Philosophical Medical Ethics

Doctors and patients

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In my last article and intermittently throughout this series I have suggested that doctors do not have an overriding duty to benefit their patients, and that sometimes moral obligations to others will supersede this duty. That of course does not conflict with what to doctors is the obvious claim that they do have special, supererogatory, moral obligations to their patients—that is, moral obligations that are over and above the ordinary moral obligations we all have to each other.

In this article I shall outline some prima facie moral duties of doctors to their patients that emerge from my preceding discussions of philosophical medical ethics. Their importance seems to stem from the fact that they follow from four general ethical principles that various moral theories would accept, plus the special self imposed supererogatory duty of beneficence that doctors as members of the medical profession profess. I have tried in preceding articles to point to the complexity and some of the nuances underlying these principles. Here I shall try to summarise their prima facie implications more baldly and boldly with less philosophical circumspection, but I shall not discuss the manifold problems that arise when these obligations conflict. I suspect, however, that even the prima facie obligations will be startling and contentious enough for many doctors, though for others they may be self evident.

Respect for autonomy

Firstly, in their relationships with their patients doctors must remember that apart from any special moral obligations they have the standard moral obligations that all of us have to each other: to respect each other's autonomy, not to harm each other (nonmaleficence), to be just, and to benefit at least some others (beneficence). The extent and nature of these last two general moral obligations are more debated than the first two, but in the absence of justification to the contrary they ought to be followed at least to the extent determined by our social, including legal, obligations.

In addition, doctors voluntarily take on an additional moral obligation—what might be called the principle of medical beneficence—to benefit their patients' health and to some extent the health of others. They undertake to do so by trying to save their patients' lives when these are threatened by disease and other "maladies" (in the sense used by Culver and Gert[1]); to cure, palliate, and prevent their maladies; and to ameliorate the suffering that these cause. If we accept our general moral obligations these additional duties of medical beneficence ought only to be exercised to the extent that our patients want and allow us to exercise them. Thus our general duty to respect their autonomy requires that if they do not want to be helped we generally have no right to help them (though I have previously outlined a rationale for certain exceptions to this norm). Even our general duty not to harm others requires for the most part that we try our best to obtain their willing consent to what we propose as most interventions designed to help others carry a risk of harming them and that risk is probably increased considerably if they are carried out without people's understanding and consent, let alone if they are carried out against their will.

The doctor may advise, but the patient is then given the opportunity to decide whether to accept that advice. A patient's rejection of medical advice should not lead to a shrugging of the shoulders. . . . What should follow instead is a genuine attempt to understand the patient's reasons . . . for rejecting the advice.

If we add to these general moral obligations the special obligation of medical beneficence then our duty to respect our patients' autonomy should generally be reinforced; in most cases doctors will benefit their patients more if the rationale of their proposed beneficial actions is understood and approved by their patients. Respect for a patient's autonomy should thus be seen as a presupposition of the doctor-patient relationship, not only because it is the underlying assumption behind any voluntary interpersonal relationship but also because in any case such respect will probably improve the beneficent outcome that the doctor intends to produce.

Doctor-patient relationship

None the less, it is uncontroversial to assert that the principle of respect for autonomy has had little milage for most of medicine's long history except, perhaps, when patients have been doctors' social equals or superiors (Plato alluded to this distinction when he differentiated between the doctor-slave patient relationship, in which the patient did what the doctor told him to do without discussion and that was the end of the matter, and the doctor-rich citizen relationship, in which explanation and discussion were the norm[2]). The medical sociologist Dr Ann Cartwright is not alone when she says she likes her doctor to treat her "as an equal,"[3] but this is by no means a medical norm.

The implications for the doctor-patient relationship of taking the principle of respect for autonomy seriously are legion. Among the more important are the following prima facie duties: to give the patient at least what he or she considers to be adequate information, and often more if the doctor knows that more information will probably be appreciated and relevant to good decision making; not to lie to or otherwise deceive the patient (unless he or she deliberately chooses such deception); and to allow the patient to

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have at least strategic control over which course of action to pursue—that is, the doctor may advise, but the patient is then given the opportunity to decide whether to accept that advice. If this principle is taken seriously, a patient's rejection of medical advice should not lead to a shrugging of the shoulders, a cooling of attitude, and "if you can't trust my advice, perhaps you'd better find another doctor." What should follow instead is a genuine attempt to understand the patient's reasons (or other motives) for rejecting the advice and a search for the next best option.

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One of the keys to respect for autonomy is good communication, and thus respect for patients' autonomy requires doctors to acquire and maintain skill in communicating with them—not just in telling but also in understanding.[4-13] As Sir George Pickering said in his Nuffield lecture, although a few doctors are born communicators, most are not, but they can learn[14] (and when such teaching is set up we need to incorporate the patients' assessments of the appropriate standards for "good" doctor-patient communication).

If respect for autonomy requires that we cannot treat people without their understanding consent then still less can we use them for the benefit of others without such consent, whether in research or medical teaching, and their refusal of such consent should not detract from their ordinary medical care. Even a prima facie obligation to be punctual stems from the requirement to respect autonomy (assuming the obligation to keep one's promises derives from the requirement to respect autonomy) because to offer someone an appointment is a form of promising.

An infinite range of other specific prima facie obligations derive from the principle of respect for autonomy, including, perhaps, the provision of more information about doctors' interests, qualifications, attitudes, and moral stances to patients and potential patients as well as making it as easy as possible for patients to have a real choice of doctor. There is often an unwritten agreement, especially among general practitioners, not to accept patients who wish to change from neighbouring doctors with whom they are dissatisfied. Respect for autonomy would seem at first sight to require otherwise. The same applies to the General Medical Council's advice that "in the interests of the generality of patients a specialist should not usually accept a patient without reference from the patient's general practitioner."[15] For the General Medical Council to precede this remark with the assertion that "an individual patient is free to seek to consult any doctor" is, to say the least, disingenuous, though it is presumably supposed to reflect the World Medical Association's affirmation in the Declaration of Lisbon,[16] subscribed to by Britain, that "the patient has the right to choose his physician freely." (Dissatisfaction with professional restrictions on advertising and restrictions on patients' choice of doctor have reached the leader columns of *The Times*).[17]

In summary, the principle of respect for autonomy asks the doctor to have at the back of his mind the question, Would the patient, if he could consider it, wish me to do what I am doing or intend to do? If not, How can I justify doing it? Usually the best way to answer the first question is to ask the person concerned.

Non-maleficence and beneficence

The second and third principles—that is, non-maleficence and beneficence—almost always need to be considered together in the context of the doctor-patient relationship, for although non-maleficence can be considered independently of beneficence, any obligation to help others that may result in harm, including almost any medical intervention, has to be considered in the context of the coexisting obligation not to harm others. Countless important prima facie medical obligations stem from these two principles, of which I shall indicate a few.

Firstly, if a doctor professes to be able and willing to benefit his patients then he or she had better be able and willing to do so; and as he is under a general obligation not to harm others he had better do so with minimal harm (the real force of the traditional "primum non nocere" slogan). This has straightforward implications for medical education before and throughout professional life for as members of a profession we are obliged (by accepting these two principles) to ensure that we practise in ways that do actually benefit our patients with minimal harm. This entails continual research to discover what these ways are, educating ourselves to practise in these ways, and continually monitoring our performance to make sure that we practise and continue to practise accordingly. Thus continuing postgraduate medical education, including some form of audit, is a moral obligation, as distinct from an optional extra taken on by enthusiasts, the sort of obligation that "springs from a mutual respect and a desire to improve the lot of patients."[18] (As the Royal College of General Practitioners[19] and Dr John Lister,[20] among others, have pointed out, there are also other, prudential reasons for the profession to undertake more rigorous self assessment of the quality of its service.)

What about medical mishaps? It seems that doctors—and I include myself—have a tendency to close ranks in their own individual and group interests and against the interests of our patients to an extent that is incompatible with our professed adherence to a principle of benefiting our patients. We have had inculcated into us throughout our professional training and socialisation a sort of public school ethos that we do not "split" about a colleague even when we know that the colleague has made a damaging mistake (let alone when we merely know that he is unpleasant to his patients) or is frankly incompetent. Such behaviour is incompatible with the principle of medical beneficence that doctors profess, and if we are to continue honestly to profess it we need a radical new orientation to eliminate this tendency.

During a tour of various establishments that teach ethics in the United States, I visited West Point Military Academy, which teaches ethics to its cadets (and also to officers at various later stages in their careers). Part of the undergraduate teaching is carried out by the cadets themselves and includes among other components promulgation and justification of an "honour code." When I first

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discovered that this required cadets to report each other's moral misdemeanours of lying, cheating, and theft I was repelled by the sort of disloyalty and threat to friendship that such a code required. Just as the military (sexistly) speak of "brother officers" so the International Code of Medical Ethics affirms that "my colleagues will be my brothers"[21]; surely brothers do not report each other's misdemeanours unless they are really awful. On reflection, however, I am not so sure. Should not our professed medical ethic of benefiting our patients require something similar to the cadets' honour code? Should we not educate ourselves from student days onwards that our primary loyalty should be to our patients and if that conflicts with our personal and professional friendships and group loyalties, even with our loyalties to our medical "brothers,"

the prima facie assumption should be that the patients' interests come first?

Of course, ideally no doctor would deceive, cheat, or defraud his patients, nor in any other way harm them unnecessarily, but we do not live in an ideal world. I do not think my own personal reluctance to "dish a colleague" is rare within our profession—according to Sir Douglas Black, such reluctance was one of the themes emerging from a Royal College of Physicians' symposium on medical accountability[22]—yet if we are to take our self imposed moral obligation to benefit our patients seriously such reluctance should become rare. The case against medical in-group loyalty superseding loyalty to patients was argued powerfully by a solicitor who helped to found the organisation Action for the Victims of Medical Accidents.[23]

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Admit mistakes to patients

While on this theme, I read with interest the assertion of a past president of the Law Society that "of the three true professions, it would seem overall that the ethical standards which are required of the lawyer exceed those of any other profession." Part of this claim rested on an aspect of legal practice that was "unlike any other profession"—notably, that solicitors "are obliged by the rules of professional conduct to inform a client if they have acted negligently or improperly in the performance of their work. This is not incumbent on ... the surgeon or physician who tends you in ill health. . . ."[24] Admittedly, a solicitor friend had never heard of this fine self imposed obligation, but is it not entirely admirable and one that we as a profession committed to benefiting our patients should take up? Interestingly, it seems that the law may be nudging us in that direction, at least so far as answering patients' questions truthfully and completely is concerned, not only concerning proposed treatments (as in the judgments of Lords Keith and Bridge in the Sidaway case[25]) but also, in a more recent Court of Appeal case, concerning treatments that have already been given.[26]

If we do decide to accept the implication of the principle of medical beneficence, that we should tell patients if we have made mistakes, it would also be reasonable for us to press for a national scheme of no fault compensation. We are bound to make mistakes from time to time, some of which are bound to harm our patients, and compensation should not depend on a legal requirement to show "negligence." Nor if we are concerned with the ethics of the matter should we allow our legal protection societies to stop us apologising to our patients; if we think we have made a mistake we almost certainly have, and we should out of common decency, let alone the principle of medical beneficence, say we are sorry. This requirement may in any case be of considerable benefit to the doctor as well as to the victim of his mistake, as Dr Hilfiker points out in a wise and humble paper.[27]

Finally, in this consideration of the implications of beneficence, should we not build into medical training and standards a requirement to be nice to our patients? Doubtless it is true, as is heard over and over again in response to this suggestion, that, firstly, all doctors are nice to some of their patients some of the time and, secondly, patients would prefer a medically competent but unpleasant doctor to a charming ignoramus. But is the first sufficient if we profess beneficence and as for the second would not a combination of the two be even better? Being pleasant, warm, concerned, and, where appropriate, compassionate on the one hand and being medically and scientifically competent on the other are not mutually exclusive attributes.[28] Quite apart from any moral obligation of beneficence Dr Mendel suggests that we are paid to be nice to patients[29] (he also suggests that the short appointment is one of the worst enemies of "proper doctoring" in this and other respects), and doctors writing about their own experiences as patients indicate the importance they attached to the friendliness of their treatment, or its absence.[30-34]

My personal impression, however, reinforced by what I hear from my patients and the medical stories of my friends, is that doctors, and taking their cue from them staff throughout the National Health Service, including receptionists, have a propensity for retreating into a sort of dismissively neutral frame of mind and face, especially when patients show the slightest sign of dissatisfaction. Such lack of friendliness, aloofness, and inadequate communication from staff experienced and observed during Member of Parliament Mr Patrick McNair-Wilson's stay in hospital were apparently among the causes that prompted him to introduce his government supported Hospital Complaints Procedure Bill.[35 36] Does not medical beneficence require at least a consistently friendly and pleasant medical demeanour?

I am not suggesting that we ought, or even that we could, become real friends with each of our patients; indeed strictly speaking the principle of beneficence requires no emotional ties at all (as distinct from a principle of benevolence that would require good feelings, beneficence requires only good actions). Some affection, some interest, and some genuine concern is, however, as a matter of empirical fact likely to make it easier for a doctor to be beneficent to his patients in all these different ways, and while there is a positive danger to medical care if the emotions play too large a part, so there is if they are cut out altogether. My impression is that as members of a profession we have strayed too far towards impersonality and detachment and that we need to correct actively the balance and encourage and foster the sort of "moderated love" for our patients described by the Scottish theologian Dr Alastair Campbell.[37]

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Justice

Justice too should have its impact on the doctor-patient relationship. I indicated in my earlier articles on justice the lack of agreement about which substantive principle of justice should be adopted, but I also indicated that most theorists would accept Aristotle's formal principle according to which equals should be treated equally, unequals treated unequally in proportion to the relevant inequality, and that that formal principle alone had substantive implications for medical care. Doctors simply cannot evade the conclusion that there are various circumstances in which the interests of others may supersede the interests of their index patient of the moment. But perhaps we need to make it clearer to our patients that although we work hard to support their interests, we also have obligations to others that on rare occasions may override their interests (perhaps not so rarely if it is an inchoate principle of distributive justice that allows doctors to provide the incredibly short consultations that on the whole are the unwelcome lot of so many NHS patients).

Professional codes of medical ethics such as those promulgated by the General Medical Council and the British Medical Association already indicate the many competing moral concerns that may

override a doctor's primary obligation to his patient of the moment. As individual doctors, however, I think we tend to imply, if not actually say, to our patients that their particular welfare and interests are always paramount, their secrets are in absolute trust, whatever they medically need they will get, etc. Perhaps we should make it clearer that although we consider ourselves individually and collectively to have a strong obligation to each of our patients, we do not and could not purport to have an absolute obligation to them.

Considering the implications of beneficence, should doctors not build into medical training and standards a requirement to be nice to their patients?

Perhaps we should also give them some indication or summary of our personal professional ethics and our approach to various standard medicomoral dilemmas, as the barrister Paul Sieghart suggested in his Lucas lecture.[38] Of course, the chances of the present generation of doctors actually doing this are remote, but a modest start could be made if some standard exposition such as the BMA handbook of ethics were available in every surgery and hospital firm, to be consulted by patients who were interested. Enthusiasts representing various standard and alternative medicomoral stances might consider writing explanatory handbooks for patients. Gradually it would become the norm for doctors to discuss medicomoral issues with those patients who wished to know if they were morally "compatible" with their doctors and to negotiate particular issues. I do not believe that this, even if it were widely available, would take up a large proportion of our time as doctors, nor should it. But the offer and ability to discuss critically and knowledgably such issues with our patients would greatly enhance the quality of our overall medical practice.

All the above implications of the four "standard" moral principles are prima facie and each applies only if one of the others does not supersede it. None the less, even as prima facie obligations they present a formidable set of requirements, and I do not delude myself that we can always live up to these duties even if we accept them. I certainly cannot, try as I may.

My impression is that as members of a profession we have strayed too far towards impersonality and detachment and that we need to correct actively the balance and encourage and foster the sort of "moderated love" for our patients described by the Scottish theologian Dr Alastair Campbell.[37]

One conflicting motivation that I have not considered is self interest. To some degree self interest is a moral obligation in so far as it is also required to some degree by at least three of the four principles. Respect for autonomy, non-maleficence, and justice are moral obligations that extend to all, including ourselves. Moreover, if we flourish ourselves we are better able among other things to carry out our obligations to others, including our obligations to benefit our patients. Whether we have a duty of beneficence to ourselves independently of such considerations is more doubtful. Utilitarians would generally argue that we do to the extent that such self beneficence maximises overall welfare. Whether this is accepted, at the very least self beneficence (or looking after number one) needs to be distinguished carefully from the other moral obligations influencing the doctor-patient relationship. Certainly the special moral obligation that we profess of beneficence to our patients would seem to imply that when an uncomplicated conflict arises between benefiting them medically and benefiting ourselves then prima facie their interests should take priority. If it does not entail at least this what is left of our claims of being a profession?

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