

- Patients and families bring their individual experience, capabilities, motivations, and expectations to the healthcare delivery system along with their illnesses, their needs, and their bodies.

5 All individuals and groups involved in health care, whether providing access or services, have the continuing responsibility to help improve its quality

- Healthcare organisations have an obligation to establish processes that identify new procedures or discoveries that have the potential to benefit the care of patients, and to minimise the time required to incorporate these improvements into their system.
- Individual clinicians have an obligation to support and participate in improvements that reduce costs and to suggest how the money and other resources saved could be reinvested to accomplish better care for patients
- Individual clinicians should not impede improvements in patient care because the financial implications of the improvements may affect them adversely

- Individual clinicians have an obligation to change practices that may serve their interests but are costly to the system as a whole
- All who work in the healthcare delivery system have an obligation to share ideas about “best practices” and to learn continually from each other.

The members of the Tavistock Group are Solomon R Benatar, University of Cape Town/Groote Schuur Hospital, Cape Town, South Africa; Donald M Berwick, Maureen Bisognano, Institute for Healthcare Improvement, Boston MA, USA; James Dalton, Quorum Health Group, Brentwood TN, USA; Frank Davidoff, *Annals of Internal Medicine*, Philadelphia PA, USA; Julio Frenk, World Health Organisation, Geneva, Switzerland; Howard Hiatt, Brigham and Women's Hospital, Boston MA, USA; Brian Hurwitz, Imperial College School of Medicine at St Mary's, London; Penny Janeway, Initiatives for Children, American Academy of Arts and Sciences, Cambridge MA, USA; Margaret H Marshall, Supreme Judicial Court of Massachusetts, Boston MA, USA; Richard Norling, Premier, San Diego CA, USA; Mary Roch Rocklage, Sisters of Mercy Health System, St Louis MO, USA; Hilary Scott, Tower Hamlets Healthcare NHS Trust, London; Amartya Sen, Trinity College, Cambridge; Richard Smith, *BMJ*, London; Ann Sommerville, BMA, London.

Professional and public attitudes towards unsolicited medical intervention

Matjaz Zwitter, Tore Nilstun, Lisbeth E Knudsen, Branko Zakotnik, Johann Klocker, Stefan Bremberg, Gerda Frentz, Ursula Klocker-Kaiser, Jette Pedersen

Several studies have investigated medical intervention in common aspects of lifestyle, and the subject has been discussed from a legal, ethical, and practical point of view.¹ Fluoridation of water supplies, legal enforcement of safety measures such as compulsory wearing of seat belts or helmets, and restriction of unhealthy habits such as drinking alcohol or smoking are typical examples of paternalistic programmes—actions that aim to prevent harm or promote the good of others, irrespective of the individual's own wishes.²⁻³ What is the position, however, when a doctor's action is neither solicited nor part of his or her contractual duties? In such a situation—which we define as unsolicited medical intervention—the doctor can only speculate about whether his or her action will be welcomed and hence understood as an act of beneficence or whether it will be regarded as an unjustified paternalistic intrusion into privacy.⁴

According to the 1949 international code of medical ethics of the World Medical Association⁵ and to legislation in many different countries, doctors are obliged to offer first aid in an emergency. However, apart from this relatively clear situation, dilemmas in relation to unsolicited medical intervention have rarely been discussed. The European Code of Medical Ethics, issued in Paris in January 1987 by representatives of the medical associations of the European Community, emphasises the principle that “doctors can only use professional knowledge to improve and maintain the health of those who put themselves in their care.”⁵

We aimed to assess the attitudes of doctors and the expectations of the lay public to unsolicited medical

Summary points

Lay people are more likely than doctors to believe that unsolicited medical intervention is appropriate

Attitudes to unsolicited medical intervention are not related to age or sex

Nationality affects attitudes to unsolicited medical intervention

Doctors nowadays may feel a need to resist rather than support increased intrusion of medicine into everyday life

intervention by asking them to consider the ethics of unsolicited medical intervention in three scenarios. We believed that a comparison of the responses of doctors, subgroups of doctors, and lay people would help us to identify gaps between expectations and reality.

Survey of attitudes

A survey was undertaken in four European countries—Austria, Denmark, Slovenia, and Sweden. In each location, an explanatory letter, a questionnaire, and a stamped addressed envelope were mailed or handed out personally to doctors and to lay people. No further

Institute of Oncology, Zaloska 2, 1001 Ljubljana, Slovenia

Matjaz Zwitter, radiation oncologist
Branko Zakotnik, medical oncologist

Department of Medical Ethics, Lund University, SE-222 22 Lund, Sweden

Tore Nilstun, moral philosopher
Stefan Bremberg, general practitioner

National Institute of Occupational Health, DK 2100 Copenhagen O, Denmark

Lisbeth E Knudsen, genetic toxicologist

continued over

BMJ 1999;318:251-3

Oncological
Institute, 1st
Medical
Department,
General Hospital,
A-9026 Klagenfurt,
Austria

Johann Klocker,
medical oncologist

Institute of
Preventive
Medicine,
Copenhagen
Municipal Hospital,
DK 1399

Copenhagen C
Gerda Frenzt,
dermatologist

Jette Pedersen,
project coordinator

Centre of Mental
Health, General
Hospital, Klagenfurt

Ursula
Klocker-Kaiser,
psychiatrist

Correspondence to:
Dr Zwitter
mzwitter@onko-i.si

Scenarios

Traffic accident

A traffic accident has just occurred. Neither the police nor the ambulance has arrived. A doctor is passing by. He has promised to pick up his daughter and take her to a dancing competition. The doctor does not know if anyone has been hurt, or how badly, but he knows his daughter will miss the competition if he is half an hour late in collecting her. There is no phone in his car.

Suspicion of melanoma

A doctor travelling by bus stands next to a 50 year old woman who has a black spot on her face. The doctor is almost certain that the lesion is a melanoma. In a few minutes the doctor will be getting off the bus.

Genetic predisposition to breast cancer

Without informing individual blood donors, a doctor is using surplus blood to test a method for genetic screening for breast cancer. Blood from a 20 year old woman shows that she has a hereditary predisposition for breast cancer—she will almost certainly develop the disorder when she is between 30 and 75 years of age. The test result is also confirmed by a reference laboratory abroad. The only link to the woman is her home address, and her general practitioner is not known.

explanations or help were provided in answering the questions, and strict anonymity was assured. No reminders were sent to those who did not respond.

Doctors

Doctors were chosen at random from the membership list of a particular section of a medical society, medical practice, or another similar association. Altogether, 845 doctors were contacted and 583 returned the questionnaire (response rate 69.0%). The four groups of doctors included in the survey were general practitioners (166 respondents), surgeons and gynaecologists (186), radiation oncologists or medical oncologists (114), and doctors working in laboratory medicine or epidemiology who had no direct contact with patients (111). The specialty of six doctors who responded is unknown.

Lay people

Adults were approached on urban streets and asked to participate. Saturday morning was the preferred time, as overrepresentation of unemployed people might have occurred if approaches had been made on weekdays. Altogether 569 of the 1096 people (51.9%) who were contacted responded.

Scenarios

Three scenarios describing unsolicited medical intervention were prepared (box). The same scenarios, with minor modifications in wording, were presented to the doctors and lay people. The question for the doctors was whether or not they would intervene. For the lay people, the question was whether or not (in their opinion) the doctor should intervene in such a situation.

People's responses

Traffic accident

Altogether 96.2% of doctors who responded (561/583) said that they would intervene, and even more lay

people (97.9%; 557/569) believed that the doctor should help in such a situation. Although the number of those who did not favour intervention was small, the difference between the two groups was significant ($P=0.02$). Surgeons were more inclined to intervene than other doctors (182/186, 98%, compared with 373/396, 95%; $P=0.06$). Neither sex nor age influenced the respondent's preferences. Across the four countries, 95.3% to 99.6% of all replies favoured intervention. Danish respondents were significantly less likely to support intervention than respondents in the other three countries ($P=0.002$).

Suspicion of melanoma

Only 23.3% (136/583) of the doctors but 34.4% (196/569) of the lay people would have addressed a stranger in such a situation ($P<0.001$). General practitioners (19%, (32/166), of positive replies) and surgeons (18%, 34/186) were significantly less in favour of intervention than oncologists (34%, 39/114) or doctors without direct contact with patients (27%, 30/111; $P=0.01$). Sex and age had no influence on the attitudes of the respondents. Significant differences were seen between countries—47% (98/209) of Austrian respondents but only 21.5% (148/687) of Danish respondents agreed with intervention ($P<0.001$).

Genetic predisposition to breast cancer

Only 39.5% (230/583) of doctors but 62.6% (356/569) of lay people favoured contacting the carrier of a breast cancer gene ($P<0.001$). The specialty of the doctors had no influence on their response. Nor were responses influenced by sex or age. Respondents from Austria were again most inclined (79%, 164/209) and those from Sweden least inclined to intervene (39%, 64/156; $P<0.001$).

Discussion

In all the situations presented, both intervention and non-intervention have ethical benefits and costs for some of those involved. Our identification of these benefits and costs is based on the principles of respect for autonomy, non-maleficence, and beneficence.^{6,7}

The benefits of intervention by the doctor in the scenarios described are as follows: direct help to someone who has probably been injured in a traffic accident; the possibility of earlier consultation and perhaps better prognosis for a person with a



suspected melanoma; and knowledge of a long term health risk for a young woman with a predisposition for breast cancer that may lead to better chances of early detection and more successful treatment. In the language of medical ethics, intervention by a doctor could be described as an act of beneficence to all three persons. Intervention in the second and the third scenarios might also be understood as promoting autonomy—that is, increasing the options of the women so that they could make an informed choice.

However, intervention by the doctor is also associated with ethical costs. In the first scenario, the doctor would have to change his plans and break a promise to his daughter. The ethical cost of intervention in the second scenario is invasion of privacy. The woman concerned might also find it embarrassing to discuss her “black spot” on the bus. The woman is certainly aware of the lesion on her face; she has probably seen a doctor already or she may have refused treatment no matter what the nature of the black spot.⁸ In the third scenario, the most obvious ethical cost of intervention is a lifelong emotional burden for a young woman told that she has a hereditary predisposition to cancer at an age when any medical action would be premature.^{9–11}

In the past, doctors have strived to convince lay people of the importance of public health measures such as proper sanitation, vaccination programmes, or a healthy lifestyle. The doctors of today and tomorrow face a different challenge—the public has high expectations of prevention, early detection, and treatment of diseases; disease or death are not regarded as natural

events; and a poor outcome is often attributed to a medical omission or mistake rather than the natural course of a disease. In such an environment, important health policy decisions, such as breast cancer screening programmes in young women, are made for political rather than medical reasons.¹² We conclude that doctors nowadays feel a need to resist rather than support a trend towards the increased invasion of medicine into everyday life.

MZ, TN, and LEK thank Dr Kirsi Vahakangas for inviting them to the International Meeting on Molecular Epidemiology and Ethics in Oulu, Finland, where they discussed the idea for this survey.

Competing interests: None declared.

- 1 Gochman DS, ed. *Handbook of health behavior research*. New York: Plenum, 1997.
- 2 Harris J. *The value of life*. London: Routledge, 1985.
- 3 Dworkin G. *The theory and practice of autonomy*. Cambridge: Cambridge University Press, 1988.
- 4 Ratzan RM. Unsolicited medical opinion. *J Med Philos* 1985;10:147-62.
- 5 Reich WT, ed. *Encyclopedia of bioethics*. New York: Simon and Schuster, 1995.
- 6 Beauchamp T, Childress JF. *Principles of biomedical ethics*. New York: Oxford University Press, 1994.
- 7 Gillon R, ed. *Principles of health care ethics*. Chichester: Wiley, 1994.
- 8 Moseley R. Excuse me, but you have a melanoma on your neck! Unsolicited medical opinions. *J Med Philos* 1985;10:163-70.
- 9 Zwitter M, Nilstun T, Golouh R. Ethical principles of autonomy and beneficence in genetic screening for breast cancer. *Radiol Oncol* 1996;30:310-3.
- 10 Hook EB. Problem of offering unsolicited clinical genetic advice and diagnosis to nonmedical friends and strangers. *Am J Med Genet* 1997;68:485-6.
- 11 Ponder B. Genetic testing for cancer risk. *Science* 1997;278:1050-4.
- 12 Fletcher SW. Whither scientific deliberation in health policy recommendations? Alice in the wonderland of breast cancer screening. *N Engl J Med* 1997;336:1180-3.

(Accepted 14 August 1998)

Narrative based medicine

Narrative in medical ethics

Anne Hudson Jones

The contributions of narrative to medical ethics come primarily in two ways: firstly, from the use of stories (narratives) for their mimetic content—that is, for what they say; and secondly, from the methods of literary criticism and narrative theory for their analysis of diegetic form—that is, for their understanding of how stories are told and why it matters. Although narrative and narrative theory, like the form and content of a literary work, are inextricably bound up with each other, I will discuss them separately to help chart the evolving appreciation for the importance of narrative in the work of medical ethics.

The use of stories

During the past two decades, stories have been important to medical ethics in at least three major ways: firstly, as case examples for the teaching of principle based professional ethics, which has been the dominant form of medical ethics in the Western world; secondly, as moral guides to living a good life, not just in the practice of medicine but in all aspects of one's life; and thirdly, as narratives of witness that, with their

Summary points

Narrative contributes to medical ethics through the content of stories (what they say) and through the analysis of their form (how they are told and why it matters)

The study of fictional and factual stories can be an important aid to understanding in medical ethics

The techniques of literary criticism can be applied to the analysis of ethical texts and practices and can inform the understanding of different perspectives in an ethical dilemma

To understand and accept a patient's moral choices, a practitioner must acknowledge that the illness narrative has many potential interpretations but that the patient is the ultimate author of his or her own text

This is the fourth in a series of five articles on narrative based medicine

Institute for the Medical Humanities,
2,210 Ashbel Smith Building, University of Texas Medical Branch,
301 University Boulevard,
Galveston, TX 77555-1311, USA

Anne Hudson Jones,
professor
ahjones@utmb.edu

Series editor:
Trisha Greenhalgh

BMJ 1999;318:253-6