

Are We Clinicians Away from Ethics?

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Abstract

Medicine has always stood at the intersection between science and society. From antiquity to the present, everyone has faced health challenges that prompted the formation of groups of healers and the development of codes of ethics to govern the treatments that they offered. Medical codes of ethics blend the moral precepts, normative behavior, and social duties of the population in which they are used, and they change as new medical therapies and social issues arise. The written codes of ethics are based on modern terms for many of the issues raised in Charak Samhita. They also represent an effort to codify the essence of “the clinical encounter between physician and patient” and the role of society while emphasizing the importance of compassion, beneficence, nonmaleficence, respect for persons, and accountability. Medical ethics have been an integral part of Charak Samhita and its complete incorporation in present-day medical teaching and clinical practice will yield great results to this noble profession. Is it true that we clinicians are away from practice of ethics in medicine? Are we not following a structural approach to identify, analyze, and resolve ethical issue in clinical practice? We as clinicians should have some working knowledge about informed consent, confidentiality, patient’s rights, and end-of-life care. At times, clinicians and patients disagree about the choices that may challenge their lives. It is then that ethical problem rises. While dealing with a patient, ethical problem can be avoided when the case is analyzed in four important areas: medical/surgical indications, preference by patient, quality of life with or without treatment, and other circumstantial features, for example socioeconomic, legal, or administrative aspects of the case.

Keywords

- ▶ ethics
- ▶ clinicians
- ▶ do-not-attempt resuscitation
- ▶ medical law

Medical Ethics from Ancient Era till Date

The Indian medical ethics, legal thought, and philosophy were developed and described way back in Charak Samhita.¹ Charak’s ethical ideal is well evident in his advice to the physicians. It prescribes an elaborate code of conduct. A physician, according to Charak, is “he who practices not for money or caprice but out of compassion for living beings in the best among all physicians.” Medical ethics is a field that separates legal obligation from moral obligation and the relationships except the fiduciary duty of the physician to his/her patient. Charak Samhita visualized the physician as a spiritual leader of the medical team—the team that has four components: physician, patient, nurse, and drugs.

Since ancient time, medicine has increasingly drawn and driven into ethical debate that raises the clash between scientific method (small, step-by-step approaches and trial and error and answering small questions) and philosophical, mental, physical, and ethical questions.² By dealing with the birth and end process of human life, medicine and medical law are rendered ineluctably ethical in nature. On the other hand, medical law is inseparable from medical ethics. Mortality and medical error sometimes are incorporated into legal doctrine. However, most of the rules in this era are increasingly institutionalized and embedded in institutional protocol, administrative mandates, and court protocols. These developments have important consequences for the ways in which we describe the setting of a legal framework

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and the establishment of ethical standard for regulating scientific and technical societies.

Are We Clinicians Away from Ethics?

We physicians live in the era of medicine characterized by a rapidly expanding scientific base, emergence of new technology, and an abundance of diagnostic and therapeutic modalities. Rapid introduction of these new technologies into the practice at times prevent us from the thorough understanding of their clinical importance. In this setting, we physicians consistently face the challenging dilemma of having a greater capacity to intervene than ever previously, concurrent with an increasing uncertainty about when and how to act.

Is it true that we clinicians are away from practice of ethics in medicine? Are we not following a structural approach to identify, analyze and resolve ethical issue in clinical practice? We as clinicians should have some working knowledge about informed consent, confidentiality, patient's rights, and end-of-life care.¹ At times, clinicians and patients disagree about the choices that may challenge their lives. It is then that ethical problem rises. While dealing with a patient, ethical problem can be avoided when the case is analyzed in four important areas: medical/surgical indications, patient preference, quality of life with or without treatment, and other circumstantial features, for example socioeconomic, legal, or administrative aspects of the case. Take an example. Mr. X, a 65 year-old man, came to the emergency room with the complaint of acute chest pain and diagnosed to have acute aortic dissection. He refused the treatment because of financial constraint and collapsed in front of you. Resuscitation started, he was shifted to the operating room, surgical intervention was done, and he was discharged from the hospital on ninth postoperative day. These are the actions of beneficence; means performing the surgery benefitted the patient. While at the beginning, the patient refuses treatment, which raises questions about basic principles of autonomy, that is, duty to respect patient's consent. Should we respect the autonomy of Mr. X in this point? Is Mr. X competent enough to make a decision or have a moral or legal right to refuse medical or surgical care? Or are we clinicians paternalistic? These questions may bring up an ethical debate. It is not true that ethical problem involves only one ethical principle. The actual ethical problem is the complex collection of many problems. Therefore, good ethical judgment ends in evaluating several ethical principles in the actual situation under consideration. Therefore, the ultimate goal of ethics while dealing with a patient ends in the followings points: to improve quality of care and patient's life as well as the quality of work environment for clinical practitioners while using an interdisciplinary approach and identifying and offering guidelines relating to ethical issues faced in clinical practice. In spite of the provision of best of the above, the difficult time for a clinician arises in the following circumstances:

Do not resuscitate/do-not-attempt resuscitation (DNAR). Should we get consent for it?³

When should we report a colleague's error?⁴

Should those who can pay/have otherwise power be able to jump the queue?

While dealing with a psychiatric patient, should we hide medication in a patient's food?

In these cases, the clinician with other health care team members, patients, and their family members examines the basic ethical principle (autonomy, beneficence, nonmaleficence, and justice).^{5,6}

If we have autonomy, we can make our own decision. Respect to autonomy means that the moral obligation to respect the autonomy of others in so far as such respect is compactable with equal respect for autonomy of all potentially affected. During management of a patient, autonomy means we should obtain their consent before we do things to them and maintain their confidentiality. However, at times autonomy is not considered, for example Mr. X case. Sometimes patients/relatives do not want to hear a bad prognosis or choose a treatment mode and leave everything on you. In this case, respecting such attitudes means respect for a patient's autonomy.

Practicing beneficence and nonmaleficence means we are committed to improving the situation and doing "no harm," thus improving the situation. We clinicians have the skill and knowledge to prevent or treat the harm occurring to a patient due to the underlying disease condition. During the treatment course, the possible benefits against the possible risks of an action (investigation, drug, or procedure) are always weighed. Beneficence also includes protecting and defending the rights of others, for example, resuscitating a patient who developed sudden cardiovascular collapse, talking to community about AIDS prevention. Some designated therapies for a particular disease also involve serious risks; for example, amiodarone used for the treatment of arrhythmia put the patient at risk of hypothyroidism. Here the term *nonmaleficence* carries little meaning. The pertinent ethical issue in this scenario is whether the benefits outweigh the side effects of amiodarone. A balancing between beneficence and nonmaleficence is essential while ordering a particular test, medication, or procedure. After giving an informed consent, the patient is the ultimate person who assigns weight to risks and benefits. The fourth principle is "justice" that has certain categories such as treating patients as equals, air distribution of scarce resources, respect to people's rights, and respect to morally acceptable laws.

Now let us analyze the aforementioned difficult situations more widely.

1. Do not resuscitate/DNAR: Since the original inception of DNAR orders, respect for autonomy of the patient and their relatives to make final decision has been emphasized. This aspect is reinforced legally in the "Patient Self Determination Act of 1991."⁷ This act gives an emphasis on improving communication with patients and relatives, which is preferred over the treating physicians making an unilateral decision based on appeals to medical futility regarding the resuscitation status of their patients. This is again

called patient's autonomy.⁸ However, prior to writing a DNAR order, attending physicians should discuss resuscitation preferences with the patient and/or the surrogate decision maker, and this conversation should be documented in the patient's medical record. This statement should include persons present for conversation, who were involved in the decision-making process, the content of conversation, and details of any disagreement.⁹ In situations in which the health care team unanimously agrees that cardiopulmonary resuscitation (CPR) would be medically futile, they are not obliged to perform it. In this scenario, the patient and/or their surrogates still have a role in the decision about a DNAR order. After an honest discussion regarding the clinical situation and limitation of medicine with them, the DNAR order can be written.⁹ In instances when CPR is not futile but the patient/surrogates want a DNR at the time of admission, their request should be honored. This is called *patient's autonomy* and is supported by law in some countries. What if the patient is on extracorporeal membrane oxygenation (ECMO) who is already at high risk of death, resulting in high potential for conflicts regarding continuation of treatment? Withdrawal of ECMO support raises complex ethical issues that include not only patient's autonomy but also medical autonomy and standard of care, futility, moral distress, and psychological harm to providers, as well as resource allocation (perceived waste of resources on non thriving patients). In such a situation, a variety of laws and legal precedents exist that determine the legal limit of a clinician's actions regarding withholding or withdrawing such life-sustaining technology.⁹ These laws are, however, not final, and more work must be done to create guidelines for stopping ECMO life support.¹⁰ Ethics committee consultation should be taken, which can yield recommendations and some clarifying explanations that support the final decisions to end ECMO care among patient's family members and members of ECMO care team. This can delay unwarranted legal action.¹¹

2. Medical errors account for a serious problem and pose a threat to patient safety. It includes a wide area of domain starting from wrong diagnosis, medication error to provide wrong treatment. In simple terms, it is defined as "an act of omission or commission in planning or execution that contributes or could contribute to an unintentional result." The incidence varies from 7 to 47% where world literature is concerned.^{12,13} Medical errors are usually considered to be preventable; however, "whether all medical errors are truly preventable" can be debated. Reporting of colleague's error is again a big question. At one end, reporting a colleague's error may anguish the patient and relatives unnecessarily, and on the other end, there is fear of criticism and anxiety about a soiled reputation in your colleague. This may lead to undesired malpractice litigation, loss of self-esteem, and loss of self-confidence in your colleague. Moreover, media may use these examples as fuel to fire a campaign against medical profession.

Irrespective of the above facts, honest disclosure of errors including offer of an apology for harming a patient should be considered to be one of the ethical responsibility of the medical professionals.

3. Jumping the queue based on money/influence? When it comes to queueing, the universally accepted norm is first-come-first-served, and any deviation is a mark of iniquity and can lead to undesirable queue rage. In general, I agreed people should be treated based on the severity of medical need. However, at times a different situation can arise; for example, some known friend who is a past marathon winner with a lower limb injury needs urgent magnetic resonance imaging (MRI) and intervention because he has to run marathon within 20 days. In this situation, one has to justify clinically and ethically to determine the course of his/her action, weighing harm and benefits, with an act to preserve respectful relationship with other patients.
4. Hiding medication in the food: The practice of illicitly administering medications to psychiatric patients who refuse or resist treatment is a common practice.¹⁴ Srinivasan et al noticed that this practice may be culturally appropriate for our country, where psychiatric services are sparse and most patients with major psychiatric disorder live with their family members and the family members are the primary care givers for them. The authors find that the practice of hidden medication is a viable solution to avert crises during medication refusal. In spite of these benefits, administrations of concealed medication have many interwoven problems, for example legal issues, ethical issues, cultural factors, and clinical judgments. The major ethical issues are autonomy, justice, and beneficence. Most of these problems can be avoided by a clear informed consent that has adequate information for the individual to make decision, and that decision is made voluntarily.¹⁵ It is very clear that patients who received concealed medication have not been engaged in informed consent because they are unable to make a decision. It is the family members who are the primary decision makers and so are given the informed consent for concealed medication. Some situations are exceptions to applications of informed consent, for example in case of a psychiatric emergency, where forcibly injecting tranquilizing medicines is a common approach. Informed consent for treatment is not required in clear emergencies that result from a medical condition, because the patient's consent is implied. In such emergencies occurring at home, it is reasonable to allow the competent care givers to administer concealed medications. At times, the patient is expected to violently restrict taking medicine. In this scenario, use of emergency concealed medication should clearly be short term.

Patient participation in decision making or expressing opinion about different treatment methods or giving a choice for their treatment empowers the patient-physician relationship as well as improves services and his/her health.^{16,17} All patients have the right to know treatment decisions, have timely access to specialty care, and have

confidentiality protection.^{18,19} Physicians or their qualified health care providers are required to provide adequate information about the illness, its diagnosis (provisional or confirmed as it may be), proposed investigation, and possible complications. If the patient is not in a state to understand this, the physician or health care provider is required to provide the information to the care taker. This has to be done in a simple language that the patient or care taker can understand. Physicians and health care providers are responsible for clarifying all the treatment options to the patient/care givers. After a detailed study of their choices, the patient/care takers can opt for a treatment that may or may not be the first choice of the treating physician. Apart from this, the treating physician and the hospital must respect the patient's decision if he/she chooses to seek a second opinion from a physician/hospital of his/her choice. Furthermore, if he/she chooses to come back to the first physician and hospital after getting the second opinion, the hospital still cannot compromise on the quality of health care.

Risk communication to the patient/care takers is an essential part of medical care.^{20,21} For example, discussing a patient's cardiovascular risk, their risk reduction by taking a statin, and the explanation of surgical risk scores to patients/care takers is important not only as a right to patient education but also to protect the physician/hospital from future litigation if any adverse consequence arises during the course of treatment.

Multidisciplinary team (MDT) work is a key feature of present-day health care. MDT work in the health care is composed of different professionals, ideally possessing a variety of skills necessary to produce safe and effective care.^{22,23} Each person in the team is responsible for the provision of treatment in which they specialize. When all of this work comes together, the patient is able to follow a care plan that keeps everyone in the same page. Most of the MDT has a key worker assigned to patients, serving as that person's primary contact point to the get of the team. MDT approach gives a patient access to the entire team expert and gets collaborative support from a wide range of experts and the best treatment option. The major disadvantage of MDT approach is that most of the team has wide mix of specialists; for example, some just start their careers whereas others are about to finish up their careers. This may, at times, hamper the treatment outcome. Respect and trust among team members, the best use of skills, maintenance of transparency, and agreed clinical governance structure are essential for optimum team functioning and effective patient outcome.

Violence against physicians is a unique problem in some parts of the world.^{24–26} The Prevention of Violence against Medicare Persons and Medicare Institution Act, which has been notified in nineteen states of the country during the past few years, has failed to address this issue. The main cause of violence include poor image of physicians and their role in social media, low health literacy, poor-quality health care, cost of health care, lack of adequate security for health care persons, lack of faith in law and order machinery, poor communication between patient and physician, as well as mob mentality.^{27,28} The only way to prevent the violence

against physicians needs to address the above points. Most importantly, any complaint filed by a patient or relative in the court of law, forum, or commission should be automatically within the institution infrastructure and there should be cancellation *ab initio* if proof of violence by patients or the relatives can be provided by the hospital or physician. This single major step will stop all the violence by patient attendants. This should be in addition to the punishment for violence under the Prevention of Violence against Medicare Persons and Medicare Institutions Act and relevant sections of Indian Penal Code.

Conclusion

We are not the legal experts and we are the only who has a responsibility to act ethically. We all have ethical dilemmas in our life, for example whether to keep or return a wallet we find on pavement, whether to help a troubled colleague at some cost to themselves, and to what extent expose a colleague when something goes wrong on a patient. In general, ethics is not only about issues and policies published in a book or journal, it also carries a high moral and personal component. We clinicians experienced such dilemmas that are the ongoing conflict in our mind between ethical duty, moral responsibility and extreme self-interest. Moral values such as trustworthiness, compassion, mutual respect, and a commitment to reach shared goals make a clinical encounter between the physician and patient/his colleague morally unproblematic. At times, a disagreement may arise among the treating physicians and/or patient that may challenges their values. This is the time when ethical problems arise. In this scenario, the treating clinicians along with patients and families can work in a constructive way to identify, analyze, and resolve many of the ethical problems that arise in medical profession. It is not only the treating clinician but also the hospital administrators, quality reviewers, and members of institutional ethics committees who are responsible for maintaining the best ethics for their clinicians and patients that lie at a center of quality care. Finally, the Medical Council Act has the power to remove many unethical activities existing in medical profession. However, most victims of medical negligence may not have any interest in proceeding against the physician or may not be aware of procedures to be followed. At the same time, unnecessary media hike raises disciplinary action against a physician who is not actually guilty of negligence. Prompted revisions to the codes of medical ethics and law that reflect contemporary concerns and the impact of new therapies and technological innovations may give rise to a better horizon to the health care system.

Conflict of Interest

None.

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