Family Medicine Theory in Action for GP's

Theory in Action – A regular opportunity to explore core concepts of our discipline using actual patient interviews and interactions as triggers for discussion. Presented by Dr Anne Wright and Professor Bruce Sparks from the Department of Family Medicine, University of the Witwatersrand.

No 3. "Primum non nocere" (Above all do no harm) (? Hippocrates *c.*460–357 BC)

A Brief Exploration of Bio-medical Ethics

The patient's stories ...

Setting ......

a busy practice where you are steadily working through a list of Tuesday morning patients.

The patients ......

The next patient is Sophie Brown a university student who requests a sick certificate for an examination which she missed the previous day. She is now better, but claims she was too sick to go to write the important examination due to the cramps and loose diarrhoea. You issue her with a certificate, booking her off for Monday.

Sophie is followed by Margaret Smit, aged 72, who has returned for the results of a barium enema to investigate narrowing of her stool. The X-ray indicates an apple-core carcinoma of the upper rectum. She says she wants to be told everything about her condition, but you are concerned about her ability to deal with a diagnosis of cancer due to her previous bouts of severe depression. She seems to sense your hesitation and says, "Will I have to have a 'bag' fitted, Doctor?" You prefer not to tell her the truth saying, "I don't think you should worry yourself about it now, but I would rather the surgeon explain everything to you, Margaret."

Three patients later you happen to be visited by Thelma Frere, for a minor complaint. She is also a personal friend of Margaret Smit's. You tell her about Margaret's consultation and your concern about her mental state and the inability to deal with the diagnosis. She agrees that "To know the truth would kill her".

After your mid-morning cup of tea you see 26 year-old John Smith whom you recently diagnosed as HIV positive. He now has a cough. He still refuses to inform Joan, his sexual partner of 3 years, and mother of their 2 year-old daughter, that he is positive. You treat his acute respiratory problem but feel frustrated about his unwillingness to disclose his diagnosis to her.

Martha Ferreira, aged 82, comes in just before lunch for a medical certificate for her motor insurance company specifying her fitness to drive. Her daughter has phoned you to say, "She only drives to the shops and back, Doctor, and we keep an eye on her". Martha too says that without her mobility she would 'rot' at home. Two years ago she had a TIA with full recovery. Her BP is 160/100 and her vision is 16/20 for her left eye and 12/20 on the right. You decide that in view of the short distances she needs to drive and her desire for independence, that despite her advancing years and relative debilities, she can still drive. You issue a certificate indicating that she is fit to drive.

Your first patient after lunch is Lucas Molefe, a managing director, who complains about the way in which he was treated by the surgeon, Peter Britz, to whom you had referred Lucas. You had stated that you were a personal friend of his and indulged in mutual sporting activities and trusted him implicitly. Lucas is particularly upset that he was moved from his semi-private ward to a general ward during his recent hospitalisation in a private clinic, because the bed was required after one day by another of Dr Britz's patients, a Mr. Britz, who happened to be white. He believes that such behaviour was racially based. On the one hand, to agree with Lucas would cause you great discomfort, for although Peter is somewhat 'verkrampt' you don't believe his action was really racist. On the other hand, Lucas is an important patient of yours since you run an occupational health clinic at his factory once a week.

As you are about to leave that evening your receptionist asks you to write a script for amoxycillin for her domestic who has a very sore throat. She requests that you issue it in her name so that she can claim it from the medical aid. You comply – after all it's a relatively cheap script and the medical aid won't even feel it!

Reflection .....

And later that night as you wearily slump in front of the TV, aimlessly paging through a journal, your attention is caught by a CPD advert which reads "attend one weekend course and earn your 'ethics points' the painless way". What's all this fuss about "ethics" you wonder. What's there to learn? I'm not a bad guy, I know the rules and I basically stay legal ... so I'm ethical... I can't even recall when last I had an 'ethical' problem, my patients never have them.[1]

And then you start thinking about the day at your rooms.........

From a simplistic point of view, our interpersonal behaviour is controlled and sifted by various levels of rules. At the coarsest level, ***common law and the judicial system*** control for the major crimes and "big sinners". At a medium meshed level, the Health Professions Council of South Africa (HPCSA) controls our clinical behaviour by ***professional rules and regulations.*** Within the clinical setting and in our daily interaction with patients and their families, ***ethical considerations*** apply a finer mesh to temper our behaviour.[2]

The request of the first patient, Sophie Brown, highlights the important distinction that must be made between medico-legal and ethical issues. Very often the two are thought to be either synonymous or consequential; that is, "ethical behaviour" is assumed to refer to that which is medico-legally correct, or similarly, it is assumed that behaviour which is "legal" must also be ethical. Neither of these assumptions is necessarily correct. "Ethics" refers to moral dilemmas and moral reasoning. Answers to ethical problems are sought in theories of moral philosophy, ethical codes and the formulation of ethical principles. Medico-legal matters on the other hand, are informed by what is considered ethical medical practice, by the laws of the country through regulations and rules which are encompassed in Acts, by rulings of the HPCSA, and by international and national codes of professional conduct. The rules which affect medical practitioners most are those which are sometimes called the "Medical Council Rules", or those within the Medical, Dental and Supplementary Health Service Professions Act 56 of 1974.[3,4]

There may be conflict between law and medical ethics. For example it may be lawful, except in an emergency, for a doctor in private practice to refuse to see a patient in terms of the legal principle of freedom to contract. However, on the other hand, the ethical guidelines of SAMA[5] and the HPCSA[6] state that, ethically, no doctor (private or non-private) may refuse to treat any patient solely on the grounds that the patient is HIV infected.

So to return to Sophie Brown: to issue a sick certificate simply stating that she had diarrhoea is medico-legally unacceptable and fraudulent behaviour since you have not confirmed the presence of diarrhoea. On the other hand it would be acceptable to state the facts and write a certificate stating. *"As I am informed, Ms Sophie Brown, had diarrhoea on Monday 10th November 1999. I saw her for the first time on Tuesday 11th and I consider her unfit for duty on 10th November 1999."* Similar fraudulent behaviour is inherent in the certificate of fitness to drive, issued to Martha Ferreira.

A decision to disclose John Smith's diagnosis to his wife would be contravening the "Medical Council Rule" of disclosure of information regarding a patient to a third party without his consent. But, on the other hand, Council has also recommended disclosure to a sexual partner, if the patient refuses to do so despite encouragement to do so. Council also recommends that other health professionals who are at risk of infection from the patient should be told the diagnosis.

While medico-legal decision-making is inherent in the management of several of your patients, ethical decision-making was also explicitly and implicitly part of your day. For example, Margaret Smit presented you with the dilemma of whether or not to uphold her autonomy as a patient and disclose a bleak and maybe unbearable diagnosis. Your uneasiness about that decision leads you to confess all to Thelma. Does the comfort gained from her reassurances justify the possible harm to Margaret through your breach of confidentiality? John Smith challenges you to weigh up his freedom to refuse disclosure versus your duty to consider the welfare of the wider family. And Lucas Molefe has caused you to reconsider the issues of prejudice in the allocation of resources and your duty to a colleague. How are these issues and questions posed in ethical terms and how can you be assisted to make ethical decisions?

There are many different frameworks for the discussion of bio-ethical (or biomedical ethical) problems. In this discussion, only three will be briefly referred to: moral theories, ethical principles, and a Family Medicine case-based approach. Probably the oldest approach is that which places emphasis on moral theories as guides to decision making. Here one is typically presented with a smorgasbord of theories – be it utilitarianism, deontological theories, social contract theory, religious ethics, feminist ethics, virtue ethics – and one either argues for one theory above the other or one shows how each would address the problem.[7] So, for example – and this is indeed oversimplifying matters – utilitarian theories (consequentialism) assert that "morality is all about maximising happiness and minimising misery: that one's actions are right insofar as they tend to that end, wrong insofar as they tend to decrease happiness or increase misery" [8]. Deontological theories, for example, Kantian theory, hold that people have intrinsic moral worth that prevents them from being used merely as a means to an end (no matter how important or valuable that end may be).[9] To return to the patients. A utilitarian might conclude that while disclosure of the diagnosis might satisfy Margaret Smit's queries and concerns, the consequences for the rest of the family (and the doctor and Thelma) would be unbearable (or vice versa). A deontological argument would conclude that Margaret has the inherent right to know irrespective of the consequences – and that the doctor has a duty to truthfully (and appropriately) answer her questions.

Similarly a utilitarian would argue that John's request for non-disclosure is outweighed by the possible benefits of disclosure to his family and the community.

While the fundamental significance of moral theory must not be negated, there are practical problems with this "top-down" deductive approach. These include the difficulty in knowing which theory is preferable, or which is better in a particular situation. Also the theories often seem difficult to apply and rather remote from the everyday world of the GP and her patients.

Perhaps the best known approach to medical ethics and one which has been very influential for the past 20 years is that of the principles of biomedical ethics or "principalism".[10] The four principles are: respect for patient autonomy, non-maleficence, beneficence, and justice. Adequate discussion of the interpretations of the principles is completely beyond the scope of this brief article – the reader is referred to the library section – but a simple paraphrase has been provided by Arras and Steinbock:[11]

(a) respect the capacity of individuals to choose their own vision of the good life and act accordingly (autonomy). It also implies that one not only has an attitude of respect for that capacity but that one acts to enable the person to carry out their choice. Included within the ambit of this principle are considerations of confidentiality, disclosure, and informed consent. Respect for patient autonomy is considered to have primacy over the principles of beneficence, non-maleficence and justice although this is challenged by some circumstances as is illustrated in the case of the patient John Smith.-

(b) refrain from harming other people (non-maleficence): The notion that "Primum non nocere" – above all do no harm -, was first expounded by Hippocrates is not substantiated. Galen is thought to have attached the phrase "above all". However despite the time honoured tradition that "do no harm" is the "first" principle, moral philosophers challenge this on grounds that, *inter alia*, clinical medicine frequently involves some risk or harm to the patient. It is argued that respect for autonomy, which allows patients to decide on the level of risk and harm they're prepared to tolerate - may take precedence over non-maleficence.

(c) foster the interests and happiness of other persons and of society at large (beneficence)

(d) act fairly, distribute benefits and burdens in an equitable manner and resolve disputes by means of fair procedures (justice). But how are resources to be "justly" distributed? Beauchamp and Childress list the following possible principles: to each person an equal share; to each person according to need, or effort, or contribution, or merit, or free-market exchange.[13]

While the principles are regarded as constituting serious moral duties, they are not absolute or placed in a hierarchical order, but are meant to be weighed and balanced against each other according to the particular situation. Consider again the patient Margaret Smit. Respect for her autonomy would suggest that her desire for full disclosure be acknowledged and that she be told what she wants to know. The doctor however feels that because she is a depressive, it would be in her best interest for her not to know that she has cancer and so hedges around the issue. This violation of her autonomy is referred to as paternalism which is broadly defined as a doctor "acting on the basis of his perceptions of what is in the best interests of patients and who ignores or override the patient's wishes".[14] However it might also be argued that in this case where the capacity of the patient to act autonomously is unclear, the principle of autonomy should be tempered by that of beneficence or even non-maleficence.

Again, the dilemma presented by the patient John Smith is a very contemporary example of the "on balance" approach of principalism. The duty to observe confidentiality, entrenched in the Hippocratic Oath, is supported by the principle of autonomy – patients have a right to determine who has access to information about themselves – and the non-observance of confidentiality may be a violation of the principles of beneficence and non-maleficence. However, your duty to observe the autonomous decision of John not to disclose his HIV status must be balanced against that of a duty to consider the welfare and best interests of his partner and their child.

Although principalism is very influential, various criticisms have been made:[15,16] the principles do not provide guides to action as is claimed for them, but are rather moral checklists, things to consider and remember when considering ethical problems; the principles are often invoked in a mechanistic and empty way (a mantra rather than guidelines); like moral theories, principalism is "top down" with insufficient latitude for "cases" to influence principles and following from this, the apparent inflexibility of principalism to be modified by cultural contexts is also cited.

A third approach to moral reasoning is that of case-based ethics which stresses the particularity of problems, and places far less emphasis on the role of moral theory and "routinised appeals" to the principles. An example of this kind of work is that of Christie and Hoffmaster- who offer a "bottom up" inductive approach argued specifically from the context of family medicine. They focus not on the dramatic "headline making"

events - heart transplants, euthanasia, genetic engineering - of much conventional bioethical writing, but on the "more mundane, more pervasive, problems that arise in the daily practices of family physicians" [18] - the sick certificates, the difficult disclosures, the requests for unwarranted fitness reports, confidentiality that goes awry, and patient advocacy. They argue that the inherent moral quality of the patient-doctor relationship in family medicine[19], the complexity and subtleties of practice, the use of systems thinking, questions of boundary issues and power relations, the inevitable involvement of families and others, all mitigate against "a reductionistic and atomistic moral view... a black and white approach that sees every issue in terms of autonomy and paternalism".[20] To meet these requirements they propose a case-based "factor theory" method according to which relevant factors for each "case" are identified and then contextually assessed. They conclude: "a factor theory makes applied ethics messy, but no purpose is served by trying to conceal its messiness behind the artificial simplicity of a philosophical theory……"[21] Thus, for example, while principalism might confine discussion of Lucas Molefe and Peter Britz to the moral issue of the injustice of a racially based allocation of resources, and dismiss other issues as self-interest and not moral dilemmas, a more contextual approach could allow for issues of patient advocacy and collegial relations to enter the debate.

And in conclusion .....

The buzz of your cell phone wakens you from your reverie. It's Lucas wanting to know if you've spoken to Dr Britz yet. You mumble something, switch off the phone, pick up the journal from the floor and sign up for the weekend course in ethics ....

The Library ...

1 Gillon R. Philosophical Medical Ethics. Chichester: John Wiley & Sons; 1992: 9, 13, 34 – 40. (Objections to the need for medical ethics are discussed. This book which was originally written as a series of articles for the British Medical Journal and contains excellent short discussion of ethical theories and principles of medical ethics.)

2 Sparks BLW. Micro-ethics of the consultation. CME 1998;16(9):846-7.

3 Strauss SA. Doctor, Patient and the Law. Pretoria: JL van Schaik; 1984.

4 Van Oosten FFW. The interaction between medical law and medical ethics. CME 1996;14(10):1459-66.

5 Medical Association of South Africa. Guidelines for the Management of HIV/AIDS. Cape Town: MASA Publications, 1992.

6 South African Medical and Dental Council. The management of Patients with HIV infection or AIDS (revised guidelines). Pretoria; SAMDC, 1992.

7 Arras JD, Steinbock B. Ethical Issues in Modern Medicine. California: Mayfield; 1995:1-39. (A concise, readable overview of ethical theories.)

8 Gillon R.(1992) Ibid: 21

9 Gillon R (1992) Ibid: 17

10 Beauchamp TL, Childress JF. Principles of Biomedical Ethics. 3rd ed. Oxford: Oxford University Press; 1989. (The most authoritative account of the principles)

11 Arras JD and Steinbock B. (1995). Ibid:34–7.

12 Gillon R.(1992) Ibid:115-25 (For a discussion of some challenges to autonomy having primacy)

13 Beauchamp Tl, Childress JF.(1989). Ibid:261–2.

14 Christie RJ, Hoffmaster CB. Ethical Issues in Family Medicine. New York: Oxford University press; 1986:48.

15 Arras JD, Steinbock B.(1995). Ibid: 36-7

16 Gert B, Culver C, Clouser KD. Bioethics: a return to fundamentals. New York: Oxford University Press; 1997:74–91.

17 Christie RJ, Hoffmaster CB (1986) Ibid.

18 Christie RJ, Hoffmaster CB (1986) Ibid:xii

19 It could be argued, maybe using McWhinney's view of the family physician and family medicine, that for a family physician to be ethical is to behave like a family physician.

20 Christie RJ, Hoffmaster CB (1986). Ibid:86.

21 Christie RJ, Hoffmaster CB (1986). Ibid:190.

"On the up side, you're the healthiest patient in ICU"