Medical ethics and the practitioner

Medical ethics is based on the four principles of beneficence; non-maleficence; autonomy and justice. Attempts at resolving conflicts from simultaneous adherence to the four principles and balancing the issues concerning that particular situation against optimal ethical action form the basis for many of our ethical dilemmas. Practising professionals are comfortable with cut -and -dried choices - yes and no answers. Ethical issues force us into gray areas. There are no navigational aids to help chart our course. These conditions make it necessary for us to constantly and critically keep formulating, reviewing and updating positions whenever difficult situations present themselves. To be able to deal with ethical problems in medical practice, formal and non-formal educational inputs are necessary for schooling the practitioner's mind.

The practitioner operates within a social milieu, harnessing intricate and powerful biotechnological tools for the welfare of patients and of society. Proficiency in medical practice needs to be measured in holistic terms. Mere skill in technological interventions cannot constitute a measure of proficiency in practice. The professional approach must, in addition, be scientifically contemporary, morally right, ethically balanced and socially progressive, just and compatible. Proficient practice implies an optimal mix of these attributes.

Smart isn't necessarily good [1]

Tangible outcomes can be measured, which is why they tend to be in spotlight, but it would be erroneous to imagine that less obvious outcomes simply do not exist or are not important. Viewed from the perspective of aesthetics of medical practice, these latter consequences - not classified among the attributes of the 'smart' practitioner - enrich medical practice by their presence and degrade it when they are not to be found. The constant pursuit for sharper understanding, appreciation and nurturing of practices born of moral and social ethics, thus becomes the responsibility of the enlightened practitioner.

Ethics in clinical practice

Most of the energy of the average doctor is spent on his clinical practice where almost every encounter brings him face to face with an ethical issue. Most of us learn to deal with these by formulating our own thumb rules. These need periodic review and update.

The doctor-patient relationship occupies a pivotal position in clinical medicine and is intimately linked to four major ethical issues: (a) paternalism vs. patient autonomy; (b) confidentiality of information; (c) truth telling; (d) the role of gate keeper or rationing officer.

(a) Paternalism vs. patient's autonomy

Although the word 'therapy' is used in clinical practice principally in the context of remedial treatment received passively by the patient, in fact, it entails much more. When we so enable them, our patients can participate actively in therapy with greater benefit to themselves. Medical intervention is guided by the training and the expertise of the practitioner. Each intervention must, however, bring into focus the sense of trespassing on the person of the patient. Whilst the scientific consequences of any particular intervention are best appreciated by the qualified who is, thus, more adept at evaluating the merits of the intervention, it is the patient who has to live through the consequences and, must therefore, hold the final decision over the options. Every person - whatever the level of maturity and development - holds a set of constantly updated moral, ethical and other values, specific and unique to that individual, which serve to guide decision making.

Any medical intervention must be based on these two evaluations - scientific (which the practitioner is best adapted to evaluate) and personal (over which the patient holds the prerogative). The physician deciding on medical intervention without regard to the wishes of the patient is said to act paternalistically, adopting, as it were, the role of the father in the family. In doing so, he fails to respect the autonomy of the patient. In the past, doctors decided what was best for patients and paternalism was the order of the day. After Mill's enunciation of the principles of Liberty [2], the realisation that every human being of adult years and sound mind has a right to determine what shall be done to him / her has gained prominence. Respect for autonomy of the patient is now a guiding principle in ethical medical care.

Extremes of paternalism or autonomy are rarely evident in practice. Most ethical predicaments are faced somewhere along the continuum between these two extremes. Both paternalism and autonomy are based on good intentions. Mass vaccination without regard to consent, is an example of the paternalistic end of the continuum. Voluntary euthanasia lies at the opposite end of the continuum.

The doctor making paternalistic decisions, combines the roles of doctor and parent. In doing so, the doctor has come to a conclusion that the scientific merits should

override patients personal evaluation of choices and options and he questions the competence of the patient. In case of a adult with sound mind, this violates the dignity of the person and could be considered unethical. However, since the doctor also must seek to benefit his patients, if, in his opinion, acceding to the wishes of the patient would seriously compromise the principle of beneficence, the situation poses an ethical dilemma for the doctor.

Competence of. patients to offer consent

If a medical intervention is not to constitute trespassing of the person of the patient, it must be carried out only after obtaining the informed consent of the patient. Four aspects of informed consent (extent of disclosure; comprehension by the patient of what is disclosed; the extent to which the consent is truly voluntary; and the competence to consent) present difficulties in practice.

The patient may consent to a procedure in various ways. When the patient, of his own accord, lies down on the table, he implies consent to being examined. This consent is voluntary, based on the understanding that the doctor has to check him to find out what is wrong. This consent cannot be taken as blanket permission for subsequent intervention. This can only be carried out after disclosing to the patient relevant information necessary to enable him to deliberate on the benefits, costs and risks of the interventions and the possible outcome, and agree to the proposed intervention or refuse it Most doctors inform the patient on such important matters during clinical visits which provide the opportunity to chat to the patient and put him at ease. It also provides the doctor an opportunity to assess how much of the information provided has been understood by the patient.

In everyday practice, commonly performed tests such as the complete blood count or examination of urine are often carried out after a brief but adequate explanation. When any other intervention is proposed, it is necessary to ascertain through dialogue that the patient has received and understood the facts even if it means repeatedly presenting the information in various ways.

When an intervention entails a potential for risk, ethics and the law require written informed consent. It is the spirit of informed consent that really matters to the ethical conscience. Thus, a written consent obtained by making the patient sign on a pre-cast form without any explanation is disrespectful to the autonomy of the patient.

The consent of the patient is also necessary when a patient has to be referred to another doctor or institution. The patient has the right to know about the doctor or the institution to which he is referred. The patient also has the right to dictate his preference. When the doctor and the patient agree on the consultant or institution, the patient's wish should prevail. If the doctor sincerely believes that the patient's decision is faulty, he has the right to withdraw from the doctor-patient relationship after making the reference as desired by the patient without feeling hurt or offended.

The various forms of consent are meaningless when the patient is incompetent to make decisions. Competence refers to the ability of a person to make a rational decision after consideration of benefits, risks and outcomes of intervention and non-intervention.

This ability to decide on what affects oneself could be hampered by the stress of illness, the over-powering surroundings of a health care institution and other factors. Many of these can be reduced - even abolished - by a positive doctor - patient relationship. Under some conditions, the ability to decide has not yet matured (as in infants and children) or is severely compromised (as in coma or mental incapacitation). It is then necessary for the next-of-kin to take on the role of a guardian and decide on behalf of the patient.

Of the four aspects of informed consent, judging competence is perhaps the most difficult. Some clinicians feel that they possess an intuitive ability to decide which patient is competent. This is an unreasonable attitude. It is also well to realise that competence must not be equated with literacy or affluence. When can a patient be deemed incompetent to offer consent? Becky Cox White's book Competence to Consent[3] provides valuable material for conceptual analysis of competence. Her definition of competence serves as a working statement for assessing competence. 'A person is competent for the task of giving a free and informed consent if (1) he is generally informable and cognitively capable of performing the actions involved in making a decision, (2) he knows that decision making requires these tasks, (3) he knows how to perform these tasks, and (4) given his situation, we can reasonably expect him to be able to make decisions.'

At least one person, other than the practitioner, qualified to make such a decision, must also be of the opinion that the patient is incompetent before he is deprived of his autonomy. It is highly unethical to label a person incompetent in order to adopt a paternalistic model of intervention. 'Competence does not vanish just because professional decisions are contested, nor does compliance guarantee its presence.'

When therapy likely to restore health or decrease disability is refused, questions regarding competence are likely to arise. Abnormal behaviour of the patient may also arouse suspicion about his competence. When the competence of a patient is suspect, we must look for impediments such as the stress of the illness, or unfamiliar surroundings, sometimes perceived as hostile by the patient are responsible. For the ethical physician, ther-

apy carries a greater responsibility towards the outcome of the intervention when the patient is not competent.

In facilitating autonomy of the patient, we use two concepts : (a) the ethics of caring (beneficence) and (b) the ethics of justice (egalitarianism). Mary Mahowald successfully integrates these in her book Women and children in health care. In the review of this book, Lainie Ross[5] notes that. Mahowald is critical of the paternalistic model in which 'father knows best' - a model that emphasises physician beneficence to the potential neglect and violation of patient autonomy. She is equally critical of a model that features informed consent and patient autonomy exclusively as it ignores the autonomy of the physician and the professional obligation of doing good and avoiding harm to the patient. Focusing exclusively on the patient's self determination, says Mahowald, is maternalistic because the essential task of motherhood is 'to foster another human being's developing autonomy . . . even at the expense of the nurturer's autonomy'. Mahowald's model is 'parentalist' where both nurture and protection combined. This model provides a framework for nurturing the patient's autonomy whilst ensuring that the doctor's autonomy is not sacrificed.

When the practitioner and the patient are from different cultures, this may be arduous as the value systems different and communication between the two a little more difficult. The paper by Jecker et al [6], will help those attempting such an exercise. Three steps are suggested: (a) Trying to see the situation from the patient's point of view. 'He practices an intensive, systematic and imaginative empathy with the experiences and modes of thought of persons who may be foreign to him but whose foreignness he comes to appreciate and to humanly engage.' (b) Use alternative methods such as consultations with family members; harnessing the services of interpreters; consultations with practitioners from institutions that regularly service the community; and other means to achieve optimal communication. (c) Meeting ethical constraints so that measures proposed and adopted are consistent with the health care provider's conscientiously held beliefs and are compatible with the patient's values and the values of his culture. It is often necessary to re-examine personal values and reinterpret, reorder, or change them in the light of the case. When differences arise they should be resolved through a fair procedure that does not presume to pass judgment on the patient's culture and traditions.

Telling the truth

The association between the doctor and patient is a fiduciary relationship, based on trust. Both parties are expected to tell the truth., Most will agree with Plato that 'in the hands of a doctor truth could be used as a medicine - to be given or not, as the doctor directed, in the dose that was deemed most efficacious.'[7] It is important to distinguish between 'truth' and 'truth telling'. In a fiduciary relationship, it is crucial that one is not lying. When there is doubt, the question asked is, Is it the intention of the doctor to mislead?' In common perception, lying is unethical. Why, then, does one find doctors justifying the telling of half truths or lies?

The argument often put forward is that, at times, the truth might be far from beneficial and could also be harmful. The duty of the doctor to do good to the patient then prevents him from telling the truth. How valid is this position? The evaluation of benefits and risks of telling the truth has to be made on a much wider base. Illness - and its consequent uncertainties - cause stress. It is then difficult to decide whether the short term harm caused by telling the truth or the long-lasting strain and stress consequent to suppressing the truth is more hurtful. When paternalism was the order of the day, 'Father (doctor) knows what is best' prevailed. Today, respecting the patient's autonomy it is unethical to hold back the truth from the competent patient on the premise that the patient might not be able to handle it. 'The duty to care, to provide the best for the patient, now includes the duty to involve the patient in deciding what is best.'[8]

How truth is told also makes a difference. Communication can empower or disable. Proficiency in the art of talking with patients can make a significant difference! Unlike medical emergencies, truth telling can always be elective. The doctor, thus, has time to discuss the issue with those close to the patient and organise the strategy for conveying facts without causing pain.

"Just as in medicine, continuing care is as important as crisis prevention. Fidelity requires that, once a professional has set to work, the work is not stopped until it is completed. The harm of an operation would be incomparably increased if the chest was left open. In ethics where principles conflict, the one that 'loses out' still exists, must be acknowledged and the balance later corrected. This is no less where truth is being told. People take time to adjust to new information, or may forget. The harm of bad telling may be worse than the harm of caring silence. If it is our duty as professionals to explain, it is our duty to do it well."'

Confidentiality

Confidentiality forms an important part of the fiduciary doctor - patient. A patient is an autonomous person with the right to privacy. When he confides in his doctor personal details which he would not to share with any other, he sacrifices some autonomy in order to help the doctor to treat him. He expects a shield of confidentiality. Breaking this trust is generally disrespectful to the patient

But is confidentiality - in a doctor - patient relationship - absolute ? 'The main discrepancy concerning confidentiality has been whether to accept it as an absolute value or rather allow breaches for the sake of more important

goals that would seem menaced by concealing information. The idea of absoluteness elicits a feeling of uneasiness, for contemporary thinking has preferred to develop views that are more contextual, perspectivistic or circumstantial. Absolute confidentiality is therefore an extemporaneous misnomer, since no social practice and no value will hold in every conceivable situation.'[9]

In order to examine circumstances where maintaining confidentiality would pose problems, let us first relate confidentiality to the principles of ethics.

Beneficence: In the doctor - patient relationship, trust has to precede confidence that personal secrets ill be safeguarded. This confidence also extends to the patient who is wards in the care of a guardian. As long as the patient (or in case of a ward, the guardian) is competent, there are very few situations where sacrificing confidentiality would serve the interest of the patient. When a mentally ill patient harbours intentions of committing suicide, breach of confidence does promote the interest of the patient. We must note, however, that such a patient is not competent. Careful consideration will help clarify situations where the principle of beneficence appears to conflict with confidentiality.

Autonomy: When a patient shares personal details with the doctor, he is knowingly compromising his autonomy. When he consents to invasive intervention, he has anticipated that the information so gained will help the doctor to help him. The fiduciary relationship gives him the confidence that this information shall not be passed on, and thus the autonomy shall not be further compromised. There is no need for any a priori proviso to be laid before he confides in his doctor. Breach of confidentiality conflicts with the autonomy of the patient.

Justice: If there is any principle which can come in conflict with maintenance of confidentiality, it is, in rare situations, that of justice. Justice demands fairness to the patient, the doctor and others in the society and to society itself.

Can maintenance of confidentiality of patients be unfair to others ? Yes. Take the case of the doctor who finds his patient has Human Immunodeficiency Virus (HIV) infection. The patient continues to have sexual relations with his wife, who is deliberately kept ignorant about his HIV status. Maintaining confidentiality would be unfair to the wife. Consider a psychiatrist who learns from his patient with homicidal tendencies that he intends to kill his wife. In both cases, maintenance of confidentiality could mean death to the wife.

Breach of confidence is justified under such exceptional, compelling circumstances and must be preceded by strenuous attempts at pre-empting them by counseling the patient and exploring all other alternatives.

The doctor employed by an insurance company is not breaching confidence for the patient knows in advance that the information about his health status will be passed on to insurance company

Rationing of medical care

The medical profession functions under several restraints - limitations of time; effort; materials,; monetary resources and so on. Doctors are, of necessity, called upon to function as gate-keepers (taking in some and leaving out the rest) or as rationing officers allocating scarce resources to specific patients. This is at once unenviable and disheartening as every patient expects the very best and ethics demands action in the best interest of patients. The interests of a patient and social justice may come in conflict. How does one practice the golden rule in this flux ? There are no straight answers. Honest, sincere, consistent, non-partisan, transparent and yet positively discriminating (not indiscriminate) approaches, particularly when doctor or institution is clearly seen to have no vested interest, will satisfy ethical conscience and obtain the approval of patient and society. Public announcement of policy in advance will pre-empt bitter feelings amongst patients.

Differences between a professional and a businessman: [10]

The medical profession	**Businessmen (the market)**
Promotes interests of patients.	Promote their own interests, not those of customers.
Fees incidental to professional activity	Profits central to business activity
Concerned with real 'needs' of the patient and important aspects of human life, such as 'health', 'justice' or 'education'	Concerned with wants or preferences (often trivial)
Has a duty to comment on broad matters of public policy	No such public or social function
Has political and commercial independence which makes its comments relevant to public policy	Lacks independence. Its comments on public policy express vested interest or right - wing policies
Has a knowledge base which requires a broad education	Has shallower, opportunistic knowledge base for which 'training' is a more appropriate term than education.

References:

1 Coles Robert: Storyteller's ethics *Harvard Business Review* April 1987

2. Mill James Stuart: On liberty. In Ed.: Warnock M *Utilitarianism* Glasgow :Collins 1974

3. White Becky Cox: *Competence to Consent* Washington DC: Georgetown University Press 1994 p 209

4. Mary Briody Mahowald: *Women and children in health care : an unequal majority.* Oxford University Press, New York 1993 304 pp. quoted from Lainie Friedman Ross

5. Lain Friedman Ross: Just caring *Hastings Centre Report* January - February 1995 Special supplement p 47

6. Jecker Nancy S, Carrese Joseph A, Pearlman Robert A: Caring for patients in cross-cultural settings. *Hastings Centre Report* January - February 1995 Special supplement PPS. 6-14

7. Higgs Roger: Truth-telling, lying and doctor-patient relationship In Ed.: Raanon Gillon *Principles* of *health care ethics.* Chichester :John Wiley & Sons 1994 PPS. 499 - 509

8. Calnan J: *Talking with patients - a guide for good practice.* London: William Heinemann Medical Books 1983 p 151 (See summary extract of this book in ***Medical Ethics*** 1993- *1994;* 1:3-6)

9. Kottow MH: Stringent and predictable medical confidentiality. In: Ed.:Raanon Gillon *Principles of health care ethics* Chichester: John Wiley & Sons 1994 p 471 - 478

10. Downie RS: The doctor-patient relationship. In Ed.:Raanon Gillon *Principles of health care ethics* Chichester: John Wiley & Sons 1994 p 345-352

NEWS

A promising new journal

We have just received Volume 1, No. 1 of ***Medical Issues.*** This is the bulletin of the Medical Action Forum based in Madras. Dr. Thomas George is a key figure in the production of this journal. He is familiar to our readers through his thought-provoking letters that have graced our correspondence columns. We are not provided the names of the local editors.

The journal seeks to provide a forum for debate on all matters medical but with particular reference to how we can understand the fall of our profession from grace and take steps to re-establish ourselves as the patients' friends, philosophers and guides.

The first essay, 'Political heart disease', deals with the manner in which those close to the rulers of the state evade the due process of law with the help of medical doctors. (Coincidentally, we have discussed the same topic in this issue.) Dr. Arjun Rajagopalan writes on doctors and the Consumers Protection Act - very much in the news at present. Dr. Thomas George, in his inimitable manner, writes on 'Medical education - business as usual' - highlighting commerce in the education of our future medicine men.

This modest journal can be obtained by writing to ***Medical Issues,*** B4/6 TNHB Rental Quarters, Padipadu Nagar, Annanagar Western Extension, Madras 600101. The annual subscription is Rs. 100/-. Those wishing to write for the journal should send their letters to Vidyasagar, Flat 7, Sivan Villa, 10 U. S. Nagar, Padi, Madras 600050 or fax (044)626 6289.

Ethics and the nurses

A conference on ethical and legal problems faced by nurses was held at the Royal Australasian College of Surgeons, Melbourne on '13 October 1995. The proceedings of the conference have been published under the title 'Impossible demands: ethical and legal quandries for nurses'.

The book has four parts. The first part, entitled 'Nursing in context' features Dr. Helga Kuhse's essay 'Nursing, women and ethics'. Other essays deal with industrial considerations and health policy. The second section, 'Nurses caring for the dying' discusses their work in nursing homes, conflicts in deciding on whose autonomy is to be respected, when cardio-pulmonary resuscitation should be stopped or desisted from and the extent to which the dictates of conscience should be governed by obligations to the rights of the patient. The third part deals with the legal quandries and the concluding segment discusses patient advocacy and the moral nature of the work of the nurse.

Copies are available from the Resource Officer, Centre for Human Bioethics, Monash University, Clayton, Victoria 3168, Australia at a cost of Australian $15.00 each.