

ETHICS MAN Daniel K Sokol

What to tell junior doctors about ethics

How do you whet the ethical curiosity of junior doctors and provide them with a deeper appreciation of the pervasiveness of medical ethics?

Tomorrow I must give a talk to junior doctors about “Essential ethics and law for the junior doctor.” This may be the only hour they have on the subject in the entire year. What should be included?

Consent is an obvious, unexciting choice. It is still the case that some junior doctors are asked to obtain consent for unfamiliar procedures; and, although some politely decline to do so, others do not want to make a fuss and acquiesce. And what of the patient who simply says, “I don’t want to know—just do what’s best, doctor”? Heaven also knows that some surgical patients are “consented” on the morning of the operation and have little idea of what awaits them. On the trolley heading for the operating theatre, one patient at a colleague’s hospital told the porter that she was relieved at finally having the operation as she was looking forward to starting a family. She was about to undergo a hysterectomy. The porter called the medical team, and the operation was postponed. (If I have learnt one thing as a superannuated student and lecturer, it is that an ethics presentation without stories is like an operation without anaesthetic.)

Another “essential” issue is confidentiality. I shall not bore the junior doctors with old sayings about soundproof curtains and indiscreet discussions in the cafeteria. Instead I will focus on trickier scenarios, such as when to share confidential medical details with a patient’s “partner” or when to breach confidentiality. The story this time will be of the patient who dies from a ruptured cerebral aneurysm during overzealous intercourse with his mistress. The distraught wife asks the medical team what happened. Discuss.

End of life decisions are another possibility, and there is much to be said about “do not attempt resuscitation” (DNAR) orders (*BMJ* 2009;338:b1723), quality of life, and the chameleon concept of “futility” (*BMJ* 2009;338:b2222), but junior doctors

are unlikely to make such decisions in the near future. Still, they may be unsure about the exact implications for patient management of a DNAR order. Should they, for instance, start intravenous antibiotics on a DNAR patient? To close this section, a well placed anecdote concerning a grossly overtreated patient with cancer and the consultant’s immortal words on reviewing the long list of procedures she had endured (“Jeez, it’s hard to die in this hospital!”) may stir them from their slumber and trigger a conversation on goals of care and the purpose of medicine.

This could lead to a discussion on the meaning of best interests. When we say that something is in the best interests of the patient, what do we mean? Examples from less conventional areas of medicine can provide a broader view of the concept. Sports doctors sometimes face a tension between clinical best interests and overall best interests, as when the patient, a professional boxer with a broken rib, wants to finish the round in the most important boxing match of his career. A prison doctor may also face a dilemma when she knows that a patient requesting diazepam is being coerced by some rough types to ask for the drug. The patient will not be treated kindly by the requestors if he fails to get some.

One option would be to talk more broadly about organisational ethics and problems with locums, rotas, continuity of care, targets, and patient safety. If I opened up the discussion, I could expect a torrent of stories about certain incompetent locums and, in the words of one of Eddie Murphy’s film characters, locums who “don’t speak English good” (It may be politically incorrect to say so, but safe and effective communication within the medical team and between patient and clinician is difficult without linguistic proficiency.) There might also be stories about government targets so slavishly followed that care of patients is undermined, and other dubious



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practices. NHS trusts, as public bodies, also have duties of care; and they can be sued for failing to provide adequate supervision or competent staff. This might be a good place to outline some law on clinical negligence, briefly looking at the standard of care and the controversial Bolam test, breach of duty, and causation. I will tell them that, after the 1988 case of *Wilsher versus Essex Area Health Authority*, inexperience is not an excuse for negligent care and that calling your senior when unsure is legally, as well as medically, a very wise move.

Whistleblowing remains a problem, despite the Public Interest Disclosure Act 1998 and whistleblowing procedures adopted by NHS trusts. The story of junior doctors reporting their concerns about an underperforming colleague to a senior doctor only to see their concerns ignored is a familiar one. The irony is that “the incompetent colleague” is a common question in membership examinations and job interviews, and candidates doubtlessly all give the right answer (“The care of my patient is my first concern”). The gap between the ideal world of General Medical Council guidelines and the clinical front line is a topic in itself.

Days could be spent on each of these issues, and I have ignored countless others, but the purpose of the session is not to provide the junior doctors with a solution to their problems (although I intend to give some answers at least) but to whet their ethical curiosity and provide them with a deeper appreciation of the pervasiveness of medical ethics. Most importantly, I would like them to leave the session with a spring in their step. What other profession can boast such a fascinating range of challenges and opportunities? That, perhaps, should be the essential message.

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