

Ethics in clinical practice: an overview

Ethics play as great a role in clinical practice as the other skills required of a doctor.

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of Medicine exams. In 1999 she completed a Masters in Philosophy (Applied Ethics) cum laude, focusing on the ethics of HIV vaccine trials in South Africa. In 2004 she completed her doctoral thesis on the ethics of research on human subjects, examining the role of research ethics committees in SA. She has taught Family Medicine and Ethics for 8 years, works as a clinical investigator on vaccine and other clinical trials and currently heads the Bioethics Unit at Tygerberg.

Clinical ethical reasoning and analysis are skills that are crucial to good patient care in much the same way as biomedical knowledge and procedural skills are essential to diagnosis and management of medical problems. As clinicians, we encounter a broad spectrum of ethical dilemmas during the course of practice – in primary care/family medicine as well as at secondary and tertiary levels of care. Generalist medicine is ethically complex¹ due to the underlying philosophy of the discipline. The commitment to patients as persons in a manner that transcends biological disease calls for a holistic bio-psycho-social approach to care that is fraught with ethical complexity. Treating patients and their families has the potential to sometimes produce dual loyalties and requires clinicians to arbitrate during surrogate decision-making. Continuity of care over a number of years allows for the development of longstanding relationships riddled with micro-ethical issues associated with long-term care. Consulting with patients in their homes, in hospital and in our consulting rooms adds a different dimension to the process. In our roles as resource managers and team players, our potential for encountering ethical dilemmas escalates. We may resolve these dilemmas in a variety of ways. In our attempts at resolution we need to be able to justify our actions. In order to do this, a basic knowledge of ethical theory is required. Furthermore, it is essential to develop the necessary skills to translate ethical theory into practice.

HISTORICAL PERSPECTIVE

Bioethics is a branch of applied ethics that has its origins in traditional Western moral philosophy. Over 2 000 years of moral debate, starting with the ancient Greeks, have produced secular moral theories that are still widely used and debated today. Surprisingly, only 3 major moral theories have dominated debate and these 3 theories will be briefly introduced here (Table I). Virtue ethics is the moral theory developed by the Greek philosophers, Aristotle in particular, and concentrates on the character traits or virtues that should be possessed by a person in order for him/her to do good. The theory supports the view that in order to do good one has to be good. Hence the good doctor should possess characteristics or virtues such as compassion, integrity, discernment and trustworthiness. Consequentialism is based on the belief that the consequences of actions define their morality. Utilitarianism is the best-known consequentialist theory. Here the right action is the one that produces the greatest happiness for the greatest number of people. Deontology or rule-based morality emphasises moral duty and moral rules, such as 'always be honest with your patients'. Using this theory, a doctor would make a moral decision based on a sense of duty to do the right thing. In addition, there are a number of other theories, such as liberal individualism, communitarianism, casuistry, the ethics of care and common morality theory, discussion of which falls beyond the scope of this paper.

Table I. **A comparison of duty-based ethics, utilitarianism and virtue ethics (after Hursthouse, 1991) – adapted from Hope *et al.*²**

Utilitarianism	Duty-based	Virtue
An action is right if, and only if, it promotes the best consequences	An action is right if, and only if, it is in accord with a moral rule or principle	An action is right if, and only if it is what a virtuous person would do in the circumstances A virtuous person is one who exercises the virtues
The best consequences are those in which happiness is maximised	A moral rule is one that: <ul style="list-style-type: none"> • is laid on us by God • is laid on us by reason • would be chosen by all rational beings 	A virtue is a character trait a human being needs in order to flourish
The theory thus depends critically on the concept of happiness	The theory thus depends critically on the concept of rationality (or, alternatively, on understanding God's will)	The theory thus depends critically on the concept of human virtues – compassion, trustworthiness, discernment, moral integrity

Table II. **The four principles of medical ethics**

Respect for autonomy	Informed consent, confidentiality, truth telling, and good communication
Beneficence	Doing good/acting in the best interests of the patient
Non-maleficence	Do no harm – weigh risks and benefits and minimise harm
Justice	Fair treatment – rights-based, legal, and distributive justice

Although interesting, these theories have come to be regarded as 'broad and cumbersome' and difficult to use in the clinical setting. In the 1980s a popular approach referred to as the Four Principles of Medical Ethics emanated from the USA.³ These principles include respect for patient autonomy, beneficence, non-maleficence and justice (Table II).

These principles will be elaborated on in the ethical vignettes below. While controversial in terms of scope and hierarchy, the principles provide a simple and useful way for clinicians to articulate and understand their ethical dilemmas. However, ethical dilemmas are often complex and ethical principles, alone, are inadequate to attempt to resolve an ethical conflict. While there are no easy solutions or foolproof methods to resolve ethical

dilemmas, a simple but comprehensive approach will be outlined in this paper. As a point of departure, however, we need to consider some actual ethical vignettes from practice.

ETHICAL VIGNETTES

Consider the following scenarios:

Case scenario 1

Dr AB runs a family practice on the Cape Flats. Mr Z has been his patient for the past 6 years. He is 65 years old and a poorly controlled type 2 diabetic. Mr Z has defaulted treatment and follow-up appointments for 3 months. He returns to the practice with claudication at rest and Dr AB finds signs of severe peripheral vascular disease affecting his left foot. There are gangrenous changes on his toes. Dr AB arranges for an urgent

appointment at the vascular clinic of a nearby tertiary hospital. There Mr Z is advised to have a below-knee amputation, but refuses. His decision is documented in his hospital notes. He returns to see Dr AB, who reinforces the need to have an amputation but Mr Z refuses. Ten days later, his condition deteriorates and he is admitted with septicaemia. He is comatose on admission. The family discuss his condition with the surgeons at the hospital and request an amputation. Cognisant of Mr Z's previous refusal of surgery, the surgeons consult the Hospital Ethics Committee who convene an urgent meeting. Dr AB is contacted as the family doctor to assist the committee with their decision.

Commentary

Dr AB is familiar with Mr Z's refusal of the amputation and has documented this in his patient notes. He is extremely uncertain about the right thing to do in this situation. On the one hand, he is acutely aware of Mr Z's refusal of surgery. On the other hand, as his family doctor, he feels that this is an unnecessary loss of life in the face of a known, though traumatic, intervention. Dr AB is aware, however, that the latter approach would be paternalistic.

The conflicting principles in this case involve respect for Mr Z's autonomy versus the need to do good and prevent death – beneficence/ non-maleficence. If one were to accord moral weight to the principle of respect for autonomy, Mr Z's refusal of the amputation would be respected. However, if one gave moral weight to the principle of beneficence, the surgeons would be allowed to proceed with the amputation in order to save Mr Z's life in an attempt to maximise benefit and minimise harm.

There is also the question of the family's request that conflicts with the patient's request. Whose decision should carry more weight? As health care practitioners, we owe our primary responsibility to the patient. When family members make decisions on behalf of patients who are unable to articulate their own choices, we ask family members to tell us what the patient would have wanted if s/he had been in a position to make a choice. In the event of surrogate decision-making or substituted judgement, we need to ask the following question: if Mr Z could wake up from his coma for 15 minutes and understand his condition fully, and then had to return to the comatose state, what would he decide?⁴ Such an autonomy-based approach holds validity in an individualistic society that defines a person as rational, autonomous, individual and separate from others. Other, more traditional notions of personhood are relational, communitarian and extended.⁵ The family or community are regarded as the moral agent because the family is the most important aspect of identity. In such settings family decisions are likely to carry substantial weight.

This is a difficult decision for the committee. Opinion is split between respecting Mr Z's decision and acting in his best interests in spite of his request. Members in favour of respecting autonomy argue that the patient has been counselled by the surgeons and the family practitioner on 2 separate occasions and he has twice refused an amputation. Furthermore,

Table III. **The elements of informed consent***

Threshold elements
<ul style="list-style-type: none"> • Competence (to understand and decide) • Voluntariness (in deciding without coercion)
Information elements
<ul style="list-style-type: none"> • Disclosure (of information) • Recommendation (of a plan) • Understanding (of information)
Consent elements
<ul style="list-style-type: none"> • Decision (against or in favour of a plan) • Authorisation (of chosen plan)

*Adapted from Beauchamp and Childress³

Table IV. **Problem-solving approaches**

<ul style="list-style-type: none"> • Identify the ethical dilemma and articulate the conflicting values. • Establish all the necessary information – medical, legal, ethical, socio-political norms, patient preferences, doctor's personal value system • Analyse the information obtained and build arguments • Formulate possible solutions and make recommendations or take action • In institutional settings, implement the necessary policies

the law⁶ makes provision for the right of refusal of treatment by a patient. Hence, with correct documentation, one cannot be faulted for respecting autonomy and withholding treatment.

Those members who support the amputation argue that Mr Z has a reversible cause of coma and hence should be treated. They also feel that he may have changed his mind in the previous 10 days. Of importance here is the fact that other conditions that may have an impact on the patient's capacity to consent or refuse have not been excluded, such as depression. A significant concern relates to the lack of adequate counselling by a psychologist or social worker for any patient being prepared for an amputation. Hence, significant doubt exists regarding the validity of the patient's pre-existing expressed wishes.

The verdict: Based on a thorough examination of the case the committee

decides that beneficence must preside and hence, the surgical team is advised to perform the amputation. Mr Z's wife consents.

The outcome: Mr Z makes an uneventful recovery from the surgery. A week later, he is still unhappy about the amputation but glad to be alive. His family is pleased with the decision.

Case scenario 2

Dr X is working in a busy practice on a Friday afternoon. Mr AB enters the consulting room with 2 of his employees, Adam and Ivan. They both work on his building site as general assistants. He demands that Dr X takes blood samples from both the men as he suspects that they have been drinking on duty. Neither of the men is physically ill. Dr X consults privately with each of the men and both men 'consent' to the blood test. What should Dr X do?

Clinical ethical reasoning and analysis are skills that are crucial to good patient care in much the same way as biomedical knowledge and procedural skills are essential to diagnosis and management of medical problems.

In the provision of health care, we are duty-bound to reach scientifically sound and ethically justifiable decisions with our patients.

Comments

Undoubtedly, the critical question facing Dr X is: who is my patient and with whom does my responsibility lie – the employer or the 2 men?

She has two options:

- take the blood as both men have consented
- refuse to be involved in this dispute.

Option 1: Would it be acceptable for Dr X to assume she has consent for the blood samples? One of the important pre-requisites for informed consent is voluntariness (see Table III). This is clearly a situation of coercion. Given the dependent relationship between the employees and employer, the two men are unable to refuse. Alternatively, the doctor may decide to take the blood based on section 66 of the Labour Relations Act.

Option 2: Neither of the men has presented with acute ill-health so this is not a medical emergency. There may very well be a problem of alcohol abuse or even alcohol dependence. At most, counselling and referral for rehabilitation would be indicated. Section 66 of the Labour Relations Act allows an employer to have employees tested for blood alcohol levels. However, the blood alcohol level is not pivotal in a labour dispute. Given that these are general workers and not

airline pilots, a doctor may refuse to be involved in the labour dispute, on ethical grounds (invalid consent).

In this case scenario the employer may be informed that:

- The doctor is willing to individually assess each of the 2 men and make recommendations to the patients based on her findings.
- She is not at liberty to divulge her findings to the employer even if he is paying for the consultations and even with written consent of the patients as they are in a coercive situation.
- If the employer wants her to go ahead with the consultation she will do so but is not obliged to take blood for alcohol levels. She may decide to conduct other investigations that may be determined as a result of her physical examination.

ATTEMPTING TO RESOLVE ETHICAL DILEMMAS

Problem-solving approaches to ethical dilemmas are set out in Table IV.

Identify and articulate the ethical dilemma

In both the ethical vignettes discussed, it is essential to *identify the conflicting values*. For example:

- respect for patient autonomy versus beneficence
- patient advocacy versus responsibility to third parties.

Establish all the necessary information

- What are the medical facts surrounding poorly controlled diabetes, peripheral vascular disease and amputation? What will the prognosis be with an amputation and without one? Are there any factors that have an impact on Mr Z's capacity to consent? Does he have an underlying depression? Are there other psychosocial factors impacting on his decision? What are the family dynamics? Has he been adequately counselled?

- What laws will influence your decision? Chapter 2 of the National Health Act specifies consent and refusal of treatment. This is elaborated in the article by Dada and McQuoid-Mason (p.12, this issue). In the second vignette, knowledge of South African labour law is required.
- What is the ethical standpoint? How do the four principles interact? Here we consider autonomy versus non-maleficence/beneficence. We ask if a universal ethical theory such as utilitarianism can influence a decision or, in family medicine, is the ethics of care or relationship-based ethics approach more appropriate?
- What does the patient prefer? How does culture contribute to or influence the patient's preferences? What does the family prefer and are their preferences concordant with the patient's wishes?
- What does the doctor's personal value system dictate? In South Africa, how are these value systems influenced by medical education, parental influence, political beliefs, and personal experiences? Where there is an asymmetrical relationship between doctor and patient in terms of power, educational background, culture, religion and ethnicity it is more likely that moral issues will be in conflict.
- What are the socio-political norms of the day? Are they acceptable? How will they influence medical decision-making?

Analyse the information

Considering all the information, you will go through a balancing process in which the various components are assigned different weights. In addition, you may use different approaches to the core problem and examine different outcomes. The building of sound moral arguments to justify one's decision is essential.

Formulate solutions, make recommendations, then act

In this step you will consider possible solutions or options, make recommendations, and then act on the decision.

Implement policy

In medical institutions, such as a hospital, policy may have to be implemented, created, or amended. This will be based on how the case was handled in the end. In a private medical practice, guidelines may have to be drawn up so that the

management of a similar problem in the future is much clearer.

CONCLUSION

In the provision of health care, we are duty-bound to reach scientifically sound and ethically justifiable decisions with our patients. In order to do this it is important to recognise ethical dilemmas when they arise in practice and to manage them with the same level of expertise as we manage clinical disease. Health care practitioners need to develop skills to resolve ethical dilemmas. However,

where necessary, they should be able to consult with a clinical ethics committee or a clinical ethicist in much the same way as consultation occurs with specialists in other medical disciplines.^{7,8}

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References available on request.

IN A NUTSHELL

Ethical dilemmas in clinical practice are usually complex.

When faced with an ethical dilemma a holistic approach is required.

The four-principle approach is useful but insufficient.

The four-principles include respect for autonomy, beneficence, non-maleficence and justice.

Medical facts, ethical concepts, legal precedents, human rights issues, institutional policy and socio-political norms must all be considered.

In addition, patient preferences and the doctor's value system must be considered.

Ethical analysis involves application of principles and theories and formulation of cogent arguments.

The analysis and deliberation must translate into action in the form of a decision, treatment, or policy development and implementation.

Patient care must be both scientifically sound and ethically justifiable.

Health care professionals should be equipped to manage ethical dilemmas.

However, where necessary, it may be useful to consult with a clinical ethics committee or a clinical ethicist.

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