Medical professionalism

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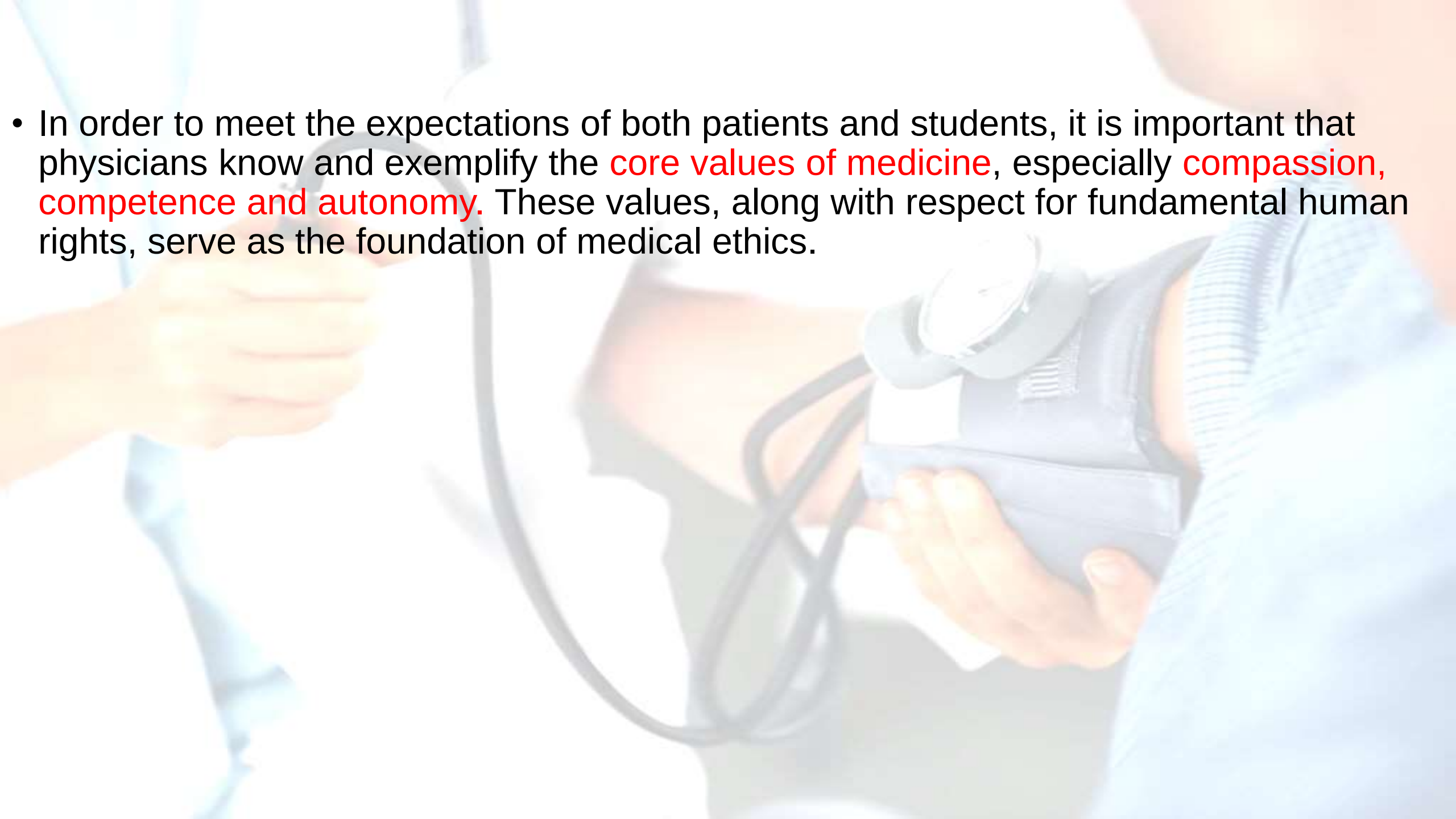
WHAT'S SPECIAL ABOUT MEDICINE?

- Throughout almost all of recorded history and in virtually every part of the world, being a physician has meant something special.
- People come to physicians for help with their most pressing needs – relief from pain and suffering and restoration of health and well-being.
- They allow physicians to see, touch and manipulate every part of their bodies, even the most intimate.
- They do this because they trust their physicians to act in their best interests.

- Many physician feel that they are no longer as respected as they once were.

- The status of physicians differs from one country to another and even within countries. In general, though, it seems to be deteriorating.
- Many physicians feel that they are no longer as respected as they once were.
- In some countries, control of healthcare has moved steadily away from physicians to professional managers and bureaucrats, some of whom tend to see physicians as obstacles to rather than partners in healthcare reforms.
- Patients who used to accept physicians' orders unquestioningly sometimes ask physicians to defend their recommendations if these are different from advice obtained from other health practitioners or the Internet.
- Some procedures that formerly only physicians were capable of performing are now done by medical technicians, nurses or paramedics.
- However medicine continues to be a profession that is highly valued by the sick people who need its services. It also continues to attract large numbers of the most gifted, hard-working and dedicated students.

- In order to meet the expectations of both patients and students, it is important that physicians know and exemplify the core values of medicine, especially compassion, competence and autonomy. These values, along with respect for fundamental human rights, serve as the foundation of medical ethics.



WHAT'S SPECIAL ABOUT MEDICAL ETHICS?

- **Compassion**, defined as understanding and concern for another person's distress, is essential for the practice of medicine.
- Patients respond better to treatment if they perceive that the physician appreciates their concerns and is treating them rather than just their illness.
- A very high degree of **competence** is both expected and required of physicians.
- A lack of competence can result in death or serious morbidity for patients.
- Physicians undergo a long training period to ensure competence, but considering the rapid advance of medical knowledge, it is a **continual challenge for them to maintain their competence.**
- Moreover, it is not just their scientific knowledge and technical skills that they have to maintain but their ethical knowledge, skills and attitudes as well.

- **Autonomy**, or self-determination, is the core value of medicine that has changed the most over the years.
- Individual physicians have traditionally enjoyed a high degree of clinical autonomy in deciding how to treat their patients.

Physicians still value their clinical and professional autonomy and try to preserve it as much as possible.

- At the same time, there has been a widespread acceptance by physicians worldwide of patient autonomy, which means that patients should be the ultimate decision-makers in matters that affect themselves.

THE WORLD MEDICAL ASSOCIATION
DECLARATION OF GENEVA

At the time of being admitted as a member of the medical profession:

I solemnly Pledge to consecrate my life to the service of humanity;

I will give to my teachers the respect and gratitude that is their due;

I will practice my profession with conscience and dignity;

The health of my patient will be my first consideration;

I will respect the secrets that are confided in me, even after the patient has died;

- I will maintain by all the means in my power, the honour and the noble traditions of the medical profession;

- MY colleague will be my sisters and brothers;

- I will not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;
- I will maintain the utmost respect for human life;
- I will not use my medical knowledge to violate human rights and civil liberties, even under threat;
- I make these promises solemnly, freely and upon my honor.

CASE STUDY #1

Dr. P, an experienced and skilled surgeon, is about to finish night duty at a medium sized community hospital.

A young woman is brought to the hospital by her mother, who leaves immediately after telling the intake nurse that she has to look after her other children.

The patient is bleeding vaginally and is in a great deal of pain.

Dr. P examines her and decides that she has had either a miscarriage or a self-induced abortion.

He does a quick dilatation and curettage and tells the nurse to ask the patient whether she can afford to stay in the hospital until it is safe for her to be discharged.

Dr. Q comes in to replace Dr. P, who goes home without having spoken to the patient.

WHAT'S SPECIAL ABOUT THE PHYSICIANPATIENT RELATIONSHIP?

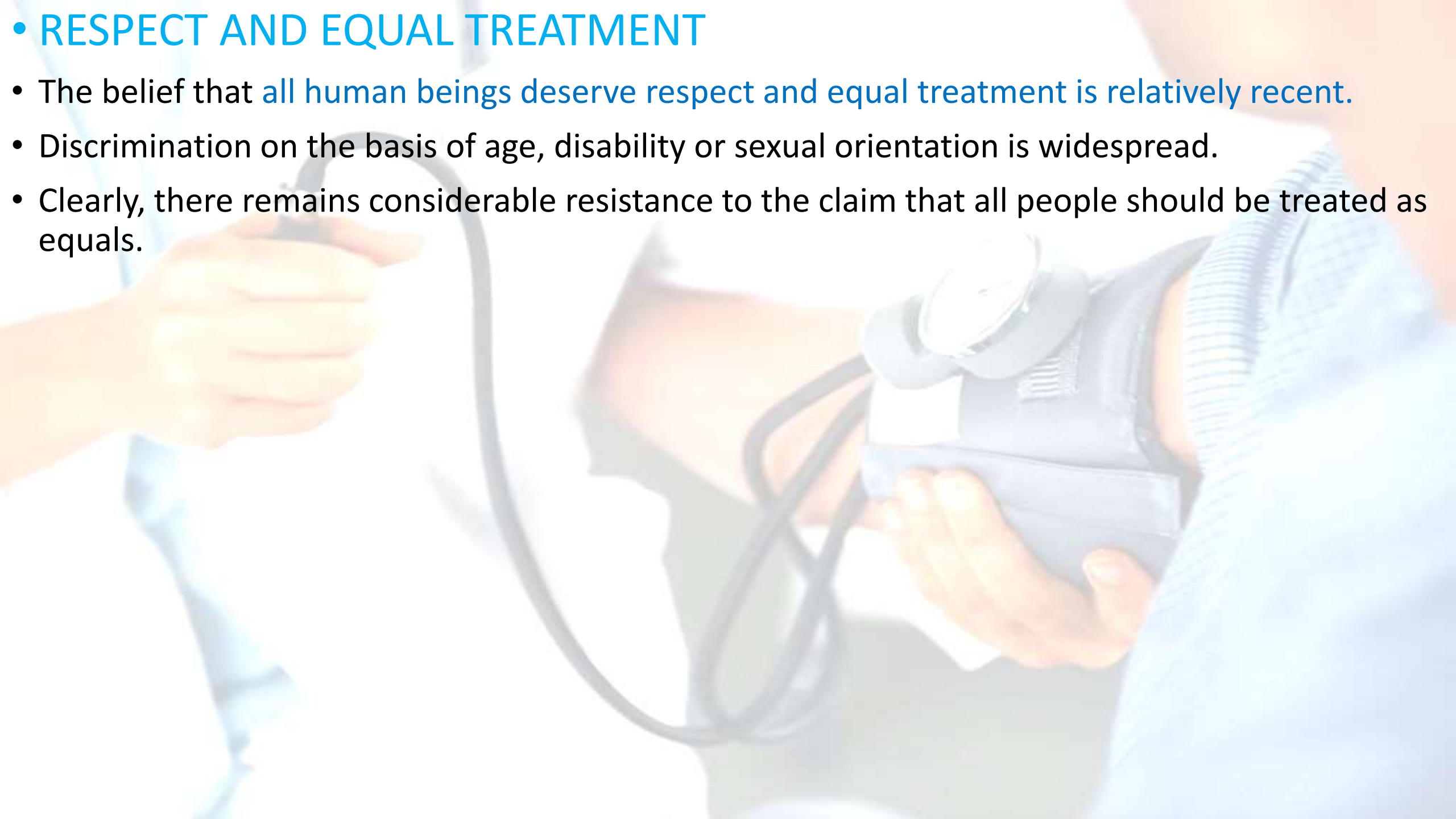
The physician-patient relationship is the cornerstone of medical practice and therefore of medical ethics. "The health of my patient will be my first consideration," and the **International Code of Medical Ethics** states,

"A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her."

the traditional interpretation of the physician-patient relationship as a paternalistic one, in which the physician made the decisions and the patient submitted to them, has been widely rejected in recent years, both in ethics and in law.

• RESPECT AND EQUAL TREATMENT

- The belief that all human beings deserve respect and equal treatment is relatively recent.
- Discrimination on the basis of age, disability or sexual orientation is widespread.
- Clearly, there remains considerable resistance to the claim that all people should be treated as equals.



- **The trust** that is essential to the physician-patient relationship has generally been interpreted to mean **that physicians should not desert patients whose care they have undertaken.**
- The WMA's **International Code of Medical Ethics** specifies only one reason for ending a physician-patient relationship – if the patient requires another physician with different skills:

- "A physician shall owe his/her patients complete loyalty and all the scientific resources available to him/her.
- Whenever an examination or treatment is beyond the physician's capacity, he/she should consult with or refer to another physician who has the necessary ability."

- However, **there are many other reasons for a physician wanting to terminate a relationship with a patient**, for example :
- **the physician's moving or stopping practice**,
- **the patient's refusal or inability to pay for the physician's services,**
- **dislike of the patient and the physician for each other**,
- the patient's refusal to comply with the physician's recommendations, etc.
- The reasons may be entirely legitimate, or they may be unethical.

- A significant challenge to the principle of respect and equal treatment for all patients arises in the care of infectious patients.
- The focus here is often on HIV/AIDS, not only because it is a life-threatening disease but also because it is often associated with social prejudices

Some physicians hesitate to perform invasive procedures on patients with such conditions because of the possibility that they, the physicians, might become infected.

However, medical codes of ethics make no exception for infectious patients with regard to the physician's duty to treat all patients equally.

- The **intimate nature** of the physician-patient relationship can give rise to **sexual attraction.**

- A fundamental rule of traditional medical ethics is that **such attraction must be resisted.**
- The Oath of Hippocrates includes the following promise: "Whatever houses I may visit, **I will come for the benefit of the sick,** remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons…."
- The reasons for this are as valid today as they were in Hippocrates' time, 2500 years ago.
- Patients are vulnerable and put their trust in physicians to treat them well.
- They may feel unable to resist sexual advances of physicians **for fear that their treatment will be jeopardized.**
- Moreover, the clinical judgment of a physician can be adversely affected by emotional involvement with a patient.

- **COMMUNICATION AND CONSENT**
- Informed consent is one of the central concepts of present-day medical ethics.
- The WMA **Declaration on the Rights of the Patient** states:
- The patient has the right to self-determination, to make free decisions regarding himself/herself.
- The physician will inform the patient of the consequences of his/her decisions.

- A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy.

- The patient has the right to the information necessary to make his/her decisions.
- The patient should understand clearly what is the purpose of any test or treatment, what the results would imply, and what would be the implications of withholding consent.

- Two major obstacles to good physician-patient communication are differences of language and culture. If the physician and the patient do not speak the same language, an interpreter will be required.
- Although the term ‘consent’ implies acceptance of treatment, the concept of informed consent applies equally to refusal of treatment or to choice among alternative treatments.

Evidence of consent can be explicit or implicit (implied).

- Explicit consent is given orally or in writing.
- Consent is implied when the patient indicates a willingness to undergo a certain procedure or treatment by his or her behaviour .
- .For example, consent for venipuncture is implied by the action of presenting one’s arm.
- For treatments that entail risk or involve more than mild discomfort, it is preferable to obtain explicit rather than implied consent.

- There are two exceptions to the requirement for informed consent by competent patients:
- 1-where patients voluntarily give over their decision making authority to the physician or to a third party.
- the patient may tell the physician, “Do what you think is best.”
- Physicians should not be eager to act on such requests but should provide patients with basic information about the treatment options and encourage them to make their own decisions.
- If the patient still wants the physician to decide, the physician should do so according to the best interests of the patient.

- 2-Instances where the disclosure of information would cause harm to the patient.
- The traditional concept of ‘therapeutic privilege’ is invoked in such cases; it allows physicians to withhold medical information if disclosure would be likely to result in serious physical, psychological or emotional harm to the patient, for example, if the patient would be likely to commit suicide if the diagnosis indicates a terminal illness.
- This privilege is open to great abuse, and physicians should make use of it only in extreme circumstances.

It is felt that such information would cause the patient to despair and would make the remaining days of life much more miserable than if there were hope of recovery.

- Throughout the world it is not uncommon for family members of patients to plead with physicians not to tell the patients that they are dying.
- Physicians do have to be sensitive to cultural as well as personal factors when communicating bad news, especially of impending death.
- In some situations a physician can determine that a treatment is ‘medically’ futile or nonbeneficial

- The physician has no obligation to offer a patient futile or non beneficial treatment.

- **DECISION-MAKING FOR**
- **INCOMPETENT PATIENTS**
- Many patients are not competent to make decisions for themselves.
- Examples include :
- Young children
- individuals affected by certain psychiatric or neurological conditions
- Temporarily unconscious or comatose patients.

- These patients require substitute decision-makers, either the physician or another person.
- When medical paternalism prevailed, the physician was considered to be the appropriate decision-maker for incompetent patients.
- Physicians might consult with family members about treatment options, but the final decisions were theirs to make. Physicians have been gradually losing this authority in many countries as patients are given the opportunity to name their own substitute decisionmakers to act for them when they become incompetent.
- In such cases physicians make decisions for patients only when the designated substitute cannot be found, as often happens in emergency situations.

- The WMA **Declaration on the Rights of the Patient** states the physician's duty in this matter
- as follows:
- If the patient is unconscious or otherwise unable to express his/her will, informed consent must be obtained, whenever possible, from a legally entitled representative.

- If a legally entitled representative is not available, but a medical intervention is urgently needed, consent of the patient may be presumed, unless it is obvious and beyond any doubt on the basis of the patient's previous firm expression or conviction that he/she would refuse consent to the intervention in that situation.
- Problems arise when those claiming to be the appropriate substitute decision-makers, for example different family members, do not agree among themselves or when they do agree, their decision is, in the physician's opinion, not in the patient's best interests.
- In the first instance the physician can serve a mediating function, but if the disagreement persists, it can be resolved in other ways, for example, by letting the senior member of the family decide or by voting.
- If the patient's legally entitled representative, or a person authorized by the patient, forbids treatment which is, in the opinion of the physician, in the patient's best interest, the physician should challenge this decision in the relevant legal or other institution."

Competence to make medical decisions can be difficult to assess, especially in young people and those whose capacity for reasoning has been impaired by acute or chronic illness.

- A person may be competent to make decisions regarding some aspects of life but not others; as well, competence can be intermittent -- a person may be lucid and oriented at certain times of the day and not at others.
- Although such patients may not be legally competent, their preferences should be taken into account when decisions are being made for them.
- The **Declaration on the Rights of the Patient** states the matter thus:
- “If a patient is a minor or otherwise legally incompetent, the consent of a legally entitled representative is required in some jurisdictions.

- Patients suffering from psychiatric or neurological disorders who are judged to pose a danger to themselves or to others raise particularly difficult ethical issues.

- Nevertheless, they may have to be confined and/or treated against their will in order to prevent harm to themselves or others.

- **CONFIDENTIALITY**
- The physician's duty to keep patient information confidential has been a cornerstone of medical ethics since the time of Hippocrates.
- The Hippocratic Oath states: "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about."
- However, other codes reject this absolutist approach to confidentiality. For example, the WMA's **International Code**
- **of Medical Ethics** states, "It is ethical to disclose confidential information when the patient consents to it or when there is a real and imminent threat of harm to the patient or to others and this threat can be only removed by a breach of confidentiality."
- That breaches of confidentiality are sometimes justified calls for clarification of the very idea of confidentiality.
- The high value that is placed on confidentiality has three sources:
- autonomy, respect for others and trust.

- Confidentiality is also important because human beings deserve respect.

- Trust is an essential part of the physician-patient relationship.

- In order to receive medical care, patients have to reveal personal information to physicians and others who may be total strangers to them---information that they would not want anyone else to know.
- They must have good reason to trust their caregivers not to divulge this information.
- The basis of this trust is the ethical and legal standards of confidentiality that healthcare professionals are expected to uphold.
- Without an understanding that their disclosures will be kept secret, patients may withhold personal information.
- This can hinder physicians in their efforts to provide effective interventions or to attain certain public health goals.

- Another generally accepted reason for breaching confidentiality is to comply with legal requirements. For example, many jurisdictions have laws for the mandatory reporting of patients who suffer from designated diseases, those deemed not fit to drive and those suspected of child abuse.

- If physicians are persuaded to comply with legal requirements to disclose their patients' medical information, it is desirable that they discuss with the patients the necessity of any disclosure before it occurs and enlist their co-operation.

- For example, it is preferable that a patient suspected of child abuse call the child protection authorities in the physician's presence to self-report, or that the physician obtain his or her consent before the authorities are notified.

- In addition to those breaches of confidentiality that are required by law, physicians
- may have an ethical duty to impart confidential information to others who could be at
- risk of harm from the patient.

- Two example
- A patient tells a psychiatrist that he intends to harm another person

- A physcian is convinced that an HIV-positive patient is going to continue to have
- unprotected sexual intercourse with his spouse or other partners.

- BACK TO THE CASE STUDY
- According to the analysis of the physician patient relationship
- Dr. P's conduct was deficient in several respects:
- (1) COMMUNICATION – he made no attempt to communicate with the patient regarding the cause of her condition, treatment options or her ability to afford to stay in the hospital while she recovered;
- (2) CONSENT – he did not obtain her informed consent to treatment:
- (3) COMPASSION – his dealings with her displayed little compassion for her plight.
- His surgical treatment may have been highly competent and he may have been tired at the end of a long shift, but that does not excuse the breaches of ethics.

- **PHYSICIANS AND COLLEAGUES**

- Dr. C, a newly appointed anaesthetist in a city hospital, is alarmed by the behaviour of the senior surgeon in the operating room.
- The surgeon uses out-of-date techniques that prolong operations and result in greater post-operative pain and longer recovery times.
- Moreover, he makes frequent crude jokes about the patients that obviously bother the assisting nurses.
- As a more junior staff member, Dr. C is reluctant to criticize the surgeon personally or to report him to higher authorities.
- However, he feels that he must do something to improve the situation.

- **CHALLENGES TO MEDICAL AUTHORITY**
- Physicians belong to a profession that has traditionally functioned in an extremely hierarchical fashion, both internally and externally.
- Internally, there are three overlapping *hierarchies*:
- the first differentiates among specialties, with some being considered more prestigious, and better remunerated, than others;
- the second is within specialties, with academics being more influential than those in private or public practice;
- the third relates to the care of specific patients, where the primary caregiver is at the top of the hierarchy and other physicians, even those with greater seniority and/or skills, serve simply as consultants unless the patient is transferred to their care.
- Externally, physicians have traditionally been at the top of the hierarchy of caregivers, above nurses and other health professionals.
- With the rapid growth in scientific knowledge and its clinical applications, medicine has become increasingly complex. Individual physicians cannot possibly be experts in all their patients' diseases and potential treatments and they need the assistance of other specialist physicians and skilled health professionals such as nurses, pharmacists, physiotherapists, laboratory technicians, social workers and many others.

- A cooperative model of decision-making has replaced the authoritarian model that was characteristic of traditional medical paternalism.
- The same thing is happening in relationships between physicians and other health professionals. The latter are increasingly unwilling to follow physicians' orders without knowing the reasons behind the orders.
- They see themselves as professionals with specific ethical responsibilities towards patients;
- if their perception of these responsibilities conflicts with the physician's orders, they feel that they must question or even challenge the orders. Whereas under the hierarchical model of authority, there was never any doubt about who was in charge and who should prevail when conflict occurred, the cooperative model can give rise to disputes about appropriate patient care.

- **RELATIONSHIPS WITH PHYSICIAN**
- **COLLEAGUES, TEACHERS AND STUDENTS**
- As members of the medical profession, physicians have traditionally been expected to treat each other more as family members than as strangers or even as friends. The WMA Declaration of Geneva includes the pledge, "My colleagues will be my sisters and brothers."
- Besides the positive requirements to treat one's colleagues respectfully and to work cooperatively to maximize patient care, the WMA **International Code of Medical Ethics** contains two restrictions on physicians' relationships with one another:
- (1) paying or receiving any fee or any other consideration solely to procure the referral of a patient;

and

- (2) stealing patients from colleagues.

In the Hippocratic tradition of medical ethics, physicians owe special respect to their teachers. The **Declaration of**

Geneva puts it this way: "I will give to my teachers the respect and gratitude that is their due."

- For their part, teachers have an obligation to treat their students respectfully and to serve as good role models in dealing with patients.

- The so-called ‘hidden curriculum’ of medical education, i.e., the standards of behaviour exhibited by practising physicians, is much more influential than the explicit curriculum of medical ethics, and if there is a conflict between the requirements of ethics and the attitudes and behaviour of their teachers, medical students are more likely to follow their teachers’ example.

BACK TO THE CASE STUDY

Dr. C is right to be alarmed by the behaviour of the senior surgeon in the operating room.

Not only is he endangering the health of the patient but he is being disrespectful to both the patient and his colleagues. Dr. C

has an ethical duty not to ignore this behaviour but to do something about it.

As a first step, he should not indicate any support for the offensive behaviour, for example, by laughing at the jokes.

If he thinks that discussing the matter with the surgeon might be effective, he should go ahead and do this.

Otherwise, he may have to go directly to higher authorities in the hospital.

If they are unwilling to deal with the situation, then he can approach the appropriate physician licensing body and ask it to investigate.


ETHICS