

## CLINICAL ETHICS

# Informal medicine: ethical analysis

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*J Med Ethics* 2005;31:689–692. doi: 10.1136/jme.2004.010769

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Received  
27 September 2004  
In revised form  
5 February 2005  
Accepted for publication  
19 February 2005

**Context:** Doctors have been known to treat or give consultation to patients informally, with none of the usual record keeping or follow up. They may wish to know whether this practice is ethical.

**Objective:** To determine whether this practice meets criteria of medical ethics.

**Design:** Informal medicine is analysed according to standard ethical principles: autonomy, beneficence and non-maleficence, distributive and procedural justice, and caring.

**Setting:** Hospital, medical school, and other settings where patients may turn to physicians for informal help.

**Conclusion:** No generalisation can be made to the effect that informal medicine *is* or *is not* ethical. Each request for informal consultation must be considered on its own merits.

**Guidelines:** Informal medicine may be ethical if no payment is involved, and when the patient is fully aware of the benefits and risks of a lack of record keeping. When an informal consultation does not entail any danger to the patient or others, the physician may agree to the request. If, however, any danger to the patient or others is foreseen, then the physician must insist on professional autonomy, and consider refusing the request and persuading the patient to accept formal consultation. If a reportable infectious disease, or other serious danger to the community, is involved, the physician should refuse informal consultation or treatment, or at least make a proper report even if the consultation was informal. If agreeing to the request will result in an unfair drain on the physician's time or energy, he or she should refuse politely.

Informal (hallway, kerbside, off the cuff) medicine is informal self referral to a physician for consultation or treatment without the usual medical record keeping or follow up.<sup>1</sup> It is not known how prevalent informal medicine is worldwide. Israeli physicians are very familiar with the phenomenon. A comprehensive search of the literature revealed that a significant proportion of reports come from Israel, although other countries are also represented.<sup>2–4</sup>

Weingarten reported 198 “off the cuff” consultations between general practitioners and patients; these occurred over a period of six months at social gatherings, at chance meetings, and in medical settings outside the regular practice.<sup>5</sup>

In one study of 219 Israeli medical students who completed anonymous questionnaires, 33% had, during their clinical rounds, informally consulted with doctors without a referral letter from their primary care physician. Students in clinical years used informal medicine significantly more than preclinical students (50% *v* 21% respectively), despite the fact that all students had government subsidised comprehensive medical insurance.

In another study, conducted among physicians in an Israeli hospital,<sup>6</sup> 91 of 111 physicians who completed the questionnaire (82%) confirmed that they had been requested by their colleagues to provide hallway consultations relating to their own medical problems. Most of them (91%) agreed to consult because “they wanted to help”, “it is unpleasant to refuse”, or “it's the acceptable thing to do”. Most of the requests were unscheduled and time consuming. Records were kept in only 36% of the cases and follow up was conducted in 62%. Physicians who provided hallway medicine also requested it from others ( $p < 0.001$ ) because of personal acquaintance, to save time, and because of ready accessibility, even though the prevailing attitude to informal medical consultation was negative or ambiguous.

Now that cellular telephones are ubiquitous, contact can be made with physicians at almost any time and place. In a

small study by a family physician, 94 requests for informal consultations over the cellular phone were documented and analysed over a three months period.<sup>7</sup> Only 11% of the requests were made over the weekend. In 63% of the cases, the clinic at which the patient was registered was open at the time of the request. The principal reasons for the requests were medication (29%) and for a second opinion (28%). In 42 cases the request for consultation came while the physician was busy with other patients.

Informal medicine may appear to be an unethical practice. The patient unfairly makes a request, which may be hard for the doctor to refuse, especially if they are friends or colleagues. The doctor deprives the patient of the benefits of record keeping and follow up. The medical profession, medical researchers, and patients in general are deprived of the knowledge that records might have facilitated. If the doctor receives payment then the violation of ethics seems even more serious. And isn't a gift or a reciprocal favour from a grateful neighbour a form of payment?

As we shall see, however, there are good reasons for considering many cases of informal medicine quite ethical. No generalisation can be made to the effect that informal medicine *is* or *is not* ethical. We must rather consider different kinds of cases. We shall use some ethical principles not as dogma but as a framework for discussion. In so doing, we are not in any way taking or endorsing a “principlist” approach. Nor are we saying that “principlism” is any better than any other approach. As in classroom discussion, so in bioethics literature, the use of fairly well known concepts as section headings can help us organise our thinking. That is the primary role that so called “principles” are intended to perform here.

A complete treatment of informal medicine might include an extensive discussion of emergency “Good Samaritan” situations, as well as doctors' self treatment. This modest contribution will, however, focus instead on the less spectacular corridor consultations, which are much more

usual and less addressed. We hope that our analysis and discussion might be of value for clinicians. Emergency situations will be mentioned only by way of comparison. Doctors' self treatment falls outside the scope of this paper. So does informal consultation about patients, and between and among doctors, which has been treated elsewhere.<sup>8-10</sup> Our focus is only on cases where a patient has requested an informal consultation or treatment from a doctor.

## AUTONOMY

Informal medicine seems *prima facie* to serve the *autonomy* of the patient. Autonomy is too often discussed within the narrow limits of decisions whether or not to accept treatment. Autonomy in a broader sense means, however, taking control of our own lives, making our own decisions about what it means to be healthy, and about what we should do to achieve and maintain health.

If no records are kept the patient has the leeway to choose what information, if any, to show to other physicians. This may be dangerous, but shouldn't the patient, especially if he or she is medically literate, have the right to decide what information to reveal to whom? Indeed, when the informal patient is a fellow physician, a nurse or a medical or nursing student, he or she may be presumed to be knowledgeable enough to be trusted to decide what personal medical information should be revealed to whom.

Of course the fact that a consultation is informal does not guarantee that no records are kept. A physician could ask for permission to transmit some of the information to the patient's usual physician. In the emergency setting, a healthcare provider who gives first aid on the spot at an accident—for example, will be expected to transmit some information to the formal staff when they arrive. The authors are indebted to one of the journal's reviewers for this comment (S Hurst, personal communication, 2004). A physician might also feel duty bound to report a dangerous situation to the patient's usual physician, or to report an infectious disease to the health authorities, even against the desire of the informal patient.

In an informal consultation, the autonomous patient might feel freer to discuss the problem openly with the doctor, perhaps expressing disagreement or raising questions about diagnosis and treatment. This might be especially likely if the informal patient is a health professional. It might seem that, even in a formal setting, a patient who is a physician or nurse would be more assertive than other patients, although we know (admittedly anecdotally) of health professionals who can be quite assertive at work, but who become passive and easily manipulated when they are the patients. A physiotherapist recently complained to one of us (FL) that when she went to see a doctor about a winter flu, he had her strip naked for the examination. Only afterwards did she realise that he had overstepped his bounds. I asked her how long she had been a physiotherapist. When she told me that she had been in the profession for twenty years, I replied that she could not blame the doctor for what happened. Perhaps, although this is not provable, she might have maintained more control in an informal consultation, where the doctor might not wield such authority. We admit, moreover, that it cannot be proved that patients in general will be more assertive in informal settings. Indeed, a good physician should encourage a patient to take an active role in all consultations. We do wish to suggest, however, that for some patients and some doctors, an informal atmosphere may have a positive effect.

Whether autonomy in these contexts serves the medical benefit of the person needing the treatment will be discussed under the category of beneficence and non-maleficence.

There is also *physician's autonomy*. On the one hand, informal medicine allows the physician to help friends and students, and to take on interesting cases, which might be impossible within the framework set by the physician's employer. On the other hand, the physician might feel undue pressure from friends and colleagues, who request informal medicine, to the detriment of the physician's autonomy. Anyone who requests informal medicine should respect in particular the physician's professional autonomy, and his or her desire to maintain good clinical practice, and to avoid malpractice. The physician's insistence on professional autonomy, when it is motivated by sincere concern for the patient and the community, may lead the physician to limit recognition of patient's autonomy. Although many requests for informal medicine may be justified, the patient should be ready to accept a physician's refusal with understanding, even though the patient may not understand or agree with the physician's reasons for refusing.

## BENEFICENCE AND NON-MALEFICENCE

Informal medicine may be very attractive in this age of intensive lifestyles. It saves time usually wasted waiting for an appointment, can save money, and can facilitate consultation with a specific consultant who is not necessarily the patient's usual physician.

There are cases where a lack of records might be in the interests of the patient.

The Human Genome Project's funding for ethical, legal, and social implications, as well as other generous sources for the bioethics of genetics, resulted in a vast number of articles discussing the right of the patient to privacy with respect to genetic information, as may be seen in the bibliography in reference eleven.<sup>11</sup> The discussions usually refer to insurability and employability. It is arguable that it is to the good of society that employers should know about genetic predispositions to dangerous conditions, and that someone with a predisposition to heart attack, to take one example, should not be hired as an airline pilot or even a bus driver. It is argued on the other hand, however, that this is personal medical information, which no one has the right to divulge without the informed consent of the patient. Similar considerations apply outside of genetic medicine, and in medicine in general. Indeed it is arguable that the ethical questions of genetics are really questions of general medical ethics. The question whether a patient has a right to conceal a predisposition to heart attack from insurers and prospective employers is the same sort of question regardless of whether the predisposition is genetic or due to other causes.

With the growing computerisation of medical records, we may get to the point that whatever a family physician records will be available to any physician and to laypeople as well. It is becoming obvious nowadays that whatever is put into a computer can easily become public knowledge. Privacy in general may be dying. This may especially be the case if ministries of health, sick funds, and health maintenance organisations put patients' files on their electronic networks. Programmers do not yet seem to know how to design safeguards that hackers cannot get past. We may be approaching an era where medical confidentiality will be only "in theory". Also, a patient may want to conceal information from the family doctor in order to make it easier to get notes later on certifying—for example, his or her ability to participate in strenuous sport, or to serve in a combat unit in the army. Turning to informal medicine when needed—for example, a prescription for an inhalator for someone with mild asthma—is a way to preserve medical privacy. It will be said that such behaviour is unethical, endangering oneself and others. However, the bioethics literature favouring genetic privacy sets a precedent for privacy in general.

It must be emphasised, none the less, that the fact that someone has a right to something does not entail that every doctor has an obligation to help that person to exercise that right. A responsible physician who is approached with a request for informal medicine will seriously weigh a number of considerations before agreeing to the request. Is there a risk of malpractice if proper diagnostic procedures are not possible in the informal setting? Is there a chance that this patient is getting multiple prescriptions for the same drug through informal consultations with several doctors? If so, is there a risk of dangerous overtreatment (such as overuse of bronchodilators for asthma)?<sup>12-14</sup>

Benevolence and non-malevolence, moreover, concern not only the individual patient but the community as well. Surely any case that might present a public health or other danger to the community is inappropriate for informal medicine—for example, dangerous infectious disease, potentially dangerous psychiatric patients, and susceptibility to seizure or accident in the workplace should obviously be treated formally, documented, and properly reported.

So, although much informal medicine may be perfectly innocent and beneficial, there are also many kinds of cases where a judicious physician might reply to a request for informal treatment by saying: “I recognise your concerns that proper documentation might lead to others learning about your case. I also admit that the bioethics literature strongly emphasises medical privacy these days. But I have to weigh your own rights and needs against clear dangers to yourself (and/or to others). I therefore strongly advise you to come to my clinic for proper diagnosis and treatment.” If the patient continues to insist on informal treatment, it may be in order to suggest looking for another doctor.

## DISTRIBUTIVE JUSTICE

The major question of justice is whether informal medicine unfairly takes up time and energy that the physician should be giving to formal patients. If the physician works for a sick fund—for example, the time spent with informal patients who are not members of that specific sick fund, may be at the expense of paying, sick fund members.

Informal medicine may be defended against this objection in at least two ways. In the first place, at least in a country like Israel, which has several sick funds, and each citizen is, by law, a member of one of them, the account can balance out. Today a doctor from this sick fund informally treats a member of that fund, whereas tomorrow a doctor from that fund might informally treat a member of this one.

In the second place, in an informal situation, the patient might feel more encouraged to discuss the case freely and openly with the physician. If the case is interesting or unusual, the doctor might learn something from it. In fact, if the informal patient puts plenty of input into the consultation, and a lively discussion ensues, this can be a good learning experience for the doctor. This is especially likely if the patient is a colleague, or a medical or nursing student. However, any educated patient with a sharp, searching mind can ask provocative questions, and put forth interesting arguments. All this might be to the benefit of the doctor's sick fund and its members. This is not to say that such interesting exchanges can take place only in informal medicine. Many “formal” doctors are warm, highly patient centred, open minded, and willing to learn from their patients. Some patients, however, even if they are physicians or nurses, can feel intimidated sitting across the desk from a physician, even if the physician is making every effort to be warm and open: and some physicians can, in spite of good intentions, maintain a chilling distance. So although informal consultation may not be the only means to open

physician/patient intellectual exchange, it is a means which should not be ignored.

Even if a doctor gives informal treatment to a friend or colleague during his working hours at a sick fund of which the patient is not a member, how much work time would the sick fund members really lose? Do we have to be stingy misers, insisting upon keeping accounts over every penny? How about a little largesse? The Talmudic saying: “This one has gained, and that one has not lost anything”<sup>15</sup> seems to apply here.

At the beginning of this article, we suggested a distinction between informal medicine for payment and informal medicine for free. Surely a doctor who is working for and receiving pay from a sick fund or private or public hospital or clinic, and who receives “under the table” payment from an informal patient during working hours, is guilty of dishonesty towards his or her employer. The violation is especially serious if the physician uses the employer's facilities for private gain and does not reimburse the employer. If, however, the informal treatment for pay takes place after working hours there seems to be no violation of ethics. If no payment of any kind is received, then even if the treatment takes place during working hours and with the employer's facilities, the employer has no ground for complaint provided that the doctor does not do this too often.

Jewish law, however, makes an interesting argument against informal medicine for free. The Talmud discusses a case where someone has caused bodily injury to another. The injurer is required to compensate the injured monetarily for pain, loss of work time, and medical expenses. The injurer, however, tries to avoid paying medical expenses by offering informal medicine. “Rather than paying you,” he offers, “I will take you to my doctor, who will treat you for free”. To this, the Talmud replies: “A doctor who treats for nothing, is worth nothing” (Babylonian Talmud,<sup>15</sup> 85a). Maimonides urges the patient to refuse the offer and to insist on money for the best available doctor.<sup>16</sup> With all due respect to Maimonides and the Talmud, however, it seems that if the injurer is offering the services of a doctor friend who really is one of the best, it would not necessarily be wrong to accept the informal and free treatment.

The Talmudic remark: “a doctor, who treats for nothing, is worth nothing”, was made only in the context of compensation for injury. Judaism says nothing against free or informal treatment in other contexts. Maimonides worked all day as court physician for the Sultan in Egypt. In the evening he returned to his village and, although exhausted, treated local patients informally until late at night.<sup>17, 18</sup> Maimonides does not state clearly to what extent these patients included indigent people who would have needed treatment for free. Given the long tradition of charity in Judaism, however, as well as that of free treatment for poor people of all faiths in hospitals in Israel before the establishment of the sick funds, it is reasonable to assume that he would not have turned such a person down. Indeed the Hebrew word for charity, *tsedaka*, translates literally as *justice*. Charitable giving—which should include treating the poor for free—is not something that one does voluntarily. One is required by justice to do it.

Christianity has a similar attitude. Dr AK Tharrien, founder of the Christian Fellowship Hospital in Oddanchatram, Tamil-Nadu, remarked: “Christianity encourages all charitable acts as service to God”. He added: “Regarding the issue of doctors' service outside clinic, if it is a charitable act, with no remuneration, it should be encouraged. But in India what is observed is many go for an extra income with no record (to escape income tax). This is unethical (A K Tharrien, personal communication, 2005).



## PROCEDURAL JUSTICE

Is it proper that physicians should make treatment decisions informally, and on their own, without the critical checks and balances of other staff members, nurses, social workers, etc? The answer to this question obviously rests on the nature and seriousness of the decision being considered. Certainly a decision not to resuscitate, or to disconnect a ventilator (to take one extreme), should not be taken by any individual physician, but is a matter for a staff meeting in which opinions of other doctors, nurses, a social worker, family, and patient should be heard. It does not seem likely, however, that informal medicine will often be required to deal with such weighty scenarios as: "Hey, Doc, if you have a spare moment, would you mind pulling the plug for me?" When it comes to less serious and more routine procedures, formal medicine is probably no less informal than informal medicine, in the sense that the physician makes decisions alone, without consulting with other professionals. Of course many decisions will be neither so serious as issuing a Do Not Resuscitate (DNR) order, nor so routine as prescribing an antibiotic for a simple infection. One expects that in such cases a physician treating informally will be just as responsibly circumspect, and just as willing to consult with other professionals, as when treating formally.

## CARING

Heartfelt caring for a patient is a concept that has come up more in the nursing ethics literature than in that of medical ethics. It should, however, be mentioned here. Indeed, informal nursing also exists. So does informal medicine practised by nurses. It might seem that a caring professional would respond unhesitatingly to a patient's request for informal treatment or advice. A professional who *really* cares about the patient, however, would carefully weigh the question whether this specific case is an appropriate one for informal medicine, or whether it should be handled in a more formal context. So in most cases, probably, the concept of *caring* does not really decide any issues either in favour of, or against, informal medicine.

## CONCLUSION

At one extreme of the spectrum, it is clear that a physician treating informally for pay or reciprocal favours on the employer's time and with the employer's facilities is behaving unethically. At the other end, in an informal emergency situation, one who knows how to save life and does not do so is behaving unethically. So it is clear that no generalisation of the form: "Informal medicine is ethical" or "Informal medicine is unethical", is warranted

With respect to non-emergency situations, we may probably conclude in general that when no payment is involved, or when employer's time and facilities are not being used, and when the patient is fully aware of the benefits and risks of a lack of record keeping, then informal medicine is ethically unobjectionable. As we have already mentioned, however, when informal, undocumented treatment presents clear and serious risk to the patient or to the community, the physician should try to persuade the patient to accept formal treatment. If the patient refuses to agree, then in some cases the physician may have to refuse to treat the patient at all.

## GUIDELINES

No generalisation can be made to the effect that informal medicine *is* or *is not* ethical: each request for informal consultation must be considered on its own merits.

When an informal consultation does not entail any danger to the patient or to others, the physician may agree to the request if he so wishes.

If, however, any danger to the patient or to others is foreseen, then the physician must insist on professional autonomy, and consider refusing the request and persuading the patient to accept formal consultation.

If a reportable infectious disease or other serious danger to the community is involved, the physician should refuse informal consultation or treatment, or at least make a proper report even if the consultation was informal.

If agreeing to the request will result in an unfair drain on the physician's time or energy, he or she should refuse politely.

A doctor consulting or treating informally must be just as responsibly circumspect, and just as willing to consult with other professionals, as when treating formally.

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