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The Italian Code of Medical Deontology. Historical, ethical and legal issues

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Summary. *Background and aim:* Medical deontology is increasingly important, owing to the interests and rights which the medical profession involves. This paper focuses on the relationships of the Italian Code of Medical Deontology (CMD) with both the ethical and legal dimensions, in order to clarify the role of medical ethics within the medical profession, society and the overall system of the sources of law. *Methods:* The authors analyze the CMD from an ethical perspective and through the new doctrinal guidelines and current trends in the Italian law courts. *Results:* From an ethical point of view, moral philosophical analysis scarcely seems to address professional medical ethics. Nonetheless, the CMD needs to undergo careful ethical analysis. From a legal perspective, the Italian CMD contains provisions which do not have an official legal nature. However, they are directly binding for medical practitioners, and therefore could be understood as a supplement to the general rules of the legal system. *Conclusions:* At an ethical level, rigorous debate on the CMD is indispensable, in order to update its specific principles and to make it a real moral normative document. At a legislative level, there is a possible contradiction between a legal system that does not take into account the CMD, but which then attributes significant importance to the violation of its rules. (www.actabiomedica.it)

Key words: code of medical ethics, bioethics, bio-law, legal medicine, philosophy and bioethics, history of medicine, medical ethics

Background

In the context of the growing interest in the regulation of professional conduct, involving an increasing number of professional categories (1), medicine is the profession in which ethical codification dates back furthest and is most intense. The codification of medical ethics presents aspects of particular significance, owing to the moral principles and fundamental rights involved, and the potentially detrimental effect that professional medical activity may have on patients' constitutionally guaranteed values and freedom (2). Indeed, although the Code of Medical Deontology (CMD) was originally created with the primary aim of regulating intra-professional conduct and promoting the interests of the medical category, today it largely focuses on the relationship with patients, in the light of the cultural and moral evolution of society and of the ethically sensitive implications of biomedical and biotechnological progress. Thus, in its current form, the CMD is increasingly devoted to disciplining relationships with peoples' private lives, in which legislative intervention is called upon to assume the characteristics of "lightness", "sobriety" and "elasticity" (3).

The value and role of the CMD are, however, closely related to its qualification in both the moral-philosophical and legal fields. Is the CDM a medical ethics document or is it just inspired by one? Can it

be considered an original source of law or does it simply reflect one? In order to answer these questions, it is necessary to probe the relationships of professional ethics with the ethical and legal dimensions, and to highlight their continuous and complex interweaving.

Discussion

Historical evolution and ethical issues

The term "deontology" was coined by the English utilitarian philosopher Jeremy Bentham (4). However, while Bentham referred in general to behaviors that individuals must implement in order to achieve happiness for the greatest number of subjects, the association of deontology to medicine is attributable to the French physician Maximilien Simon (5).

Medical deontology, as a discipline, studies the behaviors that physicians must observe in their clinical practice. This reflection aims at translating the fundamental principles of medical ethics recognized by the professional category into rules of conduct, thus creating a CMD, a document of self-government that lists physicians' duties and prohibitions, elaborated by professional associations (6).

The need to collect and identify the duties to which physicians are called upon to adhere in their profession has ancient roots (7). The form of the Physician's Oaths, such as the famous Hippocratic Oath (Vth century BC), can be interpreted as one of the first attempts to do so. In more modern times, a further example is the Physician's Medical Etiquettes (XVIII-XIXth centuries). These, however, are not the result of a representative group of the category, but of individual and authoritative physicians, nor do they envision sanctions: both of these characteristics distinguish, at least in the Italian context, the subsequent Codes of Medical Deontology. In Italy, the first documents classifiable as Codes of Medical Deontology emerged at a provincial level as documents issued by local medical Orders or Chambers, to which physicians voluntarily adhered (late 19th to early 20th century). As a result of the trend toward forming associations in the medical profession, the Codes of Medical Deontology became a sort of "identity document" of the profession, in which physicians recognized and united in their common claim to the exclusivity of their scientific skills and in their attempts to reaffirm and protect their social image, too often tarnished by quacks and charlatans (8-10). Thus, the Italian CMD, from its first national form (1924) assumed the role of a real political and trade-union manifesto. Following many editions of the text, at present the National Federation of Physicians' and Dentists' Orders (FNOMCeO) approved the current version (2014) (11, 12).

These numerous revisions stemmed on the one hand from the need to adapt to innovations in medical science and technology, and on the other hand from the evolution of ethical and juridical thought in the interest not only of professionals themselves, but also of patients (13). Thus, in its present form, the CMD embraces a new conception of the care relationship, in which patients acquire a central position and are endowed with a subjective and personal vision of the concepts of health, well-being, illness and care .

Particularly important is the choice of the ethical, deontological or consequentialist theory on which the CMD is founded. While deontological ethics, such as Kant's theory of ethics, is based on the assumption that duties and prohibitions are valid *ex ante*, i.e. *before* the action, regardless of its consequences, the consequentialist theory states that duties and prohibitions apply *ex post*, i.e. *after* the action and its consequences. If the deontological theory is adopted, good physicians are those who, in their intentions, respect the deontological rules, regardless of the actual consequences of their actions. In this case, the virtue of physicians will be testified by their ethical rigor and consistency, and only on the basis of that moral probity will they be judged positively by colleagues and society alike. A Code based on deontological theory will include many articles, in order to regulate the greatest number of situations in which physicians may find themselves. These will be meticulously expounded in the most diverse operational situations, and the behaviors considered appropriate will be specified. This is, for example, the case of the Italian and Spanish Codes of medical deontology. Conversely, if the CMD is based on the consequentialist theory, physicians will be deemed to be "good" according to the direct consequences of their action, regardless of their intentions. The related

Code will be synthetic, offering a set of general moral guidelines directing the conscience of physicians', who will then be called upon to implement them in their clinical practice. This is the case of the English Code. From a European perspective aimed at collecting and harmonizing the common ethical rules into a single Code, also in relation to the free movement of physicians and patients across Europe, the consequentialist theory seems to better ensure the ethical pluralism of each single country and the opportunity to articulate the rules of behavior in a situational framework (14).

The identification of fundamental ethical principles on which ethical rules are based is, however, a critical element (15). The medical community is mostly oriented towards synthesizing these in four fundamental principles that, as is well known, derive from the Anglo-Saxon movement of Principlism and, from a view of protection of human subjects, from the famous "Belmont Report": Principles of Beneficence, Non-Maleficence, Justice and Autonomy. The most recent international document to lay out the principles of medical ethics is the Kos Charter (2011); issued by the European Council of Medical Orders (ECMO-CEOM) (16), this includes 15 basic principles formulated descriptively. However, these principles of medical ethics, which have been debated at length in the literature, should perhaps be drawn together, in order to highlight specific concepts that have by now assumed an independent connotation within the ethical debate. A proposal of these principles could include the concepts of the dignity, well-being and autonomy of patients, justice, confidentiality and the independence of physicians. Moreover, the most recent reflection concerns the possibility of adding principles regarding the preservation of the environment as a determinant of individual and collective health, and the protection of animal welfare (17).

Translating the principles of medical ethics into rules of medical conduct, and hence moving from the principles of medical ethics to the rules of medical deontology, is a complex task (18). For example, while the medical profession may theoretically endorse the principles of patients' autonomy or dignity, determining what these actually mean and, above all, how they should be incorporated into clinical practice, can prompt dilemmas and conflicts. Indeed, the subjective aspect that today characterizes the health dimension and the care relationship itself creates a major obstacle to reaching unanimous agreement on the enunciation of broad and undefined concepts underlying the principles of medical ethics. Even from this perspective, the consequentialist theory seems able to better allow a more general (but not generic) Code to be applied in a more opportune and flexible way to individual clinical cases.

The issue of the relationship between medical ethics and medical deontology, not least with regard to the current placement of these topics within the academic medical sphere in Italy (19), also exacerbates discussion on the descriptive or normative nature of the CMD. Descriptive medical deontology, on the one hand, detects and describes the most common behaviors of physicians and those that they "believe" or perceive to be correct. Normative medical deontology, on the other hand, scrutinizes those behaviors in terms of their rational justification. That is to say, through the application of some methods of investigation (such as deductivism, inductivism or coherence), it tests whether, from a moral and philosophical perspective, they are really the most correct. In the former case, the CMD will be a descriptive document that only records the most common medical behaviors, without asking too many questions about their intrinsic correctness; the risk here is that these behaviors will be the result of self-referential corporate intentions. In the latter case, the committees responsible for drafting the Code should include experts in ethics and moral philosophy, with the task of coordinating the rational examination of the deontological rules. In this way, these rules can be modified or replaced by others, even if these new rules are not in keeping with the ethical sentiment most widespread in the medical community. In general, it is believed that the Italian CMD, like the other European Codes of medical deontology, has a descriptive character, as it stems almost exclusively from the work of medical members.

In the relationship between ethics and deontology, another critical point is the possible distinction between physicians' professional and private ethics. Does adherence to the deontological rules make a physician a "good" professional or a "good" person? In other words, do the deontological rules apply to physicians

when they practice their profession or are they also to be extended to the private sphere? Let us consider the hypothetical case of physicians who comply with the deontological rules governing correct behavior towards patients, but are selfish and overbearing in their private lives. Could they still be considered "good" doctors? If physicians steal from their patients, they certainly are not. If, however, the victim of such conduct is not a patient or a colleague, the doubt arises as to whether the conduct is improper in exquisitely deontological terms. In short, the question is whether the CMD disciplines medical morality by identifying common rules of conduct for all physicians, not only as professionals but also as individuals, or whether it is to be understood as a special institution of the medical community which identifies rules of conduct that are shared because of they *can be* shared by the professional category within the exclusive performance of their activity. As in the case of other intellectual professions, such as those of teachers or judges, it is undoubted that physicians have a moral responsibility for their behavior that transcends their specific professional practice, not least because they can be seen as models for society. However, it seems questionable that such moral responsibility can be discerned in a physician's mere compliance with the specific deontological rules of the CMD. Thus, the Medical Association should also guarantee the behavior of physicians as private citizens, thereby bridging the gap between personal morality and public ethics that is a feature of our modern secular democratic societies. In this respect, perplexity is aroused by the degree of discretionality conferred by the breadth of the clause contained in the third paragraph of Article 1 of the Italian CMD, which extends its scope of application to the behavior of physicians outside their professional practice (particularly when these behaviors impact on professional *decorum*).

A final question is whether the CMD can be regarded as a veritable text of moral philosophy. At present, it probably does not have the necessary features to identify it as such: the ethical theory on which it is grounded is unclear, the debate on the concrete definition of the ethical principles that inspire it seems far from concluded and the discussion of its descriptive or normative nature and of its sphere of application has been insufficient.

The Code of Medical Deontology. Legal aspects

The question of deontology has elicited some attention on the part of Italian jurisprudence, prompting a recent debate in the legal literature on the nature and value of the CMD's rules (20, 21).

It is particularly significant that Italian statute law does not expressly oblige Medical Associations to draw up a deontological code, much less to discipline this instrument, which (albeit in forms other than the present) has very ancient origins; nor does it assign to the code the value of a legal source. However, despite this lack of regulatory provision, the intrinsic cogency of a deontological code may, albeit indirectly, be deduced from the disciplinary power that is expressly attributed to Medical Associations by a specific source of law (22). Indeed, Medical Associations are invested by the law with the power to initiate administrative proceedings in order to guarantee the proper exercise of the profession (and to protect the integrity of the category), which may lead to the imposition of disciplinary sanctions. Indeed, the exercise of disciplinary authority is not only in line with the public nature of the Professional Associations; it also extends to the "indispensable requirements for the protection of the community", whereby professionals are subject to a disciplinary liability regime of the professional community, which is "obligedly constituted and represented by specific orders and colleges subject to state supervision" (23). Moreover, the law merely provides general clauses concerning "abuses or shortcomings in the exercise of the profession or (...) acts prejudicial to professional *decorum*" which indicate possible infringements of the code; it does not specify single behaviors that may fall within the instances outlined by statutory law, and which must be derived from the articles included in the CMD.

The formulation of the Code is, however, an exclusive prerogative of the "sensitivity of the professional class and its organs", and no form of collaboration or intervention by the State is envisioned, either in the elaboration phase or in its subsequent publication, which is left to the FNOMCeO. But is the Medical Association really free to establish its own deontological rules, or does this freedom have limits? If the freedom that is granted to the professional category is

seen as full autonomy, the CMD may disregard those evaluations and norms that are adopted by the general legal order, considering them inappropriate to the ethics of the profession. From this point of view, the CMD could be interpreted as a "manifesto" of the professional category, through which it can announce to society its beliefs, even if they are outdated and conflict with statute law, and play a propulsive and innovative role (24). That the CMD constantly refers to compliance with the legal system, its "framework", "boundaries" and "procedures", unequivocally reflects the total harmony between the deontological rules and constitutional principles, and the adherence of the current CMD to the dictates of the law. The ability of deontology to affect various aspects of social life has, however, conferred upon the codicist discipline (alongside the traditional function of regulating the profession) a concrete regulatory role within unexplored areas of the law that give rise to thorny issues, such as, in Italy, medically assisted reproduction and, more recently, the so-called "living will" (25).

Despite the lack of attention by state law, the increasingly widespread and penetrating role assumed by deontology in organizing social relations and in protecting individual rights raises the question of the nature of deontological rules. The very fact that there is no explicit legislative provision devoted to the CMD, unlike the forensic field (26), makes it difficult to discern the relationships between the state and the medical professional, and to place the CMD among the sources of law.

In the doctrine, deontological rules have traditionally been regarded as "extra-jurisdictional rules" or "internal rules for the medical category", and not as norms of the general legal system. In this perspective, the professional and non-statutory source of the CMD's rules excludes their legal nature. In addition, this orientation highlights the fact that the legal system - with few exceptions - neither mandates nor regulates the issuing of deontological rules by professional associations, nor does it in any way equate them to its own sources. By excluding the legal value of deontological rules, this conception also excludes the arbitration of the Supreme Court on their interpretation and correct application within disciplinary proceedings.

From a substantially opposite perspective (27,28), another doctrine argues that deontological rules do have legal value, precisely because they are the product of a professional system that is qualified as a body in the strict sense, recognized by the state, and to which a disciplinary power is legally attributed. It therefore follows that these rules, or at least those that affect the public domain, have an "external" relevance, in that they prescribe duties and rules of conduct for physicians with regard to both the general and supreme protection of patients' health and the integrity of the profession. Regarding this latter aspect, recognition of the external relevance of the CMD can be inferred from the recent decision of the Authority for the Safeguard of Competition, which imposed on the FNOMCeO an administrative sanction (subsequently annulled under the statute of limitations), on the grounds that the CMD restricted competition in advertising among professionals.

In jurisprudence, the new doctrinal guidelines were embraced by Cass S.U. N. 8225/2002, which completely overthrew the traditional approach, defining deontological rules - in that particular instance, forensic rules - as "genuine legal rules binding within the regulation of the category", which "are grounded in the principles established by professional law and by statutory provision (through a state law) of disciplinary proceedings in the event of their violation".

After the alternation of opposing pronouncements, the true turning point was marked by the Supreme Court's judgment no. 26810/20 of December 2007, although this was formulated with specific reference to the deontological code of the National Forensic Council. In this judgment, which drew on the foregoing considerations that the legal provision of disciplinary proceedings has, at least in part, a legal nature, the Supreme Court explicitly recognized the legal nature of the deontological rules, consequently upholding the legitimacy of the Court's intervention, also with regard to the different perspectives that may form in the Professional Association. Indeed, as pointed out by the Supreme Court, the traditional approach would inevitably deprive the Court of its function as guarantor of the uniform interpretation of the law, and thus "does not appear admissible in the presence of a deontological code which may affect - as, for example,

in the case of expulsion from the Professional Registry - individual rights based on statutory laws".

This line of argument, albeit developed with reference to the forensic code of deontology, can also be applied to the field of medical deontology, which has the same structural features, particularly with regard to the regulation of disciplinary proceedings in the event of its violation. The above perspective undoubtedly enhances the public's perception of the professional activity of the physician, who is called upon to safeguard the patient's health as a constitutionally protected right, and supersedes the old narrow vision of the protection of corporate interests.

In the field of penal law, the legal relevance of deontological rules, especially those aimed at defining due professional conduct, lies mainly in the use of deontological parameters to assess specific guilt and professional medical liability. Alongside the traditional function of self-regulation, the role of quality control of the service provided is growing, as is the need to provide behavioral criteria that can serve to protect the rights and interests involved in the exercise of the medical profession. In accordance with this position, Italian Presidential Decree n. 137 of 2012 provided a regulation reforming Italian professional associations, with the aim of protecting both individual subjects and society as a whole (29).Obviously, the strength of that protective function is closely dependent on whether the deontological rule is deemed legal or non-legal.

In sum, there is no specific legislation that defines the legal nature of deontological codification. Nevertheless, this does not mean that the Italian CMD does not possess provisions that are directly binding on medical practitioners – provisions that are intended to supplement the general rules laid down by the legal system and to take on an external value in assigning specific professional liability (in both civil and criminal proceedings) to the physician who does not observe them.

Conclusions

From an ethical point of view, the choice of the ethical theory underlying the CMD seems, as yet, to be the result of unawareness rather than of a practical philosophical process of identification. Nonetheless, and not least in the face of the increasing legitimacy of humanistic reflection on the medical world, a rigorous debate on the possible theoretical systems of medical ethics in its deontological translation is indispensable. Among the approaches analyzed, consequentialism seems to be the one that can best be harmonized with ethical pluralism and with the distinction between private morality and public ethics. In addition, without surrendering some fixed points and without risking an anarchist drift, medical ethics. Consequently, the CMD requires a strictly secular revision in order to ensure that its ethical principles are capable of reflecting the many nuances of a subjective interpretation of what are perhaps our most precious possessions: life and health. The reasoned development of medical ethics requires both an intellectual investment in the matter and the direct participation of experts in moral philosophy, medical ethics and bioethics in the committees responsible for updating the CMD. Moreover, this participation will stave off the risk that this document may be the mere result of self-regulation in a corporatist sense. In summary, if the CMD is to open up to the outside world, a trend which has already been manifested by its ever-increasing attention to the person as the center of medical activity, a rational analysis of its rules will be necessary. This commitment will be devoted to correcting any descriptive aspects, in order to give this fundamental document the concrete opportunity to stand as a moral normative work.

In the light of the doctrinal and jurisprudential reconstructions outlined above, it also emerges that, although the Italian Code has not been incorporated into legislation, several rulings concerning professional liability have considered these provisions as rules of law with which members of professional associations must comply. It therefore seems that we can detect some inconsistency within a legal system that does not take into account the CMD at the legislative level, either in terms of its value or with regard to its regulatory process, but which then attributes to the violation of its rules a significant importance only in terms of professional responsibility. Finally, one of the greatest weaknesses of the Italian deontological dimension is seen in its disciplinary proceedings. Indeed, on the one hand, deontological regulation has significantly evolved to

protect the patient's fundamental rights, thereby opening up to a dimension that is no longer tied only to the interests of the professional category; on the other hand, however, the disciplinary procedure still remains, in its essential lines, in the 1950s, its structure being firmly anchored to the corporatist dimension. In addition, there is a possible contradiction between the CMD's significant protection of fundamental rights and a level of effectiveness of the disciplinary instrument that may not be adequate.

Authors' contributions

Sara Patuzzo conceived the study and wrote the historical and ethical analysis. Francesco De Stefano wrote the legal analysis. Rosagemma Ciliberti coordinated the study.

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