Ethical Issues in Family Practice

This is the next in a series of columns, which will appear in future editions. The authors will use the format of a "case study" which will be presented and then be discussed by two doctors (A and B) over a well earned coffee break in their tea-lounge. The authors hope that their exploration of the ethical issues involved in each situation may provoke you, the reader, into thinking more about the ethical issues inherent in everyday Family Practice. If you would like to pursue any of the issues in more depth, please drop a line to the editor.

Not intervening in patients' lifestyles - is it justified?

CASE STUDY:
Doctor J, working in a public hospital refuses to see a patient with emphysema because the latter can't stop smoking cigarettes despite the doctor's advice. Can the doctor's argument be justified?
What follows is a discussion between two doctors (A & B), on the above question:

Dr. A: *If we follow the deductive form of the doctor's argument, it would look like this:*

- *Premise 1: Cigarette smoking is the cause of my patient's emphysema.*
- *Premise 2: My patient can't stop smoking cigarettes.*
- *Conclusion: Therefore, I refuse to see this patient.*

Dr. B: Wait, something is wrong with the argument! To make a deductive argument valid, its **premises**, no matter how many, must provide conclusive grounds for the truth of its **conclusion**.[1] In other words, to reach a deductive, logical and valid conclusion, the premises set the ground for the argument's truth. So, we need to first ask if the premises are true, and then if the conclusion is valid.

Dr. A: *That's right. Premises 1 and 2 may be taken as "true statements". However, the problem seems to be with the "conclusion". This argument is not valid because the truth of the conclusion does not relate to the truth of the premises. To make this a valid deductive argument, we would have to say something like this:*

- *Premise 1: Cigarette smoking is the cause of my patient's emphysema.*
- *Premise 2: My patient can't stop smoking cigarettes.*
- *Conclusion: So, unless my patient stops smoking cigarettes, he will continue to have emphysema.*

Dr. B: Yes that is better. Do you know that Aristotle was the first to classify systematically various valid deductive forms of reasoning, which he called "**syllogisms**"? One such form, for example holds that, "All F are G", and "All G are H", therefore, by form alone, it follows that "All F are H", regardless of what F, G, and H represent. But it must be remembered that valid deductive arguments, studied by logicians in abstraction, tell just part of the story. We must also look to content because passing a practical test of formal validity requires that there is both valid form and true content. Sound reasoning represents the strongest possible proof, that is, "true assumptions, plus valid form, yields true conclusions". I argue that our doctor's argument is not valid, because there are no conclusive grounds for the conclusion.

Dr. A: *Okay, but the ethical problem I see in this argument is his refusal to see a patient. Can a doctor in public service ever justify this?*

Dr. B: It is hard to justify not seeing a patient, even those classified as 'difficult'. I think we have our work cut out for us! Can we try an argument from the point of view of **'duty'**?

Dr. A: *You are really rattling my brain, but I will give it a try as follows:*

- *Premise 1: It is my duty as a doctor to heal the sick.*
- *Premise 2: If someone uses a substance causing physical harm, they will become sick.*
- *Premise 3: I have told my patient that cigarette smoking is the cause of his sickness (emphysema).*
- *Premise 4: Because my patient can't stop smoking cigarettes, he remains sick.*
- *Premise 5: And he makes it impossible for me to do my duty as a doctor.*
- *Conclusion: Therefore, since I cannot do my duty (as a doctor), I refuse to see this patient.*

No! That really doesn't work either, because the argument on "duty" is too narrow and the premises still don't support the conclusion.

Dr. B: In fact, the doctor by virtue of being a public servant cannot refuse to see the patient. But perhaps it all boils down to a question of the family practitioner's values. Let us assume that our doctor has tried his utmost to convince the patient that cigarette smoking is the cause of his ill health and that for whatever reason the patient is unable to stop smoking cigarettes. Can we accept this as fact? Our doctor considers the patient to have a **medical condition** for which he perceives the patient to be responsible. In addition, the patient shows a **social characteristic**, in this case **non-compliance** with recommendations that both threaten the family practitioner's authority and impedes the course of his therapy.

These are regarded as some of the characteristics that categorise a patient as being 'difficult'.[2]

Dr.A: *'Difficult' patients! Another complex problem. Could the doctor actually be saying this?*

- *Premise 1: I am your doctor therefore I know what is best for your health.*
- *Premise 2: I have instructed you to stop smoking cigarettes because smoking cigarettes is bad for your health.*
- *Premise 3: Since you continue to smoke cigarettes you are not following my instructions.*
- *Conclusion: Therefore I will terminate our relationship.*

Dr. B: But, if we put the argument into a deductive form, this is probably close to what our doctor may be thinking. Problems faced when dealing with 'difficult' patients press the concept of family medicine to its limits. For example, doctors may feel a "failure" or "threatened" on a personal level, if a patient does not comply with their advice, but they also ought to consider the motivation(s) for the patient's non-compliance. In addition, if the family practitioner's first commitment is to the **patient as a person**, then the only legitimate grounds to refuse to see the patient would have to be one centering on the patient's best interests. The intricacy of dealing with difficult patients presents a major challenge to family practitioners. When a patient is summarily refused, so is the commitment to the principle underlying family medicine: to the patient as a person. I think the primary moral question a family practitioner ought to keep in mind is this: **Is it in the best interest of his or her patient to be refused treatment or care?**

Dr.A: *So if we make a deductive argument out of this discussion, we can finally say:*

- *Premise 1: My 'difficult' patient shows both medical and social conditions presenting a great challenge to the ethics involved in being a family practitioner: (the commitment to the patient as a person).*
- *Premise 2: If I abandon this patient, then I admit my own personal failure and forsake my role as a family practitioner.*
- *Conclusion: Because of these reasons, I ought to stay with my 'difficult' patient and continue to educate, treat and support him, no matter how troublesome it is for me on a personal level.*

Dr. B: Food for thought.

Dr.A: *That's the idea.*

References:

1. *Copi, IM, Cohen C.* Introduction to Logic. *New Jersey: Prentice-Hall. 1998: 25.*
2. *Christie RJ, Hoffmaster CB.* Ethical Issues in Family Medicine. *NY: Oxford University Press. 1986: 124 – 125.*

Donna Knapp van Bogaert MA, MBA, M. PHIL Applied Ethics (Biomedical & Business) (Stell)
Department of Anat. Path, Medical University of Southern Africa (MEDUNSA), Pretoria

Gboyega A Ogunbanjo
MBBS, MFGP (SA), M Fam Med (MEDUNSA)
Department of Family Medicine and Primary Health Care, Medical University of Southern Africa (MEDUNSA), Pretoria