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ETHICS

Dismembering the ethical physician

S J Genuis

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Physicians may experience ethical distress when they are caught in difficult clinical situations that demand ethical decision making, particularly when their preferred action may contravene the expectations of patients and established authorities. When principled and competent doctors succumb to patient wishes or establishment guidelines and participate in actions they perceive to be ethically inappropriate, or agree to refrain from interventions they believe to be in the best interests of patients, individual professional integrity may be diminished, and ethical reliability is potentially compromised. In a climate of ever-proliferating ethical quandaries, it is essential for the medical community, health institutions, and governing bodies to pursue a judicious tension between the indispensable regulation of physicians necessary to maintain professional standards and preserve public safety, and the support for ''freedom of conscience'' that principled physicians require to practise medicine in keeping with their personal ethical orientation.

Personal and corporate ethical standards and behaviour are at the very heart of the medical profession's implicit contract with society.[1–3] The dual functions of physicians, to be healers and to be professionals, is an integral mixture of science and ethics[4] and MD, according to some, should represent both a medical degree and a moral degree.[5] In the early 21st century health practitioners are beset with unprecedented ethical challenges as a result of modern technology and the vast array of medical procedures and options now available. In the face of moral dilemmas and complex clinical situations, physicians and researchers are sometimes encountering subtle or overt pressure to adhere to management guidelines or ethical directives deemed suitable by governing authorities and ethicists, a predicament that threatens to destabilise the ethical standards of some health providers. When principled physicians submit to participating in actions they believe are ethically improper, or refrain from interventions they judge to be in the best interests of patients, individual professional integrity is diminished.

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ETHICAL FOUNDATIONS

Through the centuries, there have been various guidelines that influence ethical standards that govern the conduct of the medical profession, the most well known of these is the Hippocratic Oath. This covenantal pledge, previously considered to be ''the immutable bedrock of medical ethics,''[6] embodies the philosophy that physicians are accountable to transcendent forces and authority, that human life is inviolable at any stage from in-utero existence to natural death, and that primum non nocere (first, do no harm) is a critical premise of medical practice. With the dislocation of spirituality from medical practice and widespread utilisation of abortifacient procedures, the Hippocratic Oath is now considered morally and culturally irrelevant by many, and embraced by others ''as a symbol of professional cohesion [rather] than for its content.''[7]

In modern pluralistic societies with competing and sometimes mutually exclusive ethical paradigms, it is challenging to objectively demarcate ethical behaviour for professionals. Ethics entails consideration of strongly held and often divisive spiritual, philosophical, political, and social convictions.[8] It has been expressed that community ethics should be the aggregate of cultural norms, and that personal ethics and ethical behaviour is the internalisation and then practice of such values and norms.[9] However, with conflicting values in society and divisive positions on various medical interventions, what is truly ethical and moral may be very different than majority opinion or the dictates of popular culture and governing bodies.[6] Transcripts of the Nuremberg trials expose what is possible when professionals follow the defined legal system, community standards, political commands, and dictates of the ruling medical authorities of the day.[10] Accordingly, defining and applying acceptable ethical standards in a changing healthcare environment with ever-expanding technological capability remains a perpetual work in progress.

In the past, the concept of absolute truth with defined moral codes based on faith centred spiritual principles held sway in healthcare issues. Current medical ethics, however, has bypassed the notion of a ''universal, normative ethic''[11] and is increasingly based on secular principles such as tolerance, autonomy, non-paternalism, confidentiality, and non-maleficence.[12] ''Code of ethics'' documents—designed, implemented, and enforced in various jurisdictions by governing bodies—are a common vehicle for advancing such principles and a grid by which the behaviours and practices of doctors are now assessed to maintain an ethical standard of care. Such codes also elucidate the standards that publicly speak for the global morality of the profession.

To instil the necessary tools required for ethical decision making, there has been, in the past 25 years, the proliferation of departments of

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bioethics in many university healthcare settings. Most accredited medical schools now allocate time for the formal teaching of bioethics in their curriculums.[5 13] Despite ubiquitous codes of ethics and increasing attention to the field of bioethics in the past two decades, however, ''claims and complaints against doctors …[are] growing worldwide,''[14] and there is mounting concern regarding decreased professionalism and ethical behaviour among medical doctors.[14–17] Although it is difficult to objectively measure whether contemporary medical practice is any more or less professional or virtuous than in a bygone era, the Canadian Medical Association has recently reported that the profession is being eroded, in part, by mounting rates of unprofessional conduct and by declining public trust in physicians.[16] With prevalent accusations of diminishing medical integrity and professionalism,[15] it seems apparent that knowledge and understanding of contemporary ethics is no substitute for virtue and integrity of character. Accordingly, initiatives aimed at maximising and securing ethical character in physicians have been instituted.

With increasing attention given to ethical dimensions of providing care, the model of institutional or organisational ethics[18] has thrived whereby ''healthcare institutions professionally approach and manage the ethical dimension of their organizations.''[19] Under this mandate, medical institutions and governing organisations, usually responsible for physician competency, privileges, licensing and accountability, endeavour to establish ethically acceptable values based practices and policies to direct their membership in serving and protecting the public interest. Faculties of bioethics have been knighted with the task of educating and empowering medical professionals to make ethical decisions; while the governing bodies (often with input from ethics committees) have then assumed the responsibility for defining what behaviour is considered ethical and for enforcing ethical codes of conduct.

The study and practice of ethics is not a straightforward science as there is lack of moral consensus on many issues within contemporary societies and among their medical institutions. Accordingly, difficulties arise when the ethical choices of individual physicians do not coincide with patients' requests or courses of action deemed preferable by the institution or governing organisation. With potentially differing priorities and responsibilities, the interplay between individual professional ethics and the objectives of organisational ethics may conflict; ensuing imbroglios are becoming routine in contemporary medical practice. Failure to participate in actions deemed appropriate by governing authorities, however, can lead to censure and discipline of individual practitioners.

ETHICS IN COLLISION

With the complex and divisive scenarios that routinely present to contemporary practitioners in varied medical specialties,[20] it is not enough for doctors to simply be well mannered, technically competent, and compassionate.[21] In modern day medical practice, physicians often experience ethical angst in the workplace as they encounter situations that demand difficult decisions and necessitate the choosing of sides. A few examples from a range of medical disciplines illustrate the concern.

Should suicide be facilitated in a chronic depressive requesting assisted death? Should an emergency physician allow a child to die because a parent declines treatment consent? Should an overseas aid doctor perform female circumcisions in keeping with the culture, beliefs, and wishes of local patients and health administrators? Should concerned physicians release adverse drug information despite a non-disclosure pact with industry?[22] Should a surgeon perform disfiguring surgery to fulfil the erotic fantasies of a libidinous patient?[23] Should a genetic specialist recommend investigations she considers to be eugenic? Should a reluctant military physician participate in dubious prisoner interrogation procedures? Should a primary practitioner adhere to clinical practice guidelines he suspects are harmful to patients?[24] Should a disinclined gynaecologist perform a partial-birth abortion simply to eradicate a female offspring? Should an addiction specialist dispense heroin in accordance with a novel drug rehab programme she vehemently opposes? Should a rural practitioner perform a tubal ligation on an adamant 18 year old? Should a doctor refrain from using effective but unconventional nutritional or environmental interventions that are not in line with standard practice?[25] Should research physicians and medical editors accept support or advertising from pharmaceutical companies recently involved in research violations?[26] It is interesting to discuss how physicians should behave in myriad situations, but with explicit or implicit ethical directives dictated by ethics committees or governing bodies, complexity arises when the ethics of individual doctors collide with the ethical dictates of patients, authorities, or institutional committees.

Regardless of any opinion on the legitimacy of a given perspective, it is necessary to empathetically consider the plight of sincere doctors who object to a dictatorial ethical guideline in specific situations. Decisions to decline management in accordance with a patient's expressed wishes or authoritarian guidelines are rarely the simple result of a philosophical ideology or religious belief; health considerations and medical ethics are usually central to such decisions. A refusal to accede to a requested intervention often results when the physician deems the intervention to be unwise, deleterious, or damaging. From the vantage point of a competent and ethical doctor, proceeding with perceived injurious interventions or refraining from the provision of required treatment is not consistent with the principle of acting in the patient's best interests and contravenes the fundamental premise of ''doing no harm''. Although it is not possible for anyone to objectively foresee with complete confidence what will turn out to be in the enduring ''best interests'' of any patient in a given situation, the ethical physician necessarily desires to achieve the optimal long term health and wellbeing for the patient and consequently makes clinical decisions to the best of his/her ability in accordance with this objective.

Some suggest that a compromise solution lies in referring to another doctor who retains no misgivings about the proposed course of action. Yet, ethical physicians refer to consultants who they determine will undertake interventions likely to be of assistance to the wellbeing of the patient or society. From the vantage point of primary doctors, to knowingly carry out a consultation to another practitioner who they anticipate will proceed in a way the primary doctors feel is damaging, is to be complicit in harm. It is legitimate to vehemently disagree with the ethical choices of physicians in specific situations; it is, however, important to thoughtfully understand their perspective when discussing the ethics of compelling competent MDs to contravene their fundamental values and convictions about good medical care.

SEQUELAE OF AUTHORITARIAN GUIDELINES

Although it is paramount in a self regulating profession such as medicine to protect the public interest, to maintain fundamental standards of practice, and to ensure compliance with legal codes, it also behoves institutions and individuals who govern practitioners to consider the sequelae of regulatory policies regarding ethical conduct. The consequences of pressuring MDs into acquiescing to perceived unethical behaviour and ultimately acting in accordance with

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patient request or authoritarian dictates at the expense of personal conviction is difficult to fully quantify. It is important, however, to consider current trends and possibilities.

Recent findings show that many medical students perceive that the current medical environment is abusive toward their personal, moral and spiritual growth.[27] Many health professionals feel a threat to their ''freedom of conscience'' (a basic human right according to the UN Universal Declaration of Human Rights[28]) and report a type of moral or ethical distress[29] when placed in a position of subordination to authorities who exert power to elicit choices that contravene personal values. Most health providers wish to maintain ethical standards, but it is unrealistic to expect that all individuals will act according to their principles if the cost or consequences are considered too high.[30] Many practitioners are afraid to challenge authority or to seem defiant and out of step with prevailing professional wisdom. The risk of serious disciplinary action, including the inability to graduate from medical school or the loss of licence to practise medicine, has pushed health providers into reluctantly acquiescing. The prospect of facing such difficulty has also prompted many trainees to shun areas of medicine that may infringe on their ethics because they prefer to avoid the aggravation and possible consequences of dealing with issues likely to engender moral turmoil and ethical distress.

For those health providers who put aside personal conviction to comply with patient requests, ethical capitulation is not without effect on character, integrity, and morale. Implicit in the practice of medicine is the principle that ''the physician-patient relationship is based on a patient's trust that the physician is committed to the patient's best interest.''[31] Professional integrity is not fostered when physicians succumb to implementing perceived harmful interventions toward patients. Participating in decisions considered to be improper or detrimental compromises the professional relationship and sets a dangerous precedent that may predispose the physician to facilitate future interventions that are suboptimal.[31] Furthermore when health providers are primarily striving to meet externally imposed standards, rather than doing what they perceive is best, physician morale and professionalism consistently becomes compromised.[30]

Regardless of prevailing administrative guidelines or consensus ethical directives on specific issues, most patients want a doctor whom they trust will not compromise what they believe is best and who refuses to act in ways they perceive to be harmful. Furthermore, it is unlikely that the public would support any move to diminish the integrity of physicians. The ethics and integrity of competent doctors, however, are assailed when authorities punish these physicians for conscientiously practising medicine to the best of their ability.

CHALLENGES TO CONTEMPORARY ETHICS

In an era of escalating ''cookbook medicine'',[24] the organisational ethic approach whereby authorities and committees decide on appropriate ethical standards and then speak for the profession, needs to be carefully re-examined. Many times throughout history, existing medical dogma has been proved utterly wrong with the passage of time; accordingly, it should be permissible for practitioners to pursue truth, scientific fact, and moral behaviour as ultimate authority, rather than simply accepting authority or experts as the ultimate source of ethics, morality, or truth. As approaches to ethical decision making have been in flux with the move to divorce medical practice from any concept of a universal normative ethic, intellectual honesty and openness demands that current secular principles of modern ethics also be subject to scrutiny. The values of non-paternalism, tolerance, and autonomy deserve mention; medical professionalism and the philosophical imperative of universal applicability also warrant comment.

Non-paternalism and tolerance

In the contemporary medical paradigm, it has become ethically reprehensible to manage patient encounters in a fashion considered to be ''paternalistic''—where the physician is alleged to have made unilateral decisions and thus undertaken to regulate the conduct of patients. Inherent in any contrary decision, however, is the alienation of opposing points of view; any action that classifies opposing courses of action as misguided or wrong, may be interpreted as paternalistic. Thus, disagreeing with a patient's chosen course of action and refusing to accede may be considered to embody a certain degree of paternalism. Paradoxically, however, as respectful debate is an accepted requisite of free speech, labelling contrary positions as paternalistic stifles legitimate debate, limits freedom of expression, and is inherently patronising and paternalistic toward those expressing contrary views. Criticising or disciplining MDs for resolutely acting in a fashion they believe to be medically optimal for patients is intrinsically paternalistic toward those physicians.

Tolerance may be regarded as a duplicitous concept as well. Anyone deciding against the actions, thoughts, or beliefs of others may be considered intolerant; presently, an effective means to avoid scrutiny, to preclude intelligent inquiry, and to dismiss criticism or opposition is to allege intolerance. Yet, the policy of disciplining a physician for acting upon a contrary ethical stance is the embodiment of intolerance toward that physician, the specific transgression that such professionals are being accused of. Such actions by authorities may be interpreted as discrimination on the basis of ''ethical orientation''.

Autonomy

The right to autonomy has become sacrosanct in modern medical ethics. Yet, with the refusal to assent to patient demands or committee directives, physicians are not impeding the autonomy of patients, they are simply preserving their own autonomy. Refusing is not making a choice for others, but a choice for themselves; such doctors are not imposing their will on patients, but not allowing patients or establishment to impose a will on the physician. Requiring physicians to act in a specific fashion denies freedom of conscience and definitively denies choice: which negates the principle of autonomy.

It has been suggested by some ethical experts that ''informed consent'' facilitates patient autonomy and negates paternalism. In reality, however, medicine is not an exact science and the notion that comprehensive information provided by a clinician will fully enable patients to make autonomous decisions is naive. With evolving medical research, with slow diffusion of new information into the hands of clinicians,[32] with direct to consumer advertising,[33] and with dubious credibility assigned to much medical information currently published,[34 35] information provided to patients can only reflect the state of knowledge and subjective interpretation of the person providing it. For example, informed consent regarding the dispensation of preventive hormone replacement therapy (HRT) in menopause before the release of the Women's Health Initiative research[36 37] might involve mutually contradictory pieces of information.[24] Those doctors cognisant of the body of factual research data showing lack of preventive HRT benefit and potential for serious sequelae provided dissimilar information to practitioners following practice directives and conventional wisdom that advocated widespread preventive use.[24]

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Informed consent is not an objective reality that secures autonomy and negates paternalism, but a subjective interpretation heavily influenced by the state of knowledge and perception of the educating clinician, which in turn may reflect the values and perspective of that individual doctor.

A sobering reality within the ethical construct of tolerance, personal sovereignty, and autonomy is that individuals maintain ''the right to do what is wrong''. Under this same philosophical construct, however, is the autonomous right for individuals not to participate in what they perceive to be wrong. Fundamental human rights and freedom of conscience incorporate self determination for the physician as well. Accordingly, coercion and application of discipline by governing authorities with the aim of compelling physicians to conform and participate in actions not desired by the physician is a violation of the principles of tolerance and autonomy, the very values authorities are committed to upholding.

Universal applicability

Immanuel Kant's universal applicability principle is a sensible framework, according to some, by which to gauge the ethical validity of physician behaviour. In his classic book, *Groundwork of the Metaphysic of Morals*,[38] Kant argues that there is only a single categorical imperative, which is to ''act only in such a way that you can will that the maxim of your actions should become a universal law.''[38] If successive physicians fail to intervene as per client request, patient autonomy is violated and the physician community re-establishes unilateral power over medical decision making, a throwback to beneficent based care of bygone years. On the other hand, if successive physicians are morally compromised because of authoritarian dictates, collective professionalism and physician morale is diminished, a contemporary phenomenon that is increasingly evident and that ultimately compromises patient care. Many doctors have become disconcerted with their status of subordination to administrators and, with the escalating infringements on physician autonomy, have come to feel like mere technicians rather than motivated health professionals enjoying the challenges and personal rewards of practising day to day medicine. In response to such frustration, an eminent North American physician and author recently remarked ''We, as a profession, are now subservient to administrators and bean counters, the majority of whom have little or no direct experience of patient care.''[39]

Professionalism

A common perspective about professional behaviour can be summarised in a contention frequently delivered to medical trainees experiencing angst about ethical dilemmas: ''In becoming a professional, you accept certain limits to your rights and freedoms, and anyone who doesn't like it should choose another way of earning a living.'' Depending on interpretation, however, accepting such a premise has the potential to stifle medical progress and endanger medical integrity. From Hippocrates to Semmelweis to Lister to Lind, historical precedent repeatedly illustrates that diversity of thought and opinion, dissonance with the status quo, and openness to exploring new ideas are what moves medicine forward. Furthermore, as it is increasingly recognised that medical education, current practice directives, and clinical guidelines frequently receive considerable input from questionable sources with purposes other than optimal care for patients,[26 32 34 35 40] scrutiny and thoughtful dissent should be encouraged rather than suppressed to preserve the collective integrity and introspective analysis of medical practice.[41] It is legitimate for medical professionals to challenge imposed standards of practice rather than simply acquiescing to authority as the ultimate source of preferred ethics. Dissent and criticism of some aspects of medical practice should not be confused with hostility or lack of commitment to the medical profession: indeed, they may represent the highest form of dedication to the goals of health care.

It has become increasingly apparent and perhaps fashionable that ethicists and ethics committees are regarded with reverence and near veneration on hospital wards, at medical education events, and throughout academia. Equipped with training in philosophy, professional ethicists are sometimes perceived by health workers as having special wisdom, special insight, and special inspiration to elucidate what is moral, what is ethical, and what is right or wrong. The folly of supplanting individual reason and values with expert advice and authoritarian dictates has been evident throughout history. Just as with any discipline, using the services of those with specialised training can provide unique insights, important perspectives, and perspicacious acumen to assist in decision making; sensible input from bioethicists can be exceedingly valuable in clinical medicine. In an age of moral relativism with no universal ethic, however, it would be a non sequitur to conclude that good judgment or ultimate discretion automatically lies with any person or committee.

EXPECTATIONS FOR HEALTH PROFESSIONALS AND REGULATORY INSTITUTIONS

There are differing levels of doing ethics, including individual, institutional, societal, and global; at times these ethics may collide. From the clinician's vantage point, he or she has a primary obligation of personal care to each patient, while institutions enjoy the unenviable task of considering the most efficient way to use limited healthcare resources to serve the greatest good and securing safety and high quality service for all. The discussion of ethical behaviour in the face of competing values and objectives raises challenging issues. With no objective universal ethic, decisions and behaviours become morally relative with no assurance that either individual physicians or dictatorial pronouncements are objectively right or wrong. How do practitioners behave professionally in situations of mutually exclusive perspectives and how do governing bodies enforce their role of regulatory institution while permitting a physician the right to ''do their own thing''?

Modern bioethics requires collaboration based on a respect for difference in values and beliefs not on punishment for maintaining and practising specific values.[42] To force a physician to go against their conviction is to ask them to behave ethically by doing what they believe is wrong. This contradicts the intent of bioethics training that includes the provision of necessary tools to enable health providers to do what is appropriate and perhaps what is ''right'' in specific situations.[43] A medical professional cannot act ethically by doing what they consider to be wrong, unsuitable, and harmful to those entrusted to their care.

Proceeding in a fashion that the physician sincerely believes is right, acting in a manner thought to be in the best interests of the patient, or refusing to participate in any action or procedure considered harmful to the wellbeing of the patient, can be ethical even if it does not coincide with the patient's request or establishment guidelines. In fact, if the treatment in question is detrimental, its application would clearly be unethical, and ''doctors would be obliged to refuse to co-operate.''[44] Respecting both patient and physician autonomy, it is apposite in medical situations for an ethical physician to provide relevant information including available treatment options and potential sequelae, to refrain from emotional manipulation, to make the physician's personal stance known, and to use methods of persuasion that appeal to patient's rational capacities.[45] To avoid conflict as well as to preclude patient disappointment and perceived

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abandonment, it is prudent to explicitly inform prospective patients at the initial encounter about the practitioner's approach to medical care and any specific limitations that may arise.

Within a pluralistic medical community, it is inevitable that individual patients seeking controversial medical interventions will consequently experience the frustration of navigating among medical personnel to find providers of desired care. Accordingly, regulatory bodies must continue to serve as a resource for patients to guide and advise about available services within the spectrum of medical practice.

From an organisational perspective, ethical parameters, credible guidelines, and individual accountability are necessary to preserve public health and safety. While personal integrity is necessary for ethical behaviour, integrity alone is insufficient to secure proper medical decision making; sincere people can be sincerely wrong. Accordingly, it would be inappropriate to authorise doctors to behave according to their own personal morality without regard to any professional standard or approach. Yet, any influence that diminishes the personal ethics of physicians only perpetuates a decline in medical professionalism and ethical behaviour, ideals purportedly upheld by regulatory agencies. Therefore, the medical establishment must continuously endeavour to maintain a careful equilibrium between physician autonomy and regulation, respecting both critical thinking and diversity of approach, while supporting personal integrity. How does medical administration support ethical integrity in its members?

The source and maintenance of virtue brings up a quagmire of views on spirituality, family background, culture, genetics, and other determinants that factor into character development. With no consensus on a recipe for meritorious character, however, the immediate issue of relevance to medical educators and administrators is whether it is possible to engineer virtue and integrity in a physician or trainee whose propensity for ethical performance is lacking. There is no evidence to confirm that long term ethical integrity can consistently be manufactured by any amount of education, ethics training, or disciplinary action. None the less, factors that might dismember the ethical character of any trainee or physician should certainly be avoided at all stages. Encouraging physicians and other professionals to separate themselves and their values from the roles they perform, according to some virtue theorists, is a formula for the dissolution of virtue.[46]

CONCLUSION

The public has become increasingly mistrustful of doctors.[15] Despite the existence of innumerable bioethical faculties, ethics committees, and conduct codes dictating how an ethical physician should behave, there is mounting concern about decreased professionalism, arrogance, lack of integrity, and unethical behaviour among physicians.[47] It is evident that virtue and integrity cannot necessarily be generated by knowledge and understanding of ethics. Factors contributing to diminished integrity among physicians must be addressed.

At the same time that accountability and regulation are essential to the practice of medicine, a fundamental principle of the medical establishment is that ''professional associations and licensing bodies must not engage in activities which detract from the morality and integrity of the profession.''[4] The 2004 Canadian Medical Association Code of Ethics document explicitly exhorts health professionals to ''Resist any influence or interference that could undermine your integrity.''[48] Conscripting health providers to participate with actions or procedures felt by individual practitioners to be morally inappropriate compromises the personal wellbeing and integrity of the individual physician and ultimately the physician-patient relationship. Professionalism is diminished when professionals consent to divorce their beliefs and values from their tasks and responsibilities, an undertaking that is often asked of them in contemporary ethics education. Furthermore, governing bodies transgress the values of tolerance and autonomy when they paradoxically enforce a policy of intolerance against capable, principled physicians who do not tow the line. The medical community should not tolerate such intolerance.

With ongoing innovations in technological capability juxtaposed alongside a plurality of values and priorities in society, the practice of medicine can be an ethical minefield. Complex clinical situations necessitating hard choices for patients and doctors have become a routine part of medical practice and difficulty arises when the preferences of patients or administrative bodies conflict with the perspectives of the practising doctor. In dealing with this challenge, two noble values may apparently clash—the important ideal of maintaining professional standards and securing public safety, and the essential value of respecting the freedom of conscience of individual medical professionals. With the continual unfolding of new ideas and trends in health care, the ethical practice of medicine remains a work in progress; on the evolutionary road to advancement, however, history has repeatedly shown that doctrinaire wisdom may ultimately be wrong and efforts to thwart independent thinking can stifle progress. Aristotle suggested that virtue lies as a mean between extremes. To facilitate advancement in ethical medicine and to avoid dismembering the ethical integrity of principled physicians, it is vital that the medical community, healthcare institutions, and governing organisations actively pursue a healthy and judicious tension between administrative regulation and support for personal autonomy in medical practice.

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