The Scope of Professional Responsibility

In Chapter 1, several important aspects of the physician-patient relationship were examined: expectations, information exchange, informed consent, and confidentiality. Drawing an analogy to a nation, one could say that most of the chapter was concerned with "domestic relations," since these topics (especially the second and third) deal with issues wholly internal to the physician-patient relationship. However, the topic of confidentiality introduces issues of "foreign relations," that is, matters that reach beyond the domain of the professional relationship and involve other persons (else who would there be to breach confidentiality to?).

In the present chapter this focus on "foreign relations" will continue. First, the boundaries of the professional relationship will be explored (to determine, one might say, the "national boundaries" as a reference point for border disputes with neighboring territories). Second, other loyalties will be explored that could conflict with loyalty, as a physician, to your patient.

1 The Scope of Medical Service

The 1980 AMA Principles of Medical Ethics indicate the goal of professional practice in these terms:

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

Because of the position of respect and authority physicians occupy in society, they are asked by their patients (and sometimes by the society at large) to perform many services, some of which are not obviously medical in nature. Because of their compassion for patients, physicians may try to help them out in a variety of ways, not all of which are forms of "medical services." How can you, as a physician, determine which of these are appropriate? In the following cases, try to determine:

1. which (if any) such opportunities for helping patients you have a professional duty to respond to, even if you are not particularly enthusiastic about getting involved,
2. which (if any) are a matter of your own discretion, such that you would be warranted in getting involved if you chose to do so, but have no obligation to address if you are not so inclined; and

3. which (if any) are really “none of your business” as a physician, such that you would be stepping outside the scope of medical practice if you became involved.

Let us explore this issue by examining a clinical situation that raises these questions in a concrete form. The scene is a family medicine practice. You are the physician. You have a full schedule of patients this afternoon.

1.1 Case: Joyce and Brent Blackspott

Your first patient is Joyce Blackspott.

Joyce (52 years old) and her husband Brent (who is 53) have been your patients for more than ten years, but you have not seen them often during that time. Joyce comes in yearly for a Pap test. Brent follows your recommendation for males in his age group and schedules a complete physical examination every three years. (His last physical was 18 months ago.) One or the other of them has seen you once a year or so for a stubborn sore throat or other minor ailment, but neither has had any major illness. You do not have any social contacts with them, so you do not know them particularly well.

Today, Joyce is here for her annual Pap test. She seems distraught, so you ask if something is troubling her.

She hesitates, but then she summons courage and says, “Oh, Doctor, I don’t know whether there is anything you can do to help; but I don’t know where else to turn.

“The problem is that Brent has this black mole on his back that has been increasing in size over the past several months. I am afraid that it might be cancer. Both his father and his older sister died of cancer, and he has often expressed a fear that he will get cancer. But when I first pointed out to him that this mole seemed to be growing and urged him to have you examine it, he said I must be imagining things. I have tried to talk with him about it several times since, as the mole got larger and larger, but he gets angry and denies that it is a problem. I can tell he is concerned about it himself, though. I suspect he is thinking “What you don’t know can’t hurt you,” but that is not correct at all in this sort of case. There is no way to get him to seek help on his own as long as he refuses to acknowledge this as a problem.

“But he respects you, and I think he would listen to you. Would you contact him and ask him to come in to see you? Then you and I together could try to get him to face his problem and to seek help for it.”
This case raises a number of questions. (Give these questions some thought on your own before reading the next section.)

1. Are there indications that Brent may have a disease?

2. Do you have a professional right to initiate contact with Brent about this matter, since he has not raised the issue himself? To what extent does the answer to question 1 influence your answer here? What other factors influence your answer here?

3. Do you have a professional obligation to get involved with Joyce and Brent's situation? To what extent does the answer to question 1 influence your answer here? What other factors influence your answer here?

4. a) If you decide to approach Brent, as Joyce requests, specify exactly what you would say to him. b) If you decide that you would not approach Brent, specify exactly how you would explain this decision to Joyce.

5. Suppose you contact Brent, and he angrily denies that he has a problem and refuses to come see you about it. Should you pursue the matter further? a) If so, what should be your next step? b) If not, specify what you would tell Joyce at this stage.

1.2 Analysis: Physician Responsibility for Health and Disease

1. Are there indications that Brent Blackspott may have a disease?

The answer to this question is clearly "Yes." If the "mole" is a melanoma, it represents a life-threatening disease.

Of course, it is possible that Joyce is mistaken in her perception that the mole has grown in size. Perhaps a morbid fear of cancer is leading her to imagine or exaggerate what she has observed.

But, all things considered, there seems to be adequate indication of the possibility of a serious disease to justify further investigation. If Brent came in himself with this history, you would certainly want to examine the lesion, and unless it looked obviously benign, you would probably want to biopsy.

2. Do you have a professional right to initiate contact with Brent about this matter, since he has not raised the issue himself?

The problem, of course, is that Brent himself did not come to see you. The awkwardness created by his wife bringing this problem to your attention confirms the point made in Chapter 1, Section 3.1.1 about the way elements of informed consent are built into the social structure of health care. If Brent had come in, his initiative would have indicated willingness to gain awareness of potential threats to his life or sense of well-being and thus could be considered tacit consent to initial steps in diagnosis and treatment.
The existence of an established physician-patient relationship may have somewhat the same effect. Think back to the ideals and expectations for relationships with patients you expressed in the exercises in Chapter 1. Is it compatible with the sort of relationship you seek to establish with patients for you to take this kind of initiative in serving their health needs?

Furthermore, that Brent has seen you regularly over the years—indeed, has fully followed your recommendations for the frequency of visits—may indicate that he considers himself to have "placed his health in your hands." Surely, then, you would be justified in contacting him with regard to any and all information relevant to his health needs that comes to your attention. Tacit consent to this level of initiative on your part would seem to be implied in his practice of continuing to maintain a physician-patient relationship with you.

Suppose strong evidence came to your attention that suggested Brent generally should undergo certain screening exams more often than you had previously recommended. For example, suppose some element of his occupational setting became implicated as a risk factor for a certain life-threatening disease. If you were satisfied with the level of reliability of such information, surely it would be appropriate to contact him (hopefully in a manner that would not unduly arouse his anxiety) and suggest a modification in your previous recommendations. Furthermore, one would expect a positive reaction from Brent at being contacted, for he would be pleased to recognize your concern and thoroughness.

The current situation is not different in principle from this. New information has been brought to your attention that is relevant to Brent's health status, and it seems perfectly appropriate to follow this up by contacting Brent.

If Brent failed to welcome your making contact with him in this way, the reason would probably be either 1) that he is disturbed that his wife brought this information to you and/or 2) that he does not want to face the danger these symptoms represent. But both these factors can be dealt with. The first suggests that caution be exercised in the way he is approached (see item 4 for discussion of this); the second indicates that a part of the task involved is helping him come to grips with the matter.

3. Do you have a professional obligation to get involved with the Blackspott's situation?

We contend that the long-standing professional relationship you have with Brent creates a responsibility for you to take any initiatives necessary to protect and

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1. One important question that arises here is to determine the threshold of reliability that would prompt action on your part. A single case report in the literature suggesting such a connection as a bare possibility may not be enough to prompt contacting Brent. Uncertainty about data reliability has created a dilemma in connection with the results that arrive at physicians' offices from commercial multifactorial screening tests their patients have arranged independently. What is the responsibility of the physician to act upon an abnormal value on such a test?
promote his health, including contacting him to follow up on the information his wife has brought to you. If this sort of action is not now standard medical practice, perhaps it ought to be.

4. a) If you decide to approach Brent, as Joyce requests, specify exactly what you would say to him.

This is where the caution mentioned earlier comes into play. Since there is a possibility that Brent will be disturbed by the fact that his wife brought this information to you, it is important to approach him in a way that would obviate or minimize this reaction. One possible approach is to say, “Brent, your wife has expressed some anxiety that I have been unable to dispel. Help me deal with her worries by coming in and letting me take a look at that mole on your back.” By characterizing it as doing something for his wife, Brent may be persuaded to act whereas he would not admit (perhaps even to himself) that he is worried about the mole.

4. b) If you decide that you would not approach Brent, specify exactly how you would explain your decision to Joyce.

Since this is not the option we recommend, we leave it to those who choose this route to find their own way to deal with this chore that attaches to their choice. Good luck!

5. Suppose you contact Brent, and he angrily denies that he has a problem and refuses to come see you about it. Should you pursue the matter further?

Here again, the justification for any further action on your part would be rooted in your established professional relationship with Brent. There could still be a general question as to whether Brent’s refusal is an informed one. Unfortunately, even if his refusal is not adequately informed, you have no basis (absent an established professional relationship) for intervening. However, given an established relationship, we contend that you would be warranted to take some further steps to 1) urge him to see you for examination of the mole and/or 2) inform him about the risks he is running in refusing to do so.

Perhaps it would amplify this discussion of Joyce and Brent Blackspott to step away from this specific case for a moment and relate their situation to some general points about medical practice.

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2. The law does not appear to recognize a requirement on the patient’s part to base refusals of treatment on as much information as decisions to accept treatment. However, an argument that there is a moral requirement to this effect will be presented and discussed in Chapter 4, Section 2.2.1.D.
2 The "Moral Center" of Medicine

Our understanding of a subject is often heavily influenced by an image of its "heart" or "center." This core example (or "paradigm case" as it is sometimes called) plays an important role in definition and analysis of concepts; it also has a function in determining our sense of values or our judgments of right and wrong. The paradigm case is regarded as "real medicine" in a conceptual sense, and it seems more obviously justified as a field of action for the practitioner. Situations that depart from this paradigm are not only less fully deserving of the conceptual label "medicine" but they also require some justification for being included within professional practice. (There may be an inclination to ask: "What is a nice professional like you doing engaged in an activity like this?"") It may appear that the professionals have, perhaps inadvertently, stepped across the border of their home territory and begun to encroach on foreign soil.

Edmund Pellegrino (1979, 222–230) has called this paradigm situation the "moral center" of medicine. The discussion of expectations in Chapter 1 (and, we would venture to guess, your responses to the exercise in Chapter 1, Section 1.1) points toward a particular conception of this paradigm, which is examined in the present section. As you read, locate your fantasies and reflections about expectations within the spectrum of medical activities described. Also, evaluate your claims. Do you agree that there is one specific type of activity with the central place we describe? Do you agree that the one we identify occupies this position? What implications do these claims have for the expectations of all parties involved? What are specific implications about the situation of Joyce and Brent Blackspott?

2.1 Content of the Moral Center

One pair of authors (Jonsen and Jameton 1977) describes the content of the medical paradigm as follows:

a. diagnosis and treatment
b. of an illness or injury
c. for an individual
d. who presents a complaint
e. within the context of an established therapeutic relationship.

An interaction with all these features clearly present is real medicine. An individual patient presents to a physician with whom a relationship has been previously established, bringing a specific complaint that points toward a clearly defined illness or injury. The physician diagnoses and treats the condition.
(Thought exercise: Are all these elements equally important? If not, rank them in order of their importance to your decision making in specific cases. Keep this ranking in mind in the discussions that follow.)

Pellegrino and Thomasma clearly presuppose something very close to this description throughout their book, but in the following passage, they state the goals of the paradigm medical interaction: “The end of medicine . . . is therefore a right and good healing action taken in the interest of a particular patient” (Pellegrino and Thomasma 1981, 211).

2.2 Importance of the Moral Center

Why is this situation the center of our thinking about medicine? What is so important about it? Several suggestions have been offered.

Jonsen and Jameton (1977, 388–389) point to two factors that give special importance to the relationship: First, there is the fact that the relationship was established through deliberate acts of both patient and physician. Thus it is a relationship that both parties took upon themselves, an especially personal relationship. Second, there is the fact of the proximity of the patient. Here one is dealing with “actual and present persons, not statistical and future persons.” This serves to heighten the physician’s obligations.

Pellegrino and Thomasma (1981, 207–212) also stress two (somewhat different) factors: First, there is the vulnerability of the patient as a result of his illness. The special needs the patient has give rise to an especially gripping obligation for the physician to attempt to meet them. Second, there is the content of the “profession” or pledge made by the physician upon entering the profession of medicine that he or she “can and will help” the patient. By entering the professional field, the physician has made a promise to address the needs of patients.

Charles Fried (1974, 67–78) subordinates all of these more general moral considerations to something much more specific and intrinsic to the relationship:

. . . the relationship of assisting a person in need is an action and a relationship which have a special integrity of their own. They form a unit, a unit of value . . . . (p. 69)

. . . the notion is one of doing unstintingly what it is that one does, though choosing with care the occasions on which one will do it. (p. 75)

. . . this ideal implies an interest and a right on the part of the doctor as well to maintain the integrity of his activity, to work not as a tool or as the bureaucratic agent of a social system, but as one whose professional activity is a personal expression of his own nature, the relationships he enters into being freely chosen, the obligations freely assumed, not imposed. (p. 77)
2.3 The Blackspotts and the Moral Center

In your interaction with Joyce Blackspott, the element of the moral center most obviously missing is item c: the one-on-one relationship between the practitioner and the patient who has the illness. Instead, you are confronted with three entities: the wife’s concern that prompts her to bring the information to your attention; the danger to the husband that the information suggests (although the presence of item b cannot be confirmed until after analysis of a biopsy); and the long-standing relationship of each person to you.

In considering Brent Blackspott as the patient, the chief element of the moral center that is lacking is item d. He refrains from presenting any complaint, although you learn from his wife that he may have reason to come to you.

As indicated earlier, we contend that given 1) the seriousness of the disease and 2) the on-going relationship between you and Brent, intervention is appropriate.

2.4 Additional Cases

What are the limits of this justification? Examine each of the following situations, asking yourself the same questions you did in the situation of Joyce and Brent Blackspott. If you are not willing to draw the same conclusion in each of these cases, try to identify what it is about the situation that makes the difference. [NOTE: The only parts of the case described are the elements that differ from the case of the Blackspotts. Look back at the full statement of that case (Section 1.1) and replace the section in italic with the information given for each case.] Your day in the office continues . . . .

2.4.1 Joyce and Brent Phthisis  Your next patient is Joyce Phthisis.\(^3\)

"The problem is that I am afraid Brent has developed tuberculosis. He had a negative skin test a year ago, shortly after his father developed TB and came to live with us; but in the past few months, he has had a chronic cough, and I have noticed lately that he has coughed up blood several times (although he has tried to keep me from seeing this). I have tried to talk with him about this several times, as the cough seemed to get worse and worse, but he gets angry and denies he has a chronic cough or that he has coughed up blood. I can tell he is concerned about it himself, though. There is no way to get him to seek help on his own as long as he refuses to acknowledge this as a problem."

Consider these additional questions about Brent Phthisis:

1. Does the risk of exposure to Brent Phthisis’ wife and children justify action on the part of the physician in this case?

2. Should the possibility of disease be reported to the area TB control officer?

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3. If this name is unfamiliar, look it up in your medical dictionary!
3. Is there an obligation to warn others? If so, who: Brent's family, his co-workers, other associates, his clients?

2.4.2 Joyce and Brent Enditt  Your next patient is Joyce Enditt.

"The problem is that I am afraid Brent is going to kill himself. He has been getting more and more depressed over the past year, since he was passed over for promotion at work. He has talked about suicide several times in the last few months; now he has bought a shotgun, although he never had any interest in guns before. I have tried to talk with him about it several times, as his depression increased, but he gets angry and denies he has any problem. There is no way to get him to seek help on his own as long as he refuses to acknowledge this as a problem."

Consider these additional questions about Brent Enditt:

1. Is depression a disease?
   a. If not, how does it differ from conditions you would be willing to call diseases? Is this degree of depression obviously less dangerous (i.e., less likely to lead to harm to Brent and others) than, for example, tuberculosis?
   b. If you are willing to call it a disease, on what basis do you do so? Compare and contrast it with other diseases and nondiseases.

2. Should your decision be influenced by the possibility that approaching Brent Enditt might provoke him to carry out his threat? Is this a real danger?

3. What influence is contributed by your close relationship with Brent?

4. What is the influence of medicolegal considerations on your decision whether to intervene?

2.4.3 Joyce and Brent Martini  Your next patient is Joyce Martini.

"The problem is that I am afraid Brent is becoming an alcoholic. He has always had two or three martinis in the evening, but over the past year or so, his drinking has steadily increased to the point that he now drinks himself into a stupor every evening. He often stops by his club on the way home, and he is drunk by the time he gets here. I have tried to talk with him about it several times, as the problem has progressed, but he gets angry and denies he has any problem with drinking. There is no way to get him to seek help on his own as long as he refuses to acknowledge this as a problem."

Consider these additional questions about Brent Martini:

1. Is alcoholism a disease?
   a. If not, how does it differ from conditions you would be willing to call diseases? Is this level of alcoholism obviously less dangerous (i.e., less likely to lead to harm to Brent and others) than, for example tuberculosis?
b. If you are willing to call it a disease, on what basis do you do so? Compare and contrast it with other diseases and nondiseases.

2. What influence should the unpleasant nature of treating alcoholics have on your decision whether to approach Brent Martini? Would you react in the same way if Brent’s problem were increasing obesity, for example?

3. What influence on your decision is contributed by the recognition that there is a high probability of failure in overcoming the condition without a strong personal commitment on the part of the patient to change?

4. What difference does it make to your thinking here that the most successful approach for this problem is not a medical treatment but a support group of laypeople who formerly suffered from this condition themselves (i.e., Alcoholics Anonymous)?

2.4.4 Joyce and Brent Kant Your next patient is Joyce Kant.

"The problem is that over the past year or so, Brent has gradually lost the ability to maintain an erection. We have always had an active sexual relationship, and I have always (well, almost always) been a willing and eager partner. But he has been avoiding sex lately; obviously his problem distresses him. I have read that worrying about this sort of thing often aggravates the problem. I have tried to talk with him about this several times, as the problem has progressed, but he gets angry and denies he has any problem. He just says, "Sex isn’t everything, you know" as if I were the one who has the problem. I can tell he is concerned about it himself, though. There is no way to get him to seek help on his own as long as he refuses to acknowledge this as a problem."

Consider these additional questions about Brent Kant:

1. Is impotence a disease?
   a. If not, how does it differ from conditions you would be willing to call diseases? (Must a condition pose a threat to life in order to classify as a disease, or is it sufficient that it involves disability in some normal human functioning?)
   b. If you are willing to call it a disease, on what basis do you do so? Compare and contrast it with other diseases and nondiseases.

2. What difference does it make to your decision that you might find such a discussion with Brent Kant personally uncomfortable?

2.4.5 Additional Questions: General

1. For each of these cases, list some key ways in which the situation illustrated exemplifies the "moral center of medicine." List some key ways in which it departs from the moral center.
2. Rank the cases from strongest to weakest in terms of the strength of the professional right to initiate contact with the husband.
   a. To what extent does a high index of suspicion that a disease is present influence your answer here?
   b. You were asked earlier to rank the elements of the moral center of medicine in order of their importance to your decision making. What influence did this ranking have on your reaction to these cases? To what extent might a reordering of these priorities change your answer in these cases?

3 Beyond the Moral Center

Medicine extends beyond the core defined by the moral center in a variety of ways. (In terms of the geographical metaphors with which this chapter began, we might say that some exploring is done beyond the borders of the central territory—and perhaps even some homesteading takes place if the territory is found to be hospitable.) However, each step away from the paradigm requires some justification (and even then it may retain a flavor of not quite being real medicine). Let us look at some of these expansion areas.

3.1 Research

3.1.1 Day-to-Day Learning in Clinical Practice The descriptions of the moral center given earlier are incomplete in an important way. The fact is that benefiting this specific patient is not the entire goal in typical clinical interchanges. At the same time the physician is figuring out the "right and good healing action taken in the interest of a particular patient," she is working to strengthen her own clinical skills and increase her general knowledge of specific disease processes. (You can see this goal at work when the physician reads an article that comes across her desk the day after the patient for whom it would be relevant has died or been discharged from the hospital. Preparation for the next patient is suggested.)

This is a research and/or learning component in everyday clinical medicine. You try a new antibiotic with an eye both to aiding this patient and to testing its usefulness for future patients. If the dosage you tried this time appears insufficient, you may increase the dosage for your next patient and see whether effectiveness is improved. If not, you may try a still different antibiotic, or a new combination of them, with future patients.

At least this much of a research orientation is implied in the Section V of the 1980 AMA Principles of Medical Ethics: "A physician shall continue to study, apply and advance scientific knowledge. . . ."
This focus may create conflicts of loyalty within clinical practice. Invasive and expensive diagnostic tests sometimes may be employed in search of a remotely possible "zebra" or "fascinoma"—often to the exclusion of more likely approaches far more effective in addressing this patient's complaint. This fascination with knowledge for its own sake is a self-indulgence. It may have beneficial effects in keeping one's knowledge up to date and one's intellectual skills fresh, but it can interfere with the process of reaching the "right and good healing action" for this particular patient.

Think back to the ideals and expectations for the physician-patient relationship you expressed in the exercises in Chapter 1. Consider whether, and to what extent, the pursuit of knowledge for its own sake is compatible with the sort of relationship you want to develop with patients.

3.1.2 Clinical Research Clinical research is in spirit an extension and formalization of this learning component of clinical practice. As such, it is clearly different in important respects from the moral center of medicine. For the researcher, the goals of the interaction with the patient are not limited to benefiting the individual patient being treated. Rather, there is a coordinate goal of gaining knowledge that will benefit a whole group of future patients. Hence, virtually all of the elements of the paradigm, moral center case are either absent or altered in significant ways. The focus is on gaining knowledge rather than exclusively on diagnosis and treatment (item a) of this specific patient's complaint (items b and d), although helping this patient certainly may be a central goal as well. The intended beneficiary is the group of future patients rather than (or in addition to) this individual patient (item c). And the nature of the relationship (see item e) is changed as a result of this altered focus.

3.1.3 Rationale The rationale for including clinical research as a part of the mission of medicine is that acquiring new knowledge is necessary to enhance effectiveness of the central activity. It will be possible to provide the sort of help patients seek only if we continue to broaden our understanding of the nature of disease and human response to illness and, on this basis, develop new modalities of treatment. Hence research is closely related to the central purposes of medicine, even though it is also to be distinguished from paradigm activities.

3.1.4 Conflicts of Loyalties The danger here of course is that a conflict may arise between one's loyalty to the present patient and the goal of acquiring knowledge that may benefit future patients. Personal motives of eagerness to establish or maintain a professional reputation (e.g., relentless pursuit of the reportable case) may lead to a violation of the loyalty owed to specific patients (i.e., to the comparative neglect of less "interesting" cases). The popular press has offered "exposés" of several instances of alleged wanton disregard for the welfare of patients in the interest of gaining medical knowledge or statistical significance.
However, even with the best motives in the world, it is not easy to avoid difficulties in this area. Complex and difficult judgments must be made, balancing the value of the knowledge to be gained against the risk to the patient/subject present before you. These judgments are made even more difficult by the inevitable elements of uncertainty attending the situation. (After all, if there were not uncertainty, there would be no reason to do research in the area.)

3.1.5 Federal Regulation of Research In recognition of the complexity of these decisions, the federal government has taken action to review and regulate research involving human subjects. The structure for this review comes from the Code of Federal Regulations (CFR), Title 45, Part 46—Protection of Human Subjects (revised as of March 8, 1983). This was devised over a number of years by the National Commission for the Protection of Human Subjects, and has some features worth noting.

A. Decentralization The application of regulatory standards to specific cases is thoroughly decentralized, rather than being assigned to some central bureaucratic office at the state or federal level. The regulations require that each institution in the nation receiving federal funds for research establish an Institutional Review Board (IRB); this body has the responsibility to evaluate specific research protocols.

B. Diversity of Viewpoint Membership on the IRB must be diverse in order "to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects." The research sciences must be represented to provide expertise needed to understand the issues involved in the research project under review, but there also must be representatives of other groups within the institution and from the community.

C. Elements to be Evaluated Requirements that must be satisfied in order to approve a research project include:

1. minimization of risks to the subjects
2. reasonable risks to subjects in relation to the anticipated benefits (if any) to them and the importance of the knowledge reasonably expected to result
3. equitable selection of subjects
4. acquisition of informed consent from each prospective subject or the subject's legally authorized representative [A detailed list of the basic elements of informed consent is included in the regulations (45 CFR 46.116).]
5. appropriate documentation of informed consent
6. provision for monitoring the data collected to ensure the safety of subjects
7. provisions to protect the privacy of subjects and to maintain the confidentiality of data
8. appropriate additional safeguards to protect the rights and welfare of especially vulnerable subject populations (45 CFR 46.111).
However, it is left to the local IRB to determine, in terms of its own understanding of the elements involved, whether a given research protocol satisfies these requirements.

**D. Expedited Review** Procedures that involve "no more than minimal risk" may be subjected to expedited review by a subcommittee or representative of the IRB, rather than having to await full-scale review by the entire IRB.

**E. Wide-Ranging Authority** The IRB has authority to monitor the informed consent process and the conduct of the research, and to engage consultants and advisors to assist in evaluating the project proposal or activities involved in its execution.

The goal of this review process is to assist investigators, with a minimum of bureaucratic hassles, in resolving the complex loyalty conflicts that arise in designing research. (Some researchers may dispute this analysis, seeing plenty of "red tape" involved in the process as it stands—but this is a matter of perspective.)

### 3.2 Other Potential Conflicts of Loyalties

Parallel issues occur in other areas in which loyalties that develop for the physician may conflict with loyalty to the immediate patient.

#### 3.2.1 Clinical Training

Here again, goals other than the healing action for this individual patient are important—in particular, training future practitioners who can aid future patients. The clinical teacher deals with the immediate patient indirectly, through the clinical interaction of the student practitioner; the trainee deals with the immediate patient, with the twin goals of rendering care and developing personal skills for future use. The rationale for this enterprise is clearly the need to provide skilled health care for other patients now and in the future.

The notion of the moral center implies some important guidelines for teaching activities. (1) Students should not initiate procedures on patients until they are sufficiently skilled to render "the right and good healing action for a particular patient." This core value must not be compromised in the interests of training. (2) Clinical teachers must convey the other elements of the moral center in their own interactions with patients (and with students, insofar as similar norms are applicable) to provide a role model for their students.

#### 3.2.2 Company Physician

The physician employed by an industry promotes the health of workers. This may be accomplished through a variety of activities, including:

1. Monitoring the health effects of the work environment and perhaps establishing a baseline for potentially hazardous elements in the environment.
2. Preemployment physical examinations to determine the fitness of a person for working in that environment. (This may necessitate a detailed individual health history to assess its relevance to conditions in that environment. For example, the risk of lung damage for workers in a uranium mine is apparently greatly increased if they smoke. Hence, a physician must inquire about this risk factor in a preemployment physical.)

3. Physical examinations to determine the safety to the employee and others of having that employee return to work at a certain stage of recovery from a job-related injury.

4. Physical examinations to determine the safety to the employee and others of having that employee return to work at a certain stage of recovery from illness or non-job-related injury.

However, these goals may conflict in several ways with loyalties to the individual patient. These conflicts are addressed by the Judicial Council of the AMA (1984, 23):

5.09 Confidentiality: Physicians in Industry. Where a physician’s services are limited to pre-employment physical examinations or examinations to determine if an employee who has been ill or injured is able to return to work, no physician-patient relationship exists between the physician and those individuals. Nevertheless, the information obtained by the physician as a result of such examinations is confidential and should not be communicated to a third party without the individual’s prior written consent, unless it is required by law. If the individual authorizes the release of medical information to an employer or a potential employer, the physician should release only that information which is reasonably relevant to the employer’s decision regarding that individual’s ability to perform the work required by the job.

A physician-patient relationship does exist when a physician renders treatment to an employee, even though the physician is paid by the employer. If the employee’s illness or injury is work-related, the release of medical information as to the treatment provided to the employee may be subject to the provisions of workers compensation laws. The physician must comply with the requirements of such laws, if applicable. However, the physician may not otherwise discuss the employee’s health condition with the employer without the employee’s consent or, in the event of the employee’s incapacity, the family’s consent.

Whenever statistical information about employee’s health is released, all employee identities should be deleted. (IV)

One interesting aspect of the foregoing statement is the insistence, even in the situations in which no physician-patient relationship is in force, that the duties of confidentiality still must be carried out. One would expect parallel judgments about other loyalties inherent in the physician-patient relationship.
3.2.3 Military Physician  The physician in the military faces a similar sort of dual loyalty. If the absolute best interests of the patient were the sole consideration in the military physician's mind, the prime advice to be given to every patient would undoubtedly be "Go home. You can get hurt here." Service in battle is obviously fraught with hazards, and even military training carries considerably more risk of injury than almost any civilian occupation.

However, as a military employee, the physician is committed to the goal of preserving and enhancing the patient's capacities to serve in the organization. If the physician accepts the premise that maintenance of a military force has a social value, then he may not have special difficulties of conscience about promoting this goal. However, even then there is still the problem that this goal may sometimes conflict with what is felt to be in the best interests of the patient's health.

One step toward reconciling these dual loyalties is to recognize that another aspect of one's goal is an attempt to minimize the risk to the individual patient. This can be accomplished through careful monitoring of the health status of individuals, as well as evaluating the risks inherent in proposed activities.

The physician also is obligated, by virtue of a pledge made upon joining the armed forces, to follow detailed regulations concerning the practice of medicine. On occasion this may conflict with specific professional judgments; thus the individual will have to consider whether to abide by the regulations in the situation at hand. (For examples, watch any episode of "M*A*S*H").

3.3 Conflicts of Loyalties: Toward a Policy Solution

How can the conflicts of loyalties arising in these and other situations be avoided and/or resolved? Several proposed policy solutions will be discussed in the present section.

3.3.1 Absolute Priority to the Patient's Welfare  The traditional way of dealing with this sort of situation is to insist that the patient's welfare take absolute priority in any situation of conflict. This, for example, is the spirit of the following provision from the Declaration of Geneva: "The health of my patient will be my first consideration." However, this sort of statement is extremely vague and thus may not be easy to apply in concrete situations.

Furthermore, it seems unrealistic in the extreme form in which it is stated. Surely it is not unreasonable to increase the cost (or even the risk) to a given patient by a small amount (say, by ordering an additional blood study that may not be absolutely necessary for effective management of this patient's case) in the interest of gaining knowledge that could provide considerable benefit to future patients. After all, it can be argued that patients have some obligation to contribute to medical knowledge, since they are beneficiaries of past research in the care they have received.

This standard can serve usefully, nevertheless, as a focus for self-examination: which loyalties have primacy in your own decisions? But more concrete guidelines are needed to structure evaluation of choices and motives.

3.3.2 The Golden Rule Another guideline that has been appealed to is the Golden Rule: "Do unto others as you would have them do unto you." However, this may have problems, especially in the research context. Stated without restrictions, the Golden Rule can serve as an invitation to impose our own personal value choices on other people. The clinical researcher, for example, is likely to strongly favor research values and thus would probably be willing to be used as a subject of clinical research, if appropriate. (Witness the many researchers who have volunteered as subjects in their own or colleagues' projects.) But the fruits of clinical research may not be valued as highly by other patients, and thus it would be a violation of their own value priorities to apply the Golden Rule to them in this way.

3.3.3 Informed Consent "The best way to tell whether the shoe pinches is to ask its wearer." Similarly, the best way to determine whether a given step to promote knowledge would be acceptable to the patient is to ask the patient. More generally, informing the patient of possible conflicts of interest can put the individual on guard so that later choices can be monitored from that perspective. For example, with regard to one specific area of possible conflict, the Judicial Council of the AMA (1984, 14–15) relies on disclosure as a primary patient protection:

4.04 Health Facility Ownership by Physician. A physician may own or have a financial interest in a for-profit hospital, nursing home or other health facility, such as a free-standing surgical center or emergency clinic. However, the physician has an affirmative ethical obligation to disclose his ownership of a health facility to his patient, prior to admission or utilization.

Under no circumstances may the physician place his own financial interest above the welfare of his patients. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient or prolong a patient's stay in the health facility for the physician's financial benefit would be unethical.

If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit. (II)

A parallel procedure could be helpful in other areas of possible conflict, such as clinical teaching, clinical research, company employment, or military status. In each case, revealing to the patient the potential conflict is a first step. This should be followed by a thorough provision for informed consent for each specific element of the interaction. A willingness to share with patients the basis for
recommendations being made is essential to allow them to resolve for themselves any questions about the influence of external loyalties. When a given procedure serves primarily an external goal (e.g., the blood study for clinical research purposes), this could be explained to the patient. If the patient is convinced of the value of this purpose, he will agree to the procedure. If the patient cannot be made to see the point, perhaps it should not be done.

3.3.4 Peer Review Traditionally, one powerful safeguard against overzealous pursuit of loyalties that conflict with the welfare of patients has been various formal and informal mechanisms of peer review. The most formal variety of peer review takes place in hospital practice, through tissue review, death review, and quality-assurance review procedures.

The cooperative nature of hospital practice (which will be discussed in some detail in Section 3.5) also provides additional peer review. The consultants called in to assist with aspects of a patient’s care will review the entire chart and thus have an opportunity to evaluate the decisions being made by the primary physician and by other consultants involved in the case.

The teaching hospital intensifies this element of peer review still further. Cases are discussed in depth by a variety of faculty physicians, even without formally requested consultations; in addition, the questioning and intellectual exploration of the issues by physicians-in-training may prompt rethinking of all elements of decision making.

Less formally, the medical community’s “standard of care” has an influence on the decisions of individual physicians. The effect of this via its possible use in legal proceedings is perhaps the most obvious basis of its appeal, but this is far from the whole story. A consensus reached by the professional community on an issue is to be taken seriously in one’s own decision making on the matter.

Trends are developing that may establish national norms by specialties, and perhaps even lead to the formation of algorithms for clinical decisions. If these continue to gain acceptance, they may become the basis for evaluation in much of the peer review process. This development would be regrettable, in our judgment, if it resulted in the application of these algorithms in a mechanical way. Much to be preferred are case-by-case judgments based on interpretation of the particulars of the individual situation and on standards that have gained understanding and acceptance through thorough debate among those who apply them.

Another mechanism that can serve as a safeguard against gross violations of professional ethics is the possibility of professional sanctions for improper practice.

One issue for discussion is the extent to which peer review and other “checks and balances” are likely to be preserved in the forms of medical practice likely to predominate over the next few decades.
3.3.5 Legal Liability  The spectre of a malpractice suit can also serve as a safeguard against improper choices among conflicting loyalties. One is likely to think through a choice especially carefully if he realizes that it might have to be explained and defended in a courtroom. (This is not to say that the current increase in the number of malpractice suits is wholly benign in its effects. Our claim here is only that the possibility for legal redress by the patient may have some good effects, even though other effects may be far from beneficial to anyone concerned.)

3.3.6 Other Safeguards  Additional mechanisms may help to guard against conflict of interest. For example, the American Heart Association has considered a policy stipulating that the cardiologist who determines the need for coronary arteriography ought not be the person who does the procedure (and thereby profits from it). This is intended to remove any temptation of making such a decision on the basis of profit motives.

Similarly, the following guideline might be proposed as a device for checking your motives in connection with a decision you face: Consider whether you would still regard the procedure as necessary if it were to be carried out by (and thereby profit the specialist you most dislike personally. If you are sufficiently convinced of the clinical value of the procedure to answer affirmatively, then the procedure is probably needed.

3.4 Family Medicine

As the goal of family medicine is to take the family as the unit of care, it departs from item c of the paradigm. This may create problems in practice when the interests of the individual appear to conflict with those of the family unit. [For one example of this sort of case, see Eaddy and Graber, (1982).]

The rationale for this step beyond the paradigm is that this wider focus is adjuvant to the central, individually-oriented practice, since the roots of an individual patient’s problem and/or the means to alleviate it may lie in family dynamics and home environment.

3.5 Team Care

Just as focus on more than one patient is a step away from the moral center, so is involvement of more than one health practitioner. The “established therapeutic relationship” referred to in item e of the paradigm is clearly a one-on-one relationship.

The rationale for this step away from the paradigm is to enhance the effectiveness of treatment. The burgeoning complexity and technical sophistication of today’s medicine make it impossible for the primary physician to master all the
skills required to render ideal medical care for all patients at all times. This has led to specialization and differentiation of roles in the health professions and to cooperative team efforts in dealing with individual patients.

These developments present three especially important challenges:

1. To preserve the strengths of the traditional physician-patient relationship with the primary physician in an atmosphere of diversified (fragmented?) treatment.
2. To foster appropriate features of the physician-patient relationship (notably trust, honesty, and candor) with other members of the health care team.
3. To develop cooperative working relationships among members of the health care team for the benefit of the patient.

3.5.1 Expectations in Interprofessional Relationships The following exercise is designed to help you think about these issues before reading the guidelines offered in the following sections. Think of specific examples from your own experience in dealing with consultants. Answer the following questions by generalizing from elements of these situations that you found especially satisfactory and elements you found frustrating. The first exercise focuses on relationships with physician consultants; the second focuses on dealing with nurses, technicians, and other nonphysicians involved in cooperative efforts in the care of patients.

A. Physicians

1. Spell out what you expect from consultant physicians in each of the following areas:
   
   a. trust in professional integrity and competence
      — truthfulness
      — dedication to the moral center
      — shared commitment to the best interests of the patient
      — upholding your relationship with the patient
      — providing your standard of care
      — courtesy and mutual respect
   
   b. communication with you, as primary physician
   
   c. communication with the patient
   
   d. communication with others involved in the patient’s care
   
   e. independence (initiative?) in planning and carrying out elements of patient care
   
   f. other (specify):

2. In what areas of expectations do you think physicians are likely to disagree?

3. Where you perceive discrepancies between your expectations and those of others, what steps could be taken to resolve or prevent misunderstandings and/or conflicts?
4. What expectations do other physicians involved in consultation rightfully have of you as the primary physician?

5. Where there are expectations you are unwilling to satisfy, what steps could be taken to resolve this discrepancy?

6. What obligation does the primary care physician have to evaluate the competency of the consultant? What are the limits of his capabilities to do this?

B. Nonphysician Practitioners

1. Spell out what you expect from nonphysician cooperative practitioners in each of the following areas:
   a. level of competence
   b. professional integrity:
      — truthfulness
      — dedication to the moral center
      — shared commitment to the best interests of the patient
      — upholding your relationship with the patient
      — providing your standard of care
      — courtesy and mutual respect
   c. communication with you, as physician
   d. communication with the patient
   e. communication with others involved in the patient’s care
   f. independence (initiative?) in planning and carrying out elements of patient care
   g. other: __________________________________________

2. What expectations in these areas do you think nonphysician practitioners have for themselves?

3. Where you perceive discrepancies between your expectations and those of others, what steps could be taken to resolve these?

4. What expectations do other practitioners rightfully have of you as physician?

5. Where there are expectations of you that you are unwilling to satisfy, what steps could be taken to resolve this discrepancy?

6. In general, what key differences do you see between interactions among physicians and interactions with nonphysician practitioners?

Difficulties in interprofessional relationships are illustrated in the following case. As you read it, compare the relationships illustrated with the expectations you just outlined.
3.5.2 “The Compazine Incident”

Background

I was a second-year resident on an ICU service, functioning as an intern once again. It was a rough service with very ill patients, long intensive hours, and, unfortunately, an attending physician who was not very supportive. This attending frequently relied on the information given by the ICU nurses (whom he knew well) rather than the information given by the “interns” and the supervising resident.

This incident began with the admission of a patient who had just been discharged from another hospital, two weeks after a massive infarction of the anterior myocardium, giving rise to an early ventricular aneurysm. He had been doing well at home until he developed some angina-like chest pain and took a nitroglycerin. He promptly passed out and was brought by [the Emergency Medical Squad] to the emergency room, where he began to vomit. His vital signs were stable, but since he had ST segment elevations across the precordium on EKG, he was admitted to rule out extension of the previous myocardial infarction.

The Incident

The incident was precipitated by the supervising resident insisting that I give this elderly gentleman an intravenous bolus of 100 mg of lidocaine. I felt this was too large a bolus for an older person. However, the resident insisted. The large bolus was given and the patient promptly began vomiting and developed paraesthesias. We finally stabilized the patient and admitted him to the ICU with an intravenous drip of lidocaine at 2 mg per minute. He was still nauseated, so we were allowing him only clear liquids by mouth. At approximately 2:00 AM, I received a call from an ICU nurse saying that the patient was nauseated and had just vomited. I ordered that the patient be restricted to nothing by mouth and be watched closely. The nurse asked if I would order Compazine to be given for the nausea and I said no.

Fifteen minutes later I received a frantic call from the same nurse saying that the supervising resident had ordered IM Compazine to be given seven minutes ago and now the patient’s blood pressure was 60/0 and he was comatose.

After a quick burst of profanity on my part, I said that I would be right down and raced to the ICU. The patient was as the nurse described him. Fortunately, he quickly responded to IV fluids and Trendelenburg positioning. After the patient’s vital signs stabilized, I notified the supervising resident, who rushed over to the patient and began giving orders to increase the IV rate. I told him that I thought that the Compazine may have been responsible for the hypotensive episode. He naturally disagreed with me, but I let the matter drop since there was a lot of emotion involved at that time.

The patient recovered uneventfully, but I was furious with both the supervising resident and the nurse who had deliberately circumvented my order. (It turned out that she had been unhappy with my refusal to order Compazine and had sought out the supervising resident and asked if he would order Compazine, not telling him
what I had said.) The next morning I sought out the head nurse of the ICU. After I told her my side of the story, she began to lash out at me, claiming that I was not interested in my patients and that the nurse in question had to actually ask me to come down and take care of the patient when his blood pressure dropped. In addition, she began to tell me that she was not comfortable with a “non-cardiologist” (meaning me) taking care of a cardiac patient in the ICU. At this point, I went from angry to livid. With poorly concealed rage, I informed her that I was very angry with nurses circumventing our (the interns’) orders on a regular basis and that if they have doubts about our orders, they should bring them up with us directly or with the attending on rounds. I also told her that the nurse on duty the preceding night was lying outright when she stated that she had to insist that I come down to see my hypotensive patient.

Gradually we both calmed down. It turned out that the nurses felt that they should be more involved in the treatment of patients. I agreed to try to involve the nurses more in the treatment plans for the patients. However, I added the reservation that I didn’t feel that the nurses should be managing the care of the patients. The head nurse didn’t answer; she pursed her lips and turned away.

Discussion

The issue raised in my mind surrounds what to do when a nurse feels that she should manage the patient’s care and deliberately circumvents your orders. To what extent should you involve the nurses in the treatment plan for the patient? Was I as negligent of my patient’s care as the head nurse claimed? I felt that I was being very diligent in the care of my patients and that my patients were doing very well in general. How do you deal with the resentment you feel when everybody begins to treat you like an intern again? More specifically, what do you do when your supervising resident (who is also a second-year resident with less ICU experience than yourself) insists on your doing things that you feel are inadvisable? How big a fuss should you raise regarding the Compazine incident and the subsequent behavior of the nurse when it is going to put you in conflict with your supervising resident, the nurse on duty, and the head nurse as well? (Kushner et al. 1982, 128–130)

NOTE: If you are a medical student, for whom the status of intern is a goal to which you aspire, you may have difficulty appreciating the author’s feeling that it is demeaning to be “functioning as an intern once again.” But take our word for it: once having endured their prescribed sentence in that status, residents are not eager to be thrust back into the role. If you are a practitioner who is confident that days of functioning as an intern are firmly behind you, you may also escape the grip of the emotions conveyed in this story. In this case, translate the character of the supervising resident into a specialist you have consulted whose demeanor toward you makes you feel like an intern again.
3.5.3 Case Analysis This case situation illustrates virtually everything that could go wrong with interprofessional interactions. Communication was inadequate on all sides, roles were ill-defined, and personal feelings interfered with careful judgment serving the interests of the patient. Let us examine these problems in detail.

A. Resentment To begin, the author of the case carries into the situation considerable resentment, which undoubtedly influences his perception of events. Some of the sources of these feelings are:

1. "the resentment you feel when everybody treats you like an intern again"
2. being subordinated to a supervising resident no further advanced in training than the author, and with "less ICU experience"
3. "an attending physician who was not very supportive." In particular, he "frequently relied on the information given by the ICU nurses (whom he knew well) rather than the information given by the [house staff]." (This remark also suggests underlying negative feelings toward the ICU nursing staff in advance of the events recounted.)
4. anxieties about the ICU setting, suggested when it is described as "a rough service with very ill patients [and] long intensive hours."

Some of these elements point toward conditions that ought to have been addressed in advance either by the author or by those supervising this training program. If the roles of the attending physician, the supervising resident, and the ICU nursing staff had been clarified, perhaps a good deal of this resentment would have been avoided and the incident would have featured more cooperation and negotiation and less emotional confrontation.

B. Supervising Resident In addition to the general underlying resentment at the supervising resident's role, two specific incidents cause difficulties for our author:

1. his insistence on a dosage of lidocaine that the author felt was "inadvisable"
2. his responding to the nurse's request for Compazine without checking this out with the author.

Both of these problems stem, in part, from circumstances of the training setting. The author of the case appears to have primary responsibility for the care of the patient, but his training status limits his authority. (However, it would be unrealistic to ascribe the whole problem to the training setting. Sometimes consultants act in similar ways with regard to primary care physicians when called in to consult on a case.) Furthermore, even in the context of training, key elements of the ideal procedure for consultation should be observed (see Section 3.5.4). This would not only have the educational function of preparing the participants for interactions in which they will engage in the "real world" of practice, but it could have the practical benefit of heading off resentment, such as the author felt at the way things were handled.
For example, the supervising resident should have explained the reasoning behind the initial lidocaine order, thus gaining willing agreement by negotiation and persuasion instead of relying on an authoritative order. If the two could not agree, a third professional should have been brought into the discussion to arbitrate the disagreement. (In this setting, the third person probably would be the attending physician; in a practice setting, it could be an additional consultant.) When the nurse called asking for Compazine, the resident should at the very least have contacted the author to discuss the matter before giving the order.

C. Nurse  Several elements of the interaction with the staff nurses (and one of them in particular) introduce difficulties:

1. The author is troubled, in general, by the desire on the part of the ICU nurses for a greater role in patient management.

2. He is disturbed further by the extent to which the attending physician appears to validate these desires by taking seriously the nurses’ evaluations of the patients’ conditions.

3. The telephone call at 2:00 AM may have been regarded by the author as no more than a routine minor nuisance. However, there are indications that it had greater significance than this for the nurse involved. Although she did not explicitly ask him to come down to assess the patient and give her guidelines for managing his continuing nausea, this is probably what she really wanted and expected. (It is likely that his failure to meet her expectation here is the basis of her later charge that he neglected his patient and did not come down until asked.)

4. When the author refused to order a medicine the nurse judged was needed, she contacted the supervising resident—and did not tell him the whole story about the situation.

5. She accused the author of failure to respond to her need for help with the patient until asked.

These problems could have been greatly minimized (if not avoided entirely) by acknowledging the contributions and concerns of the nursing profession and, in particular, an explicit definition of the role of the staff nurses on this unit. The particular disagreements could have been resolved by negotiation and discussion on the basis of this general understanding (see Section 3.5.5).

3.5.4 Consultation with Other Physicians

8.03 Consultation. Physicians should obtain consultation whenever they believe that it would be helpful in the care of the patient or when requested by the patient or the patient’s representative. When a patient is referred to a consultant, the referring physician should provide a history of the case and such other information as the consultant may need and the consultant should advise the referring physician of the results of the consultant’s examination and recommendations
relating to the management of the case. A physician selected by a patient for the purpose of obtaining a second opinion on an elective procedure is not obligated to advise the patient’s regular physician of the findings or recommendations. (V)\(^5\) (Judicial Council of the AMA 1984, 28)

Using this statement as a basis, William Kammerer and Richard Gross (1983, 1) developed a list of nine ethical principles of consultation:

1. Consultations are indicated
   a. “upon request”
   b. in doubtful or difficult cases
   c. when they enhance the quality of medical care.
2. Consultations are primarily for the patient’s benefit.
3. A case summary should be sent to the consulting physician unless a verbal description of the case has been given.
4. One physician should be in charge of the patient’s care.
5. Overall responsibility for the treatment of the patient remains with the attending physician.
6. The consultant should not assume primary care of the patient without consent of the referring physician.
7. Prompt response should be made to consultation requests.
8. Discussions in consultation should be with the referring physician, and only with the patient with the prior consent of the referring physician.
9. Conflicts of opinion should be resolved by a second consultation or withdrawal of the consultant; however, the consultant has the right to give his opinion to the patient in the presence of the referring physician.

Two themes in these guidelines especially raise questions. First, the provision for consultation upon request invites attention to your personal reaction when a patient requests a consult. The right of patients to choose their physicians (including consultants) is firmly established in law and professional ethics, but this does not make it easy to take at an emotional level. Are you able to accept this request graciously, without viewing it as a sign of a lack of confidence in your abilities?

Some physicians find a patient request for a consult most difficult to accept when they themselves are unsure of their management of the case, since it may show that the patient has detected the physician’s uncertainties. Other physicians, in contrast, are most disturbed by a patient request for a consult when they are most confident in their handling of the case, since it may show that their self-confidence has not been communicated to the patient.

In fact, the patients’ reasons for requesting a consult may not be due to either of these factors. It may stem from something else entirely. Sometimes such a request is an expression of psychological denial ("Maybe the next doctor will not tell me

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5. We assume the consultant would be obligated to communicate with the patient’s regular physician about the case if the patient requested this be done.
this disturbing news’) or unrealistic expectations (‘‘Surely a specialist can rescue me from this fate’’). It is always wise to explore the reasons for such a request with the patient (in a nonthreatening and nonjudgmental manner, of course). By this means, they can be guided to the consultant who can best meet their realistic expectations, and unrealistic expectations can begin to be dealt with.

Second, the guidelines dictate that the primary physician remain in control of all aspects of care (especially items 4–6). These guidelines appear to have been developed with only the inpatient situation in mind. In the hospital a consultant might come by the patient’s room to do an examination, order diagnostic tests, etc., and leave the room without explaining any of his conclusions to the patient. After all, reporting to the primary physician can be direct and prompt, and the primary physician will be coming by to convey these reports to the patient in a short while. However, it would be too much to expect an outpatient to keep an appointment with a referral specialist, pay for the visit, and leave the office without learning anything about the consultant’s impressions, the results of tests, or advice for management of the case. The patient’s next appointment with the referring physician may not be for several days, a long time to wait for information from the consultation.

Furthermore, in today’s highly technical era, it is not uncommon (even with a hospitalized patient) for a physician to request “consult and manage,” which in effect turns over an aspect of the patient’s care to the consultant. However, the guidelines previously cited appear to recognize the legitimacy only of the “consult and advise” category of consultation.

The development of a consult-and-manage form of consultation is an attempt to capitalize on unique or special skills. As such, it involves trade-offs among myriad important values, including notably the sacrifice of the coherence and continuity of care provided by having one primary physician making the final decisions for all aspects of care, to gain the increased technical sophistication that a highly trained subspecialist can bring to management of the case. However, it is not enough to strike a temporary compromise between these values covering only this particular case. There should be an attempt to establish permanent procedures that would preserve both these sets of values to the highest degree possible.

Thus, for example, it is imperative that mechanisms be developed to enhance communication between physicians. Even if the primary physician cannot personally make the final decision on every aspect of care, he or she ought to be kept well-informed about on-going developments—and in a more timely fashion than a dictated note appearing on the chart a day or more later (or, in the outpatient situation, a letter that may take several days to arrive at the referring physician’s office). Furthermore, a burden is created for both the primary physician and the patient when multiple consultants present the patient with an uncoordinated array of information. This can create even more confusion when timely communication with the primary physician is lacking. In this situation the primary physician may
be left to question the patient about what the consultant said and to piece together the picture from the patient's possibly fragmented and confused recollections.

We do not propose a set of rigid rules of consultation etiquette as an alternative to the set quoted earlier. In our view no set of rules left to interpretation by each practitioner involved would be adequate to resolve the problems arising in this area. What is needed most urgently is face-to-face accommodation of expectations on both sides by the parties involved. (If a face-to-face encounter is not feasible, an ear-to-ear telephone contact may be equally effective. Communication by letter does not allow the same give-and-take, but it can be effective if it includes the elements being discussed here.) Just as we earlier stressed the important role of an individually negotiated doctor-patient accommodation (Chapter 1, Section 1.2.4.B.2), we urge negotiation of a parallel "doctor-doctor accommodation."

There may be several ways to structure cooperative working relationships to accomplish these goals, although coordination is unlikely to develop without an explicit effort to bring it about. All parties involved must communicate their expectations to the others, and a mutually satisfactory working relationship must be negotiated. The exercise in Section 3.5.1.A—in which you stated your expectations of collaborators—is a first step toward this goal.

A distinction was drawn in Chapter 1 between a doctor-patient accommodation, worked out with regard to a specific set of interactions, and a doctor-patient relationship, which includes a relatively permanent set of mutually accepted groundrules for interaction. Similarly, a parallel distinction is applicable between referring physician and consultant. The initial dealings with a new consultant may require explicit and detailed discussion about mutual expectations. However, after working together on a case or two, expectations should be clarified sufficiently that repeatable patterns of interaction will have become established.

New situations may, of course, alter expectations and thus require fresh discussion and accommodation. For example, a consultation request entered on the Friday afternoon before a big football game at the local university may invite a more independent role by the consultant in patient management than one entered on a typical Tuesday morning. For their part, however, consultants may be less eager to offer on-going management in these Friday afternoon cases than in Tuesday morning ones. These variances in expectations ought to be settled in advance on the basis of discussion, lest management of the patient's case be subject to harmful delays.

More serious, physicians sometimes develop doubts about their competence (either generally or in certain areas), and they may deal with them by increasing the frequency of consultation requests and/or expecting a more active management of the case by consultants. (This response from physicians is admirable in that it shows an overriding concern for the welfare of the patient as well as an absence of vanity.) This may also make physicians reluctant to engage in face-to-face discussions of the case with the consultant for fear that the gaps in their knowledge
will become manifest. The skillful and compassionate consultant will respond to these requests in a way that minimizes embarrassment to the referring physician and, ideally, will help him restore self-confidence (perhaps through the consultant’s continuing education function,\(^6\) by increasing his knowledge base in the area).

Related to this is the thorny question of whether a consultant can work effectively with a referring physician whose competence she doubts. On one hand the assistance of a consultant may result in better care for the patient than if the incompetent practitioner handled the case alone. However, for the consultant to “bail out” the physician on one occasion may contribute to the continuance of substandard practice with other patients, and obviously the consultant cannot monitor every aspect of every decision. Here again, the educational role of the consultant may be a partial remedy. But in cases of extreme incompetence, the consultant has an obligation both to patients and the profession to initiate stronger remedial action. Section II of the 1980 AMA Principles says firmly: “A physician shall . . . strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.” The consulting physician may be in an especially appropriate position to carry out this mandate.

In short, physicians involved in consultation need to be as sensitive to the variations and complexities of interactions with other physicians as they are to the individual needs of each patient. Just as physicians maintain distinctive patterns of interactions with different patients, they must develop individualized patterns for working with professional colleagues.

Different ways of enlisting other physicians include:

1. **Consult and advise.** The primary physician retains most fully the management of the case. The consultant’s expertise is sought, but only as one element taken into account in the decision to be made by patient and referring physician. The only doctor-patient accommodation in this situation is between patient and primary physician. The consultant is represented only by means of a doctor-doctor accommodation with the referring physician.

2. **Consult and manage.** The primary physician will continue to assist the patient in making decisions, thereby providing coordination and a certain amount of continuity of care. However, much more of the decision making (especially with regard to technical details of care) is transferred to the specialist. Each physician will need to work out an individual doctor-patient accommodation with the patient, as well as a doctor-doctor accommodation with each other.

3. **Referral, but continuing to follow.** The referring physician seeks to maintain the doctor-patient relationship, perhaps because it is a relationship of long

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6. On this role of the consultant, see Howard Brody’s description of the “good clinical consultant” (Brody, in press).
standing and is expected to continue with regard to other of the patient's health care needs. However, decision making with regard to specific aspects of care in this situation is turned over almost entirely to the specialist. One way of stating this point is to say that the doctor-patient accommodation in this situation is worked out between specialist and patient, with little if any participation by the referring physician. He will be represented through a general, on-going doctor-patient relationship (and perhaps by doctor-patient accommodations with regard to other aspects of treatment), but he will have little involvement in the accommodation concerning this aspect of treatment. The doctor-doctor accommodation is also altered in this situation. The specialist has no duty to confer with the referring physician about specific treatment decisions prior to initiating doctor-patient accommodations with the patient.

4. **Referral.** The management of the patient's condition is turned over entirely to the specialist, and day-to-day coordination of treatment decisions with the referring physician is unnecessary. The doctor-patient accommodation is worked out entirely between the patient and the specialist. The doctor-patient relationship with the referring physician is temporarily suspended, and a deeper relationship may begin to be established with the specialist. Doctor-doctor accommodation takes a different form as well. The only necessary contact may be communication with the referring physician upon discharge of the patient, to inform him what treatment was carried out and, especially, its implications for the patient's continuing health-care needs.

Doctor-doctor accommodation is especially important in the face of recent changes in organizational structures in medicine. In the past, primary-care physicians exercised some control over subspecialists indirectly through their selection of consultants. If dissatisfied with aspects of the interaction with a consultant, the primary-care physician could stop referring patients to that doctor and choose another practitioner of the same subspecialty. However, organizational structures such as HMOs, mixed-specialty group practices, PPOs, and the like may significantly limit the primary-care practitioner's range of freedom here. But this makes it even more imperative that satisfactory working relationships be established through explicit negotiations.

We have stressed the importance of the working relationship between the referring physician and the consultant, but we do not suggest this is the only basis for selection of a consultant, nor that it is always the decisive consideration. Indeed, we believe that technical competence is of primary importance. If you are convinced that a particular specialist possesses unique skills that would contribute to the best possible treatment for your patient, you have an obligation to refer the patient to him or her—even if your working relationship with this physician is far from ideal.
3.5.5 Relationships with Nonphysician Practitioners  A similar accommodation is necessary to develop working relationships with nurses and the variety of other nonphysician practitioners involved in patient care. We might speak of still another sort of informal working agreement: the doctor/limited-practitioner accommodation. However, this gives an air of simplicity and unity to what necessarily must be myriad individual negotiations with many different practitioners. The diversity here is likely to be even greater than in doctor-doctor accommodations.

A great many nonphysician practitioners in the health-care setting covet the respect, economic standing, and traditional independence of action of the physician. For example, in "The Compazine Incident," there was mention of the interest of ICU nurses in "more involvement in treatment plans for patients."

Ironically, these campaigns by limited practitioners to gain the privileges and power of physicians are based largely on a mythical view of what that status involves. Physicians' responsibilities and liabilities are often ignored. Furthermore, current "social developments" are altering the prerogatives of the physician in a direction even further away from the mythic ideal pictured by these groups. Such developments as direct federal regulation of medical practice (e.g., the proposed "'Baby Doe rules'), federal programs that have a strong indirect impact on physician decision making (e.g., mandatory prospective payment for hospital expenses), and social changes (e.g., the increase in malpractice litigation) are discussed in Chapter 5.

There is a significant grain of truth in the arguments of these groups, however, that must be acknowledged in day-to-day practice. This is that today's nonphysician practitioners are expert and highly skilled in their area of practice. Once it may have been the case that the physician knew everything there was to know about health care, and other practitioners functioned merely to carry out procedures that were ordered (and often taught to them on the job) by the physician with whom they worked. But today the amount of knowledge is so vast and the details of technical procedures are so complex that no one person can presume to be master of them all. Formal and extensive training programs have been developed for allied health professionals that incorporate large amounts of this material in special areas.

The result is that, for example, physical therapists may have an understanding of certain treatment modalities (and their physiological bases) surpassing that of the average physician. Similarly, dietitians may have a knowledge of principles of nutrition in health and illness, through their years of concentrated study, that is more extensive than that of the physician (whose study of this topic may be limited to a few lectures here and there within the medical curriculum). In other cases a level of practical knowledge may have been achieved through experience. For example, nurses who have worked for many years in an ICU may have acquired an understanding of certain aspects of acute, critical illness that could be instructive to the physician who has contact with this level of care only with an occasional
patient. In other settings nurses may gain greater awareness of patient needs than the attending physician as a result of their more continuous contact with the patient.

Furthermore, these groups of practitioners each have a strong code of ethics in which they accept a distinct professional responsibility to promote the patient’s welfare. [Codes of several health practitioner groups are contained in an appendix of the Encyclopedia of Bioethics (Reich 1978).] Consider, for example, the following excerpts from the International Council of Nurses Code:

The fundamental responsibility of the nurse is fourfold: to promote health, to prevent illness, to restore health and to alleviate suffering.

The nurse’s primary responsibility is to those people who require nursing care.

The nurse carries personal responsibility for nursing practice and for maintaining competence by continual learning.

The nurse takes appropriate action to safeguard the individual when his care is endangered by a co-worker or any other person. [International Council of Nurses, “Ethical Concepts Applied to Nursing.” Adopted by the ICN Council of National Representatives, Mexico City in May, 1973; see Reich (1978, 1788–1789)]

The best interests of the patient require that mechanisms be developed to incorporate this expertise and skill into patient care as efficiently and thoroughly as possible. A physician who fails to draw upon these additional resources—who, for example, fails to consult the experienced clinical dietician for advice and instead writes detailed orders for nutritional support in an uncommon situation on the basis of what he remembers from medical school lectures—does an extreme disservice to his patient.

The only real question is how to bring about this needed integration of expertise and skill. The push by many groups of nonphysician practitioners seems to be to demarcate zones of autonomous practice for each group, within which practitioners would have the full decision making authority traditionally possessed by the physician. The danger of this approach is that it could lead to fragmented and uncoordinated patient care—something that has already happened all too often as a result of medical specialization and multiple consultation. If the dietician succeeds in having the task of nutritional planning placed on his shoulders, as an autonomous sphere of practice, it may be left too much to his responsibility. Thus, for example, the neurologist may not bother to pay sufficient attention to nutritional implications of the treatments she is administering—much less to their possible combined effects in association with the therapies ordered by, say, the rheumatologist (yet another consultant).

The solution we propose is not to create additional zones of autonomous practice, but rather to 1) encourage development of structures for cooperative
decision making and practice involving all the practitioners whose expertise and skill are relevant to the patient at hand, and 2) provide for a coordinating function for the primary-care physician. But all this must be developed in face-to-face negotiations (or some suitable equivalent), in what we have labeled "doctor-doctor" and "doctor/limited-practitioner" accommodations and relationships.

3.5.6 Concept of the Health-Care "Team"  The closest approximation to the ideal proposed here is found in institutional units in which the nature of the tasks has fostered close working relationships in a stable group of practitioners. Notable examples include intensive care nurseries and oncology units. Important questions arise when cooperative relationships of this sort develop within a team of practitioners.

First, to what extent can relationships characteristic of the moral center of medicine be developed and maintained with the several caregivers? Is it realistic to suppose that the patient can develop attitudes of trust and openness with each member of the team? Will the frequent presence of several team members at once inhibit openness of communication? Will it be a source of discomfort for the patient? What is the role of the institution in relationship to the team and to the patient?

Second, how is responsibility assigned in team decision making and action? The model of consultation in the professional literature suggests the only acceptable team structure is one with a clearly defined "captain" who bears primary responsibility for making the final decisions. However, in actual practice, decision making for certain areas of care is often delegated to specialists asked to consult and manage. Furthermore, some teams that have worked together for a considerable time may develop decentralized processes of decision making in which all team members make fundamental contributions to key decisions. In these cases can responsibility be said to be shared equally by all members of the team? Is this a viable model for team structure in other settings?

Third, one can see how crucial this delicate balance is and how severely it could be disturbed were decisions made on the basis of considerations other than the patient's best interests, e.g., economic factors, research values, teaching needs, etc.

Fourth, can a team approach to the patient preserve the patient's ability to appraise and criticize the care he or she has received? On whom is any criticism to be focused? How is it to be brought to bear on the decisions and actions of a team?

3.6 Institutional Delivery of Health Care

Alternative forms of organization for delivery of treatment influence many dimensions of professional practice. Some recent developments are examined in Chapter 5, but it is helpful to indicate here the relevance of these matters to the discussion of the moral center of medicine.
The presupposition of the moral center is one of undivided loyalty to the patient's interests. This is summed up well in the comment by Fried quoted in Section 2.2.

In particular, it is felt that medical decisions should not be influenced by financial considerations. This is underscored by the provision of the International Code of Medical Ethics: "A doctor must practice his profession uninfluenced by motives of profit." The AMA Judicial Council makes a similar claim in the ruling on "Health Facility Ownership by Physician," quoted in Section 3.3.3.

Indeed, the image suggested by the moral center description is one of a physician who gives no consideration to the financial implications of choices that must be made. "My responsibility is to offer the most thorough work-up and treatment that I, and my institution, can provide—without consideration of cost." The hospital business office or the business function of a private practice office is viewed by many physicians as not centrally related to what they are about. These physicians may be unaware of the cost of a specific test they order, concentrating entirely on its scientific validity and usefulness.

In contrast to this ideal, health-care institutions have undergone in recent years a transformation that Eli Ginzberg (1983) terms "monetarization." This he describes as the "penetration" of the "money economy" into "all facets of the health-care system." In simpler terms, it means that financial considerations have come to influence, in various ways, the whole range of health-care decisions.

This obviously can produce a conflict of loyalties. The physician no longer bases decisions wholly on the comparison of probabilities of benefit versus harm to this specific patient. He now has to add into the calculus a consideration of economic factors. This influence is seen most dramatically when dealing with patients who lack health insurance but whose resources are sufficient that they are expected to pay for treatment. Physicians may become more sensitive to the economic implications of decisions in these circumstances. "Is this diagnostic test important enough to justify the cost to the patient? In these cases are found careful calculations of the most cost-efficient path to diagnosis and treatment decisions.

The question, of course, is whether patients in this situation receive "the bare essentials" and patients who have insurance receive excessive levels of procedures, or whether insured patients receive the ideal arrangement of procedures and the level of care received by private-pay patients is deficient. (There is, of course, a third possibility: the insured patients receive somewhat too many procedures and that private-pay patients receive somewhat too few for ideal case management.)

The intrusion of economic considerations will continue to grow with changes such as the shift to prospective billing rather than cost reimbursement. Physicians will find it necessary to include in their deliberations considerations about how to

minimize the impact of concerns over general health-care expenditures, perhaps
counting on the good will of the institution to balance and subsidize the costs of
patient care.

3.6.1 Differences in Hospital Staffs  The description of the moral center does
not include reference to the institutional affiliations of the physician and the
influence these may have on doctor-patient accommodations. These affiliations
may give rise to conflicts of loyalties, which are also undergoing change nowa-
days. New structures may not include some of the checks and balances on
professional decision making embodied in traditional structures. For example, a
tissue-review committee, which functions in connection with in-hospital surgeries
to provide review of decisions by an economically disinterested group of peers,
may not exist in free-standing, out-patient surgery facilities.

3.6.2 Filling Out Forms  Another element of practice not indicated in the
description of the moral center of medicine—and, furthermore, that we venture to
guess was rarely included in responses to the "Fantasies" exercise in Chapter 1,
Section 1.1.—is the responsibility to fill out forms of various sorts on behalf of
patients. Yet professional spokespersons clearly indicate that physicians can
rightfully be expected to fulfill this task. The AMA Judicial Council insists that the
physician’s responsibilities to patients may include these sorts of certifications
[Section 5.08: "Confidentiality: Insurance Company Representatives" (Judicial
Council of the AMA 1984)].

To get at the issues that arise here, let us consider a case.

A. Case: Perry Payne

You are a primary-care physician in private practice in a small community.
Perry Payne is a 46-year-old truck driver whom you have been following for the
past several weeks for a back injury.

Today, Perry has struggled into your office for a follow-up appointment, and
he asks you to write a note to his employer certifying that he is not able to work
and indicating that the injury prevents his returning to work for an indefinite
period.

The injury resulted when Perry fell from a ladder while he was painting a
classroom in the educational building of the church his family attends. One of the
other men who was also painting inadvertently bumped into the ladder on which
Perry was standing, knocking him to the ground.

At the time of the injury, you hospitalized Perry and consulted the orthopedist
who visits your small community hospital one day per week. After a thorough
work-up, she reported back to you that the injury was relatively minor. She
prescribed a regimen of exercises, to be administered by the staff physical
therapist at the hospital, and she said she expected that the pain and disability
would resolve over the next few days.
However, Perry’s condition did not seem to improve. He moaned and groaned and begged constantly for a narcotic pain medication for “this agony.” He refused to cooperate with the physical therapy—saying it hurt too much.

After a week of this reaction, on the occasion of the orthopedist’s next weekly trip to your hospital, you asked her to examine Perry again. Her subsequent report reaffirmed her initial evaluation. “The organic pathology is not sufficient to account for the level of pain he reports,” she said. “In my clinical judgment, his medical condition is stable and there is nothing physically wrong with him that is severe enough to interfere with his returning to work immediately. I am convinced that what is sustaining his symptoms is pent-up hostility and resentment relating to the frustrating nature of his job and elements of his life situation. I recommend psychological counseling.”

But Perry resolutely refused any suggestion of counseling. You discharged him from the hospital after a few more days, but his wife reports that he remains confined to bed at home, complies poorly with the regimen of exercises he was taught by the physical therapist, and constantly begs her to persuade you to prescribe more potent pain medication.

And now here he is in your office, asking you to provide him with a medical excuse from work. “You gotta do this for me, Doc,” he says. “My boss says that, unless I produce a note from you, he will not give me sick pay; without that, I won’t be able to put food on the table for my family.”

How should you respond to this request?

**B. Options**

1. Write the note, as requested.

2. Write a note certifying that you have been treating Perry, but word it in such a way that it conveys the message that his disability is not as serious as he claims.

3. Strike a bargain with Perry. Agree to write a note certifying disability until two weeks from today, but only if he promises to
   a. comply with the exercise regimen he was taught
   b. seek psychological counseling
   c. return to work when the two weeks are up
   d. other (specify): __________________________

4. Tell Perry the orthopedist ought to write the note, so he ought to make an appointment to see her the next day she is in town.

5. Refuse to write the note.

6. Refuse to write the note, and contact Perry’s employers independently to tell them Perry is not as disabled as he claims.

7. Other: ____________________________________
C. Issues

1. Is it consistent with a proper role of the physician to be asked to make certifications of this kind?
   a. What are the implications of this sort of request for the physician-patient relationship?
   b. What are its implications for the physician’s relationship to the employer and/or other social institutions?

2. What consideration should be uppermost in the physician’s mind when handling certifications of this kind?
   a. the medical needs of the patient exclusively
   b. the welfare of the patient generally, including elements above and beyond medical needs
   c. the rights and welfare of the employer and/or other social institutions
   d. the Truth (with a capital “T”)
   e. other: ____________________________

3. What are the implications of certifications of this kind for the issue of medical confidentiality?

4. What other ethical issues are raised by requests for certifications of this kind?

D. Case Analysis  It is clear that to refuse to fill out this form (option 5) will disrupt the physician-patient relationship (issue 1a). Furthermore, in many situations, filling out such forms can have beneficial effects for your patients. Sometimes it directly serves their medical needs (issue 2a)—as when it allows a patient to delay returning to a work situation that would impair recuperation. At other times, such an authorization by the physician might not be strictly necessary for recuperation, but it might be justified on the grounds of serving elements of the patient’s general welfare (issue 2b). This consideration might apply to the case of Perry Payne. A delay in returning to work—although apparently not strictly medically necessary—might provide the respite that would enable him to begin addressing his life problems.

Turning to the involvement of the employer and/or other social institutions (issue 1b), groups in society are only too ready to shift the burden of a variety of difficult determinations to physicians; the medical community should consider which of these tasks it is appropriate to undertake. Insisting on a “doctor’s excuse” or a “medical certification” is a relatively easy way for an employer or manager to shunt aside a difficult decision. Physicians should not always be willing to take on these roles.

Once having accepted responsibility to assist employers or managers in this way, however, the physician acquires an obligation to consider the rights and welfare of the institution (issue 2c) in making such a determination. But above all,
there is an obligation to be honest (issue 2d). Just as honesty is an obligation in the physician-patient relationship,\(^8\) it is a central social norm. Thus to write the note [containing as it does a declaration that the physician believes to be false (option 1)] would be ethically wrong, and it also would be less than honest to write a note with a disguised message (option 2).

At the other extreme, it would be a violation of confidentiality to contact the employer independently to tell him of Perry's actual condition (option 6). Perry would be unlikely to authorize release of this information, and without his authorization, disclosure would violate his right of confidentiality.

Option 4 would remove the immediate burden from your shoulders, but only to impose it on someone else—and the orthopedist is likely to bring a new burden to bear on you for creating this difficult situation for her.

Thus, we would hold that the only viable choices are option 5: to refuse to write the note, explaining to Perry why it is not justified; or option 3: to certify disability on the basis of the overwhelming impact of his life problems, but to use the occasion as a bargaining tool to persuade him to begin dealing with these problems.

If the "bargaining" in option 3 is heavy-handed, it can amount to coercion and therefore is ethically suspect. However, accompanied with a supportive and understanding attitude, it can initiate a mutually negotiated doctor-patient accommodation without any objectionable coercive component.

3.6.3 Patient Nonpayment of Bills Consideration of the monetary aspect of medical practice inevitably brings up the issue of the patient's responsibility for payment for services, and the appropriate response of the physician when this responsibility is not met. To illustrate this in concrete terms, the saga of the Perry Payne family continues.

A. Case: Perry Payne Revisited

Two weeks have passed since your last encounter with Perry Payne. Today, as you walk by your receptionist's desk, she looks up from a telephone conversation and says, "Doctor, Mrs. Payne is on the phone. She wants to make another appointment for Perry to see you. You realize, don't you, that they have not paid a cent on their bill since Perry's injury? I have pointed this out to Mrs. Payne repeatedly, and she always promises to send us a check for at least a few dollars towards the bill. But we have received nothing.

"What do you want me to do about this? Should I remind her again about the bill? Should I schedule the appointment?"

What should you tell the receptionist to do?

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8. See Chapter 1, especially Sections 2.2 and 2.3, for a discussion of this norm in the physician-patient relationship.
B. Options

1. Refuse to schedule another appointment for Perry until the bill is paid in full.
2. Refuse to schedule another appointment for Perry until some payment is made on the bill.
3. Schedule the appointment, but tell Mrs. Payne that you will refuse to see Perry unless she brings with her when they come for the appointment
   a. some payment towards the bill
   b. full payment for the entire outstanding past balance
   c. full payment for the entire outstanding past balance plus full payment for this visit.
4. Schedule the appointment and remind her once again about the bill.
5. Schedule the appointment and do not mention the bill.
6. Other: _______________________________________________________________________

C. Questions

1. Would it make a difference to your decision if you learned that the Paynes’ nonpayment had gone on for several months before Perry’s injury? Why or why not?
2. Would it make a difference to your decision if you learned that Perry was receiving sick pay from his employer? Why or why not?
3. Would it make a difference to your decision if you learned that Perry had been reimbursed by his health insurance for your treatment of him? Why or why not?

D. Case Analysis  Physicians often find it uncomfortable to discuss with the patient the financial component of the physician-patient relationship. However, this is clearly a part of the physician’s expectations from the relationship, and it ought to be dealt with in the doctor-patient accommodation along with other issues.

The patient has a clear responsibility to make serious efforts to pay the charges for professional services. Even if one questions the current private-enterprise form of medical services and views alternative financing arrangements as preferable on moral grounds (an issue discussed in Chapter 5), these beliefs about ideals do not nullify the responsibility to honor the financial commitment embodied in current doctor-patient accommodations.

If a given family is unable to pay, the physician should work out arrangements to allow responsibilities to be met to the extent possible. This has been done in the present situation by inviting the Paynes to pay a few dollars against their bill. Patients should accept this much responsibility, even if their finances are in dire straits. This does little more than acknowledge their financial responsibility.
Thus, it clearly would be justified to call the Paynes' attention to their responsibility here in some way or other. The question is how best to do it.

Since the financial arrangement is part of the doctor-patient relationship, it is appropriate for the physician to deal with it directly (especially once it has gotten to the extreme point that it has with the Payne family). Repeated reminders of this issue from your receptionist have already been tried and found ineffective. Thus we recommend against options 1–4, since they involve ancillary personnel raising the issue with the Paynes.

Of the options listed, we recommend option 5, supplemented by the suggestion that the physician initiate a frank discussion of payment when the Paynes arrive for the appointment.

However, another possibility might be preferable to any of those listed. Since you, the physician, are right by the telephone, this might be the best time and place to raise the issue with them. You could get on the phone right now and discuss with Mrs. Payne arrangements about payment on the bill. (It would be best, we think, not to link payment with the up-coming appointment. They will undoubtedly get this message from the context, and one does not want to suggest they could avoid responsibility for this bill by not making future appointments.) Then give the phone back to your receptionist to make the appointment.

Nonpayment for services can serve as a means to communicate one's dissatisfaction with the nature of the services rendered. This may provide the patient with a valuable communication tool in a system in which barriers of social status, institutional structures, and custom inhibit other ways of conveying this message. Insurance reimbursement arrangements that make payment directly to the patient have the value of preserving this capability to communicate dissatisfaction. However, it seems clearly wrong for the patient to profit from such a communication. Thus a patient who plans to take such a step should refrain from filing for insurance reimbursement for the services in question. Furthermore, if the decision is made after the forms have already been filed, the patient should return the money to the insurance carrier.

E. Case: Perry Payne Revisited Yet Again

Two more weeks have passed since your last encounter with the Paynes. Today, your receptionist informs you that Perry has called to request his records be sent to another physician in your community. She reminds you that the Paynes have still not made any payment on their bill.

What should you tell her to do?

F. Options

1. Send the other physician all the records you have on Perry. Keep nothing for your own files except a brief note.
2. Make a photocopy of all Perry's records.
   a. Send the other physician the original records and keep the copy for your permanent files.
   b. Send the other physician the copy and keep the original records for your files.
3. Select items to copy and send to the other physician
   a. the consultant's interpretation of EKGs, x-rays, etc., but keep the items themselves for your files
   b. copies of records you have generated, but not the records sent to you by a previous physician when the Paynes first came to you
   c. all objective data, but keep "subjective" material—i.e., your personal impressions of Perry and his family, discussions of sensitive issues like sexuality and family violence—to yourself
4. Discuss with Perry what information in his file should be sent; e.g., if there are records of discussions you have had with the patient about sexual matters or family violence, remind him that these are referred to in the record and ask whether these should be sent to the new physician. Then send copies of the patient-approved items to the physician.
5. Dictate a brief "discharge summary" and send it to the other physician, but keep the full records for your files.
6. Dictate a note explaining your doubts about the organic basis of Perry's current complaint, and send it with whatever records you select.
7. Dictate a note explaining the Paynes' poor payment record, and send it with whatever records you select.
8. Telephone the other physician to explain
   a. your doubts about the organic basis of Perry's current complaint
   b. the Paynes' poor payment record.
9. Refuse to send any records to another physician until the Paynes' bill with you is paid in full.
10. Refuse to send any records to another physician until the Paynes have at least started to pay on their bill.
11. Other: ____________________________

G. Case Analysis The physician's obligation to maintain records about patients is an aspect of the duty to render quality care. The assumption is that information about the patient's medical history is important for assessment of future health situations. The duty to make this information available to other physicians at the patient's request stems from the same basis: an obligation to provide these physicians with a basis for rendering the highest quality care.
However, this duty should not be made conditional on the patient’s financial responsibility. Thus, options 9 and 10 must be rejected on the grounds that they improperly mix two morally independent issues.

The problem with options 5 and 3a is they provide too little information for effective management of care. If the underlying goal is to enable provision of quality care, these seem inadequate to the purpose.

Options 6–8 raise questions of confidentiality. To communicate this information to another physician—whether in written or verbal form—obviously goes beyond Perry’s expectations when he authorized release of information. We contend that, at the very least, explicit authorization from Perry to communicate this information is required.

The response to option 3b depends, in part, on whether the records you received from the other physician were originals or copies. If they were originals, then you should forward them to the physician the patient has chosen. After all, it is possible that the originating physician did not retain copies and thus that there is no other source for this baseline material to be supplied to the new physician. On the other hand, if they are copies, then it might be advisable to suggest that the new physician contact the earlier physician to attempt to obtain the original data. You might also ask Perry his wishes about this choice.

Option 1 is probably inadvisable on personal, prudential grounds. Since questions about your past care of the Paynes might arise at a later date (e.g., in legal actions), it is wise to retain enough information to be able to defend yourself in detail regarding care rendered. This might also be essential to serve the best interests of the Paynes—for example, if Perry were to sue someone with regard to his back injury. Reference to the details of your records would be necessary to testify on his behalf.

Option 2a raises similar questions. If the original records are out of your hands, they are subject to alteration, and your possession of a copy may not be regarded in court as sufficient evidence of the original form of the record.

One problem with option 2b is that the copies may not be of good enough quality to provide needed information to the other practitioner. This can be especially true with attempts to copy x-rays, but the same thing can happen in making photocopies of handwritten notes. The obligation here is to provide the best quality copy that is feasible; if no copy is fully satisfactory, perhaps one ought to offer the other physician an opportunity to study the original in your office if you are unwilling to give up possession of it permanently.

An additional problem with option 2b is that the records might contain information that the Paynes would prefer not to have communicated to a new physician. If they had discussed with you sensitive issues they no longer regard as "live" issues, such as sexual problems or worries about family violence they now consider to have been overcome, they might prefer not to have their new physician made aware of these items from their history.
You might try to determine this on your own (option 3c), but clearly it would be more reliable to contact Perry and ask him what information to transmit. Thus our recommendation is option 4.

4 Expansions of the Scope of Responsibility

Recall that item a of the description of the moral center refers to "diagnosis and treatment," and item b focuses on "an illness or injury" (Section 2.1). A number of common and important medical activities go beyond the scope of medical services indicated in this description. Some of these have been seen in concrete examples in this chapter, but it is worthwhile to step back and view this in a general way.

4.1 Beyond Treatment

A number of clinical activities are aimed not at treatment of existing illness but at its prevention. Vaccination and patient education are two significant examples. The rationale for stepping beyond the paradigm is that this approach offers a more efficient means to achieve the same goal as the central activity. To prevent illness offers assistance to the patient no less valuable than removing the illness once it appears—indeed, prevention may significantly reduce the total amount of pain and suffering.

4.2 Beyond the Clinic

Similarly, addressing the remote, root causes of illness or injury through attention to occupational health and safety, environmental medicine, social medicine, etc., is justified by the efficiency of these approaches in achieving the same goal as paradigm practices.

4.3 Beyond Illness or Injury

A more dramatic step away from the paradigm is to shift the focus from preventing or relieving illness or injury to the broader focus of promoting positive states: 1) health promotion, 2) wellness promotion, and 3) well-being promotion. The ultimate extension along these lines is suggested in the following statement by renowned physician-educator Rudolf Virchow: "Should medicine ever fulfill its great ends, it must enter into the larger political and social life of our time, it must indicate the barriers which obstruct the normal completion of the life-cycle and remove them. Should this ever come to pass, medicine, whatever it may then be, will be the good of all" [quoted in Health Policy Committee (1982, 450)].
4.4 Palliation, Comforting, and Strengthening Coping Skills

This also represents a substantial departure from the core goal of diagnosis and treatment of the illness or injury. The rationale for including these tasks in the medical mandate is that these elements are, in many instances, adjuvant to the central task (and perhaps even continuous with it, in many respects). The most careful diagnosis and the most focused pharmacological or surgical treatment may be hampered in effectiveness if the patient is anxious, frightened, and mistrustful of their value.

However, this is not the whole justification for these elements of care. They also (especially?) seem to be called for when the condition has passed the limits of effective treatment. Here the rationale is that such activities embody a helping orientation parallel with, and a natural extension of, the central paradigm.

4.5 Conclusion

This discussion of the moral center and extensions from it is in no way intended to discount the importance of these “off-center” elements. Rather, the point is to call your attention to a character they may have in your priorities because of their distance from the moral center. You need to give thought to what importance they should have in your professional practice.

Clearly there are some things you will be asked to do by patients and/or society that will fall outside the scope of what you think is properly part of professional practice.\textsuperscript{9} Consider, for example, one final case that raises these issues.

The elderly woman explains to you that in the public housing project in which she and her husband live, two-bedroom apartments are assigned to couples without children only on the grounds of “medical necessity.” She asks you to certify that there is a medical necessity for a two-bedroom apartment in her case because her husband’s snoring keeps her awake at night when they sleep in the same room.

How should you respond to this request? Do you have any obligation to assist the patient in this matter?

\textsuperscript{9} For an interesting discussion of one such issue, see Gillick (1984).
References

Brody H: Teaching clinical ethics: Models for consideration. In: Ackerman T, Graber GC, Thomasma DC, et al. (eds) Clinical Medical Ethics: Exploration and Assessment. University of Tennessee Inter-Campus Graduate Program in Medical Ethics, Knoxville, in press.


Further Reading


Approaches the issue of the scope of medical responsibility in a more theoretical way than in our chapter, through analysis of the central concepts of "health" and "disease."


3.07 Teaching
3.04 Health Facility Ownership by Physician
6.01 Fees for Medical Services
6.03 Fee Splitting
7.00 OPINIONS ON PHYSICIAN RECORDS
8.00 OPINIONS ON PRACTICE MATTERS
9.00 OPINIONS ON PROFESSIONAL RIGHTS AND RESPONSIBILITIES


Advertising by Medical Professionals (Havighurst CC)
Civil Disobedience in Health Services (Madden EH, Hare PH)
Drug Industry and Medicine (Coulter HL)
Health and Disease
I. History of the Concepts (Risse GB)
II. Religious Concepts (DeGraeve F)
III. A Sociological and Action Perspective (Parsons T)
IV. Philosophical Perspectives (Engelhardt HT Jr)
Health Care,
I. Health-Care System (Lee PR, Emmott C)
II. Humanization and Dehumanization of Health Care (Howard J)
III. Right to Health-Care Services (Jonsen AR)
IV. Theories of Justice and Health Care (Branson R)
Health Insurance (Riesenfeld SA)
Health, International (Missett JR, Taylor CE)
Health Policy
I. Evolution of Health Policy (Strickland SP)
II. Health Policy in International Perspective (Anderson OW)
Hospitals (Williams KJ)
Human Experimentation
I. History (Brieger GH)
II. Basic Issues (Capron AM)
III. Philosophical Aspects (Fried C)
IV. Social and Professional Control (Frankel MS)
Informed Consent in Human Research
I. Social Aspects (Gray BH)
II. Ethical and Legal Aspects (Lebacqz K, Levine RJ)
Institutionalization (Wexler DB)
Mass Health Screening (Missett JR, Taylor CE)
Medical Education (Pellegrino ED)
Medical Malpractice (Hauck GH, Louisell DW)
Medical Profession
I. Medical Professionalism (Pernick MS)
II. Organized Medicine (Burrow JG)
Nursing (Stanley T)
Orthodoxy in Medicine (Kaufman M)
Pain and Suffering
I. Psychobiological Principles (Robinson DN)
II. Philosophical Perspectives (Shaffer JA)
III. Religious Perspectives (Bowker JW)
Prisoners
I. Medical Care of Prisoners (Sagan LA)
II. Prisoner Experimentation (Branson R)
III. Torture and the Health Professional (Sagan LA)
Research, Behavioral (Kelman HC)
Research, Biomedical (Levine RJ)
Research Policy, Biomedical (McCarthy CR)
Social Medicine (Silver GA)
Warfare
I. Medicine and War (Vastyan EA)
II. Biomedical Science and War (Sidel VW, Sidel M)