Ethics:
four levels for GPs

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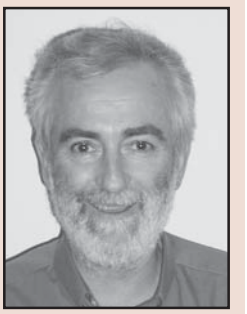

As a general practitioner with no formal training or qualifications in ethics, what meaning does ethics have for me and my practice of medicine? Is it something I associate with disciplinary committees and courts, or is it the province of academics who have the luxury of time to contemplate such issues? Does it apply much more to hospitals and high technology where decisions associated with life and death are commonplace? Do I really need only commonsense, a good conscience and to be a good Kiwi? And what is ethics anyhow?

If we accept Freeman and McDonnell's definition of ethics as *'the discussion about and theory of morality'*[1] then when discussing, arguing, or justifying a position using an ethics framework, we are primarily invoking value judgements about what is morally right or wrong, good or bad, praiseworthy or blameworthy: in our medical context we are not simply calling on medical tradition, culture, the law or religious conviction to support our case.

The terms 'ethical' and 'unethical' are often loosely used and confused with issues of 'professional etiquette' or 'professional conduct'. An example might be an indignant wail of 'unethical behaviour' when I discover that one of my patients, without my knowledge, has been referred on by a specialist colleague.

For some, including many students I teach, the concept of a distinct and identifiable ethics domain or playing field, undoubtedly influenced by and influencing other elements of human experience, is difficult to grasp. For those who find religious belief and notions of morality inseparable, I am reminded that Immanuel Kant, one of the founding fathers of duties-based ethics (deontology), and himself a devout Christian, considered that any theory of morality had to have an integrity independent of any belief in the existence of God.[2] Perhaps a more compelling argument would be to simply state the obvious that morality, moral discourse and behaviour cannot be the exclusive province of the religious.

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Oaths, declarations and medical codes of conduct and ethics, as roadmaps of morality for doctors, have their limitations. As I survey all the 'Doctors should…' statements in the NZ Medical Association Code of Ethics[3] I ask myself, 'should' according to whom? Some have discounted such codes on the grounds that they are devised by the profession for the profession, rather than representative of the morality of patients or the community.[4] The application of code statements is also problematic: How does a generality such as *'Doctors should ensure that every patient receives appropriate investigation into their complaint or condition…'* apply to the patient in front of me? Do the moral obligations regarding the equitable use of scarce resources embedded in this statement, apply in the same way to me as a GP as they would to a physician seeing the same patient?

It may be useful to consider that as GPs we have potentially four levels of ethical practice: firstly a subliminal morality built into our day-to-day modus operandi, a kind of ethics on the run; secondly, a more conscious and reflective practice associated with particular patients and dilemmas; thirdly, a kind of corporate morality associated with our discipline and profession in its relationship with medical and non-medical institutions, and finally a morality associated with issues related to

health, welfare and health care worldwide. I shall address each of these in turn.

So what is ethics on the run? By this I mean those automatic aspects of daily general practice that are grounded in established principles of ethical medical practice; consulting behind closed doors – the reflection of our duty of confidentiality; the involvement of patients in decisions about prescriptions, tests and referrals – an acknowledgement of patients' rights of decision-making; the avoidance of unnecessary tests and medications – an awareness of our duties not to cause harm and to contribute to the fair and equitable distribution of scarce resources; the daily care and attention to patients' confidentiality in the management of their medical records, test results etc. and many other examples. The innate or acquired patient-centred consulting[5] of GPs is grounded in a respect for patients' autonomy of decision-making.

What are the origins or determinants of this ethics on the run? Hicks considered that medical practitioners' explanations of the basis of their ethics was *'...rugged individualism where right and good is the morality either learned at mother's knee or carved by intuition from the hard reality of practice...'*.[4] Isn't that a simplistic if not cynical view, and does it not devalue the influence of medical education? Many of us had virtually no formal education in ethics during our undergraduate years. However, if Hafferty and Franks are correct, *'...medical training at root is a process of moral enculturation, and...the medical school functions as a moral community'*.[6] In that environment our moral values are more the product of the 'hidden curriculum' of medical schools rather than an outcome of formal teaching and learning: the hidden curriculum being those values derived from the medical school culture rather than the lectures, and the morality assimilated and adopted from the hallways and corridors as well as at the bedside. There is some rather disturbing research evidence to suggest that, irrespective of formal ethical teaching, medical school training can result in an inhibition of moral reasoning development.[7]

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The second and more conscious or reflective level of moral practice involves issues and dilemmas associated with particular patients and families; the placement in supervised geriatric care of an increasingly demented but fiercely resistant elderly patient; the mortified executive who has contracted a sexually transmitted infection on a business trip and demands secrecy; the suffering sixty-year-old awaiting coronary artery bypass graft surgery, but whose priority score doesn't reach the Ministry of Health's affordable threshold for state funded services; the worried pregnant woman wanting prenatal screening. Such cases often give us the luxury of time for reflection and a more inclusive process of clinical and ethical problem-solving. But again, do we process the moral issues more by intuition, gut feeling and conscience rather than any reliance on moral constructs or models?

If we accept Gillon's premise that medicine is 'essentially a moral enterprise' then our general practices, GP organisations, medical schools, hospitals, Medical Council, regional health authorities and the Ministry of Health are ethical entities

The third level of moral practice involves our involvement in the ethics of general practice, health and health care at an institutional or organisational level. If we accept Gillon's premise that medicine is *'essentially a moral enterprise'*[8] then our general practices, GP organisations, medical schools, hospitals, Medical Council, district health boards and the Ministry of Health are ethical entities. Within the constraints of time, place and energy, we are able individually and collectively to reflect on, and influence, the morality of such entities. How did we respond when a patient, recently reported in the *NZ Herald*, was caught between the cost-cutting measures of the Health Ministry, the rules of the Immigration Service and the medical profession's duty of beneficence?[9] While these organisations pondered his fate, the patient was left to cope with the threat of being taken off dialysis because he did not fit the criteria for funded service.

Seeing our suffering 60-year-old patient waiting for coronary bypass surgery forces us to ponder our responses to the moral issues involved in the 'health reforms'. Does rationalising medical service provision, based on crunching numbers to calculate patients' priority scores, represent a loss of *'consumer sovereignty in health care'*.[10] Do we, and the medical organisations we belong to, agree with Singer who considers that at least in the US context, the doctor-patient relationship is deteriorating, clearly linking this to *'bureaucratisation by managed care'*?[11] As the *NZFP* editor pointed out in the February 2003 edition, the health care perspectives of personal need and public good are not incompatible *'but their meeting is uncomfortable'*.[12]

Whether we are formulating or reviewing the policies of our practice, College, or Independent Practitioners' Organisation, whether we are actively embroiled in bureaucracies as advocates for our patients,

whether we are concerned about the hidden curricula of our medical schools, or whether we are anxious about the level of government interventionism in health, we cannot escape the moral issues at institutional level.

Our individual or collective responses to global and international moral issues about health constitute the fourth level of our ethical practice. Clearly we can voice our private moral protestations as publicly or collectively as we choose. How do we respond to the injustices of the current indescribable human suffering in Ethiopia and Zimbabwe or to the morality of the US administration which made economic aid to Turkey conditional upon collusion with the invasion of Iraq? We may join anti-war and anti-nuclear organisations if we wish and there are ways to channel our moral outrage at the politics of global warming and the environment. All of these issues have a direct or indirect impact on human health and well-being and are laden with moral dilemmas.

A process of problem-solving I have found useful particularly at my second level of ethical practice outlined above, but which is also applicable at the third and fourth levels, comprises the following components:

1. Identification of the relevant parties and players involved in the case (starting with the patient and doctor).
2. Setting out the decision options available.
3. Collection of the facts, information, predictions, prognoses etc., necessary to assist decision-making.
4. Determination of the moral issues (both duties/principles and likely decision outcomes or consequences) involved.
5. Consideration of the potential conflicts between the various issues for the different parties.
6. Assisting decision-making, preferably by consensus of the parties involved.
7. Arranging follow-up.

This process has some similarities to that of Philip Hebert, a GP and formally trained ethicist, outlined in his very useful book entitled *Doing Right*.[13] His sequence comprises the following:

1. The case: its facts and circumstances.
2. What is the dilemma: what decision needs to be made?
3. What are the alternatives?
4. What are the key considerations: the ethical principles and context?
5. Propose a resolution: weighing the factors for each alternative.
6. Consider your choice critically.
7. Action.

The duties/principles referred to in these constructs are usually interpreted as meaning the following four basic and prima facie (i.e. binding unless conflicting with each other) moral obligations in health care as enunciated by Beauchamp and Childress[14] and given focus to their scope of applicability by Gillon:[15] respect for patients' autonomy, the dual duties of benefiting patients while minimising harm (beneficence and non-maleficence), and justice (fairness and equity).

'The moral value of decisions depends not on what is decided or on who decides so much as on how the decision is made'

The most vexing problem with any model of ethical problem-solving is how to go about resolving conflicting moral issues. Complex ethical dilemmas highlight the problems associated with invoking duties/principles as potential solutions: the approach taken by deontologists. At least as difficult is the process of speculating on likely consequences of decisions or actions as a means of determining maximal utility of decision-making: the approach taken by utilitarians.

A number of alternative approaches have arisen in recent decades, including the reincarnation of an ancient form of reasoning termed 'casuistry'; the term refers to *'the use of case-comparison and analogy to reach moral conclusions'*.[14] After its heyday in the 16th and 17th centuries, it was denigrated as *'skilled but specious ethical reasoning'* and *'it implied the devious misuse of a philosophical art'*.[16] Its recent proponents see it as a very practical approach to case management where moral justifications emerge out of *'the messy reality of cases'*,[17] analogous to case law within the legal system. It is therefore seen as a kind of 'bottom up' (or inductive) approach, rather than the 'top down' (deductive) imposition of moral theories, duties or principles. Such an approach seems intuitively most appropriate to our clinical environment, however its critics view it as *'a method without content'*,[14] bereft of any inherent moral integrity. As a clinician, its evolution remains for me a matter of interest.

And after this discourse on four levels of ethical practice and some approaches to problem-solving, what of those who would still remonstrate with gusto *'Conscience, good character, integrity, and to hell with philosophical medical ethics'*?[18] There are major difficulties in defining precisely the meaning of these characteristics in ways that would enshrine sound moral reasoning and behaviour in clinical situations.

How do we account for some of the medico-moral debacles of the last century? Were all the doctors in the Nazi concentration camps bereft of conscience? Were the medical members of the US Public Health Service, who continued their observation of untreated syphilis patients into the early 1970s, of poor character?[1] Were all the doctors embroiled in the National Women's Hospital cervical cancer enquiry of poor conscience and lacking integrity?

Ethics embraces far more than can be dealt with by a private or collective conscience, or woolly

notions of good character and integrity. It includes a process of reflective and reasoned morality. And of ethical decision-making, *'the moral value of decisions depends not on what is decided or on who decides so much as on how the decision is made'*.[1] I am reminded of a student who not long ago quoted to me the familiar *'It's not whether you win or lose, it's how you play the game'*. I think he was right.

In considering four levels of ethical practice for GPs, as I have attempted to do, it has become apparent to me that ethics is clearly at the heart of every GP-patient encounter, and is even more fundamental than sound daily moral practice. It runs deeper than conscious and reflective reasoning and decision-making for those *'moral issues omnipresent in clinical settings'*[6] with which we must grapple. Ethics is the expression of a morality *'learned at mother's knee'*, but it doesn't rest there: it is strongly influenced by our social and medical enculturation, crafted by hard clinical experience, and as a result matures to reside *'squarely within the physician's professional identity'*.[6]

Acknowledgments

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Suggested further reading

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'Clinical ethics is not founded on philosophy, law, or theology but, instead, is a sub-discipline of medicine, centring upon the doctor-patient relationship. After 20 years of clinical ethics, the doctor-patient relationship is in worse shape than it was when the field began. The main theme in the doctor-patient relationship during the 1990s in the USA was bureaucratisation by managed care. Despite the impressive achievements described elsewhere in this article, it is troubling that the doctor-patient relationship is deteriorating even as we congratulate ourselves on how well clinical ethics has progressed. If the doctor-patient relationship is the foundation of clinical ethics, how well can the field be doing, and how well will it do in the future, if the foundation is not solid?'

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