposes that the Research and Ethical Boards (REB Research and Ethical Boards); The European Region with the European Forum for Good Clinical Practice (EFGCP) and Australia with the Australian Health Ethics Committee (AHEC) recommendations 1996. who believe that medical lifestyle counseling and building healthy habits around our daily lives is one way to tackle healthcare reform [12].

Other Cultures and Healthcare

a) **Buddhist Medicine**: Death is only a stage in an infinite life process, not an end. Chinese Medicine: The passing and coming of the seasons, life, birth and death are considered to be cyclical and eternal, believed to be regulated by the principles of yin and yang. Islamic culture and medicine: Belief that faith and the supreme god can cure disease

b) **Conflicts of Interest**: Very common between both academic and practicing physicians. Studies show that doctors can be swayed by pharmaceutical company temptations, including gifts and food [13].

c) **Treat Family Members**: "Buddhist does not have heaven". The American Medical Association (AMA) states that "Physicians in general should not treat themselves or members of their immediate family"[14].

d) **Sexual Relationships**: Results from those studies show that some forms of discipline are more likely to be offenders than others. For example, psychiatrists and obstetricians and gynecologists are two professions that are noted for having higher rates of sexual misconduct [15].

e) The Possibility of Medical Care in Vain: In some hospitals, medical futility is called a treatment that cannot benefit the patient.

Evidence-Based Medicine

[16] Evidence-Based Medicine (EBM) aims to apply the best evidence available from the scientific method of clinical decision-making. Assess evidence strength of risk factors or benefits of treatment and diagnosis. Because this is a type of applied science that can be applied to other fields such as dentistry, nursing, and psychology. In evidence-based practice seeking to elucidate the primary purpose of scientific research methods and applying these methods to ensure the most accurate prognosis of treatment outcomes, even controversial continue on the desired result. "Evidence medicine is about integrating the best research evidence with clinical experience and patient reality" - according to Dave Sackett. The following three groups are closely related: Evidence-Based Medicine (EMB); Evidence Based Clinical Practice (EBCP) and Evidence Based Treatment (EBT). Evidence-Based Treatment (EBT) is an approach that attempts to determine the way in which experts or other decision-makers by identifying such evidence for a fact and evaluating it in a scientific manner. study can be obtained. The goal is to eliminate unhealthy or risky practices for better results. Where EBT is applied, it encourages experts to use the best evidence possible, for example, the most relevant information available. The application of evidence-based medicine is an ongoing process because medical information is constantly being updated according to the number and results of new research works, especially results from re-evaluation works. systematic review that has not been done before due to insufficient information. In addition, the problem-based approach of evidence-based medicine is well suited in hospitals, because many problems arise when dealing with patients. This is a very practical and effective way of learning in the continuous learning program in the hospital.

Strength Level of Evidence-Based Medicine:[16] In 1989, the US Preventive Services Task Force (USPSTF) gave the following rating:

a) Level I: Evidence obtained from at least one properly designed randomized controlled trial.

b) Level II-1: Evidence obtained from a well-designed controlled trial without randomization.

c) Level II-2: Evidence obtained from well-designed cohort studies or controlled studies, preferably from multiple centers or research groups.

d) Level II-3: Evidence obtained from a time series case design with or without intervention. Significant results in uncontrolled trials can also be considered this type of evidence.

e) Level III: Opinion of competent authorities, based on clinical experience, descriptive studies, or expert committee reports.

According to the UK's National Health Service, there are four types:

1. **Level A**: Cohort, randomized, controlled clinical trial, Clinical decisions are based on different populations.
2. **Level B**: Retrospective cohort, case-control.
3. **Level C:** Case-control study.
4. **Level D**: Expert opinion.

Thus, we can classify evidence-based medicine into four levels:

1. **Strongest**: Randomized, controlled, cohort clinical trial.
2. **Strong**: Controlled clinical trial.
3. **Moderate**: Clinical trial across a series of cases.
4. **Weak**: Expert opinion in a few cases based on basic medicine.

Combining Medical Ethics and Evidence-Based Medicine: In medical practice, after completing a medical record included patient's history, check-up, diagnosis, and management; the final step is a treatment contract that shows the obligations and rights of the doctor and the patient. This contract outlines the effects and consequences of risk in the course of evidence-based treatment with levels from low to high combining medical ethics with 3 rights: "Non-maleficence" to the patient; "Patient's beneficence": "Patient's justice": is provided by a physician and the patient has the right "Autonomy": refuse or choose the method of treatment based on medical ethics after understanding what level of evidence-based medicine will be treated. In case the patient is not able to make a decision, the patient's relatives will make the decision instead. In case of emergency, it will be treated first and the treatment contract will be notified later.

Conclusion

Thus, in medical practice, the treatment of patients by doctors is also reflected in contracts like in economic contracts. This contract based on evidence-based medicine and medical ethics. Although there are many unknowns in treatment like risks in economic contracts, the tighter the contract, the better the doctor-patient relationship is, and the incidents and troubles will be reduced.

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ISSN: 2574-1241

DOI: 10.26717/BJSTR.2022.44.006981

Duong Dieu. Biomed J Sci & Tech Res