Editorial

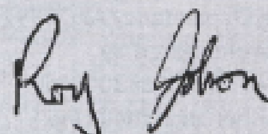
As I write this news has just come through that a colleague of ours has been arrested by the Scorpions Unit for allegedly defrauding Medical Aid Schemes of about R35million. By the time you read this, further information will surely be available.

My gut response is one of extreme dismay and disappointment. I would like to believe that this is an isolated incident. However, I find myself recalling incidents of other reports (from the media and one-to-one conversations) of colleagues selling various household items to patients using their medical aid cards as a form of currency.

I find myself wondering whether reports of colleagues employing fourth, fifth and final year medical students, as well as interns, to do locums and to assist in surgical procedures, could possibly be true. Apparently some of these junior members of our profession have become so deeply enmeshed in financial debt that they see no other way out. At least, this was the explanation I was given when I asked why I was hearing about interns (and students) failing to turn up to do their calls and not being contactable for the duration of the call. Just as alarming was the information that a blind eye is often turned to these practices because more senior members of staff (registrars and consultants) are also involved in these kinds of practices and are sometimes unavailable when they have a commitment to be available.

My other response is probably one of 'denial'. I do not want to even consider the possibility of these events being true. I would rather label them as 'rumours' and ignore them. I don't want to get involved. I don't want to have to deal with the consequences of finding out that one or more of these reports is actually true. I am grateful that I have not been given any names, dates, specific incidents or other factual details. I don't want to have to wrestle with my own conscience and sense of right or wrong in terms of a colleague's behaviour.

It seems appropriate therefore that in this edition of CPD in SA Family Practice, we consider various ethics issues. I am indebted to Dr Keymanthri Moodley for her input into the various scenarios outlined below. We have tried to use very concrete examples (the majority are based on real-life situations) to illustrate application(s) of ethical issues and some of the thinking behind them.



Roy Jobson

Appropriate completion of this edition's CPD exercise (see flyleaf) will qualify for 2 ethics points.

ETHICS VIGNETTES

Scenario 1

You notice that one of your colleagues is increasingly forgetful and at times has missed rather obvious clinical signs in patients, and written out illogical prescriptions. (You picked up the former when one of the nursing staff was unhappy with what patients had said to her and what was subsequently diagnosed. The latter were pointed out to you by pharmacists who phoned you when your colleague was not available.)

On more than one occasion you thought you could smell alcohol on her breath.

You are then told that there are ampoules of pethidine missing. An unaccounted for empty ampoule is found on the floor by the cleaner in your colleague's consulting room.

Further incidents and unrefutable evidence accumulate which convince you that your colleague has developed a dependency on alcohol and possibly pethidine as well.

Question 1
What are your ethical obligations in dealing with this situation?

Answer 1

In keeping with the Hippocratic tradition, collegial protectionism has been an important hallmark of the medical profession.

In this scenario, it appears as though the doctor's medical judgment is being impaired as a result of substance abuse. This perception will of course need to be substantiated before one proceeds further.

The ethical dilemma in this situation is one of dual loyalty – on the one hand, loyalty to a colleague and on the other hand, an obligation to protect innocent third parties – namely: patients.

By adopting a consequentialist approach to this dilemma, the outcomes of our actions are considered and form the basis of decisions.

For example we could consider Options A and B.

OPTION A:

- Approach the doctor directly and discuss your concerns.
- If she has insight into her problem and appreciates your concern, proceed to assist her with rehabilitation, time off work, etc
- If she is in denial, and is offended by your approach, you may have to follow the procedure in existence with the Health Professions Council of SA for reporting "impaired doctors". This would entail calling the HPCSA – on 012-338-9321 – to make contact. You will be given a fax number. A letter would have to be faxed to the HPCSA. In your letter you have the choice of disclosing your identity or of remaining anonymous. The matter will be referred to the Health Committee, an informal investigation will be opened and a letter will be sent to the 'impaired' doctor inviting her to co-operate with them voluntarily.
- If she refuses, the complaint could possibly become one of negligence and the necessary steps will be followed.

OUTCOMES:

1. The doctor might be rehabilitated, enjoy better health and be able to practice medicine again.
2. You will have protected the health and lives of innocent patients.
3. Trust between the public and the medical profession will be preserved.
4. If the Health Committee of the HPCSA does indeed find that the doctor is 'impaired' (and the procedures to be followed are clearly defined in the amended Health Professions Act) the following options may be followed:[1]

The health committee may –

(a) make a finding on whether or not a student or practitioner is impaired, based on an assessment or investigation in terms of these regulations;
(b) resolve on the management of a student or practitioner who has been found to be impaired with a view to the securing of patient safety and the treatment or rehabilitation of such student or practitioner; and
(c) impose any condition of registration or practice which the health committee may deem to be appropriate to achieve the objects referred to in paragraph (b), which may include conditions with regard to –
  (i) his or her status as a registered person;
  (ii) the locality of his or her practice;
  (iii) the scope of his or her practice;
  (iv) permission to handle scheduled substances such as the purchasing, acquiring, keeping, using, administering, prescribing, ordering, supplying or possessing of any or all of the substances scheduled in terms of the Medicines and Related Substances Control Act, 1965 (Act No. 101 of 1965);
  (v) the prohibition of the use or abuse of dependence-producing substances scheduled in the Regulations made under the Prevention and Treatment of Drug Dependency Act, 1992 (Act No. 20 of 1992) promulgated by Government Notice No. R. 721 of 30 April 1993, including drugs other than medicine;
  (vi) ensuring and securing the treatment and rehabilitation of the impaired student or practitioner;
  (vii) securing supervision of the fitness to practise and the performance of the impaired student or practitioner.

OPTION B:

- Do nothing.

OUTCOMES:

1. The doctor's condition might deteriorate both physically and psychologically.
2. The health of innocent patients could be adversely affected.
3. Lives may be lost.
4. The doctor might face litigation from patients.
5. A complaint of negligence might be lodged with the HPCSA by a patient.

6. You may have to consider your own role/responsibility and conscience in not having taken action.

Using a 'utilitarian' approach that is outcome based, one would choose the option that produces the greatest good for the greatest number of people. In considering the outcome, it seems that on balance, Option A might be preferable.

Acting out of a sense of duty or feelings of obligation to do the right thing irrespective of outcome is consistent with a 'deontological' approach to ethical behaviour. In this case, one would act so as to protect innocent third parties and would therefore decide to blow the whistle on the colleague.

Scenario 2

Your patient is a medical student. He has been HIV-infected for some time and discloses this in a letter to you. He needs a 'sick note' after missing an examination because he had had an episode of severe diarrhoea. You write the appropriate sick note, but inadvertently enclose and seal his letter to you in the envelope with the sick note. His HIV-status is now public knowledge as a result of your carelessness.

Question 2
What are your ethical obligations in dealing with this situation?

Answer 2
Medical professionals have since time immemorial been shrouded in an aura of almost divine perfection. As such, medical mistakes are often viewed as catastrophic events by both doctors and patients alike.

Charles Bosk,[2] in his book "Forgive and Remember: Managing Medical Failure" describes 3 types of medical errors:

1. technical errors – made by conscientious doctors whose technical skill or training or knowledge falls short of what the task requires;
2. judgemental errors – here an otherwise conscientious doctor follows an incorrect strategy;
3. normative errors – the error violates standards of conduct by failing to discharge moral obligations conscientiously. A moral judgement is then made about the person.

What is clear in options 1 and 2, is that even conscientious persons can be expected to make 'honest' or 'good faith' errors.

In this scenario, it is clear that the doctor, by a slip of the hand or a lapse in concentration, made an honest error with somewhat disastrous consequences.

What can be done under the circumstances?

1. The student needs to be sensitively informed of the error and a sincere apology must be offered.
2. The spread of this confidential information must be contained as a matter of urgency.

The outcome will depend on the damage already done and the response of the student.

However, a policy of honesty and a display of genuine remorse will reduce the damage.

What is also important is the problem the doctor will then have with his/her conscience. According to Beauchamp and Childress,[3] conscience is a form of self-reflection on, and judgment about, whether one's acts are obligatory or prohibited, right or wrong, good or bad. It is an internal sanction calling attention to the actual or potential loss of a sense of integrity and wholeness in the self. This sanction may appear as a bad conscience – including painful feelings of remorse, guilt, shame, disunity – as the person recognizes his or her acts as wrong. These are the feelings the doctor in this scenario will most likely experience and s/he will need to work through the issues as they arise, being mindful of the fact that as a human s/he too is fallible. Setting unrealistic standards makes the process that much more painful to work through.

Scenario 3

Mrs H is extraordinarily distressed. Her 60 year old husband, Prof H, had died several months previously, and she has multiple unresolved issues related to his death.

He was successfully recovering from a myocardial infarct which had been managed through having an angioplasty. He was making a supreme effort to quit smoking and was keeping fit by swimming. A month later at home, he developed a bout of diarrhoea and vomiting which persisted.

He was taken to a specialist physician who referred him for an ultrasound of his aorta and the iliac vessels, and a diagnosis of impending aortic aneurysm rupture was made. However the cardiologist had a month earlier informed Dr H and his wife that although he had a small aortic aneurysm, and atherosclerotic changes in the iliac arteries, that in his opinion it was not serious enough to warrant surgery.

The new doctors decided that an emergency aortic bypass graft was necessary. Mrs H had severe reservations about this, but was prevented from communicating with her husband because of the urgency of the surgery.

The operation was successfully performed but no macroscopic aortic lesion could be found. It was only after the operation that Mrs H was informed that her husband had not been expected to survive the surgery. (His initial complaint of diarrhoea and vomiting was seemingly ignored.)

Mrs H was not ever informed of the histology results.

Prof H was on high doses of analgesics and a decision was made to ventilate him. As he was quite drowsy, Mrs H was asked to sign consent for the tracheostomy. The nurse who wanted her to sign consent could not answer any of Mrs H's questions, and Mrs H refused to sign consent. The following morning when she arrived at the hospital the consent form was handed to her by the same nurse, and she was told that she 'had' to sign it because the theatre had been booked and the anaesthetist and surgeon were on standby. Mrs H felt unduly pressurised and signed the form 'under duress' and made a statement to that effect on the consent form.

Subsequent to the tracheostomy, Prof H started to bleed from the nose. An ENT surgeon plugged his nose – and multiple blood transfusions were given. However the bleeding continued. Twelve days later a bronchoscopy was done and an actively bleeding vessel was cauterised. The bleeding then stopped.

By then Prof H had developed a *pseudomonas* septicaemia, cardiac and renal failure. Administration of a combination of intravenous furosemide and vancomycin caused him to become deaf, resulting in immense frustration at not being able to communicate with his wife or anyone else. He was subsequently forcibly strapped to the bed resulting in injuries to his wrists.

A bolus of midazolam 5mg intavenously was administered rapidly which caused his blood pressure to drop markedly – and a few hours later a second rapid intravenous bolus dose was administered resulting in a further drop in blood pressure.

After 24 hours of continuous intravenous adrenaline Prof H went into cardiac arrest and all attempts to resuscitate him failed.

A complaint to the HPCSA was submitted and she was told that Mrs H would be receiving a response in due course. When it eventually did arrive, it was written in Afrikaans, despite her being an immigrant from the UK.

Question 3
Describe the different ethical issues raised at various points in this narrative.

Answer 3
The ethical issues illustrated here are as follows:

1. Supercession

It is evident that the new team of medical professionals treating this patient did not consult with the cardiologist initially responsible for his care. Not only would this have been professional etiquette in keeping with HPCSA guidelines, but in this case, would have been material to the treatment option chosen for this patient and it might have been life-preserving.

2. Respect for Autonomy, Informed Consent and Truth-Telling

Respect for Autonomy creates the following obligations:
a. informed consent
b. confidentiality
c. truth-telling
d. effective communication

It is abundantly clear that obtaining informed consent for both the surgery and the tracheostomy was problematic. Important information relating to prognosis with the chosen treatment option was not declared to the wife and her decision-making ability was disrespected. One wonders if the patient himself was given any information and whether or not he had capacity to consent to the operation. Consent for the tracheostomy appears to have lacked the element of voluntariness – as the wife felt pressured to sign the consent form in the absence of adequate, if any, information.

3. Beneficence and Non-Maleficence

The promise of 'primum non nocere' or 'first do no harm' was clearly violated in the care of this man. It appears as though the competence of the ultrasonographer is questionable and this is material to this case as unnecessary surgery was performed. Further aspects of medical care are also questionable including the terminal event that appeared to be precipitated by 'rapid intravenous' boluses of midazolam.

4. Role of the HPCSA

It is clear that communication is not given priority by the HPCSA. As a requirement of respecting patient autonomy, communication needs to be meaningful and appropriate and it is evident in this case, that that did not occur. Such occurrences need to be brought to the attention of the HPCSA so that policy change can be implemented at that level.

Scenario 4

You are a GP in a semi-rural town. A high profile health education group came to the local high school in order to educate the students about HIV/AIDS. Apart from including the 'Abstinence' and 'Be faithful' messages, the correct use of condoms was explicitly demonstrated using a rather large and life-like model penis.

Following this session a group of boys gang-raped a young girl. The boys were charged and are in the care of their parents.

Question 4

What are your ethical obligations in terms of the health educators?

Answer 4

Vital questions that have to be asked here are the following:

1. Was the gang-rape provoked by the HIV programme?

   or

2. Would it have happened anyway?

The response of the GP in this instance would be dependent on detailed knowledge of behavioural patterns and norms in the area. What is the prevalence of gang-rape in the town? What is the incidence of gang-rape in the town? Was this just one act reflecting an increased incidence for other reasons, or was this an isolated event related to the allegedly provocative nature of the HIV programme?

It would be important for the GP to be extremely diplomatic in approaching the Health Education Team. S/he might want to have the programme evaluated by psychologists, psychiatrists or behaviourists. It is only if there is good evidence to suggest that the programme is indeed provocative and if causation can be inferred that further steps should be taken. This is clearly a case where the risk-benefit ratio of the interventional programme needs to be assessed in keeping with the principles of beneficence and non-maleficence. Unjustified criticism of the programme could deprive the students of the potential benefits. On the other hand, the programme could cause more harm than good if it is inappropriate and provocative.

References:

1. Government Notice R.495, Section 22(1). Amendment to Health Professions Act, 1974. Regulations Relating to Impairment of Students and Practitioners. Government Gazette. No. 22351. 8 June 2001.
2. Bosk C.L. Forgive and Remember: Managing Medical Failure, Chicago: University of Chicago Press, 1979.
3. Beauchamp T. L., Childress J.F. Principles of Biomedical Ethics Fourth Edition New York, Oxford University Press 1994.

Faculty of Health Sciences

POSTGRADUATE PUBLIC HEALTH PROGRAMMES:

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For further information, contact Tizzy Pollard, School of Public Health and Primary Health Care, Faculty of Health Sciences, University of Cape Town, Observatory 7925. Email: tizzy@cormack.uct.ac.za Closing date for applications: 31 October 2002.

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