Ethics and General Practice

Every consultation has an ethical component

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Black? White.

Dinner? Plate.

Medical ethics? Life and death issues.

Who would benefit from a course in medical ethics? Doctors whose major concern is with life and death issues—for example, specialists in terminal care, gynaecologists, and neonatologists.

That the above assumption is a fair representation of the collective medical mind seems to be borne out by the attendance pattern at a recent course on medical ethics for medical and nursing teachers, where two of the eight medical participants were directors of hospices and the work of a further three was with children. What it does not explain is why I was there.

The purpose of the course was not only to discuss life and death issues but to expose medical and nursing teachers to important general ethical concepts and theories and to apply them to specific medicomoral problems. Viewed from this perspective medical ethics spans all of medical practice and concerns us all. My interest is in this wider perspective.

To illustrate my point, I have constructed the following scenario, with which I hope many general practitioners will identify. I have attempted to analyse it in the light of my new found knowledge.

A dilemma

On a busy Friday evening a distraught looking young woman presents herself at a health centre occupied by a partnership of three general practitioners. She has no appointment. With her are four children. The eldest, about 8 years old, is severely disabled and in a wheelchair. In her arms is a weary toddler, and the other two children, ill kempt but boisterous, are charging around the waiting area.

The woman gives her address as a nearby social services temporary housing hostel. She says she hopes to be rehoused in the surgery catchment area soon. Her own doctor lives some miles away. She asks that one of the doctors takes her and the children on his list. The receptionist takes her details. She explains that she does not have the power to accept or reject patients but that the doctors have a meeting each Monday to decide which families should be accepted on to the list and she should come back then to see what they have decided.

At the meeting each general practitioner has his own view on what action they should take. The first general practitioner suggests that they refuse to accept the family and refer them to the local family practitioner committee for allocation. The second general practitioner recommends that they accept the family as temporary residents only in the first instance. The third general

practitioner thinks that the family should be accepted automatically on to the practice list.

The doctors agreed that in choosing any of the three recommendations they would have fulfilled the terms of their contract. Further, because they worked as a group, whichever recommendation was reached would have implications for all three. Therefore each attempted to justify his point of view.

The first doctor turned the family down on the grounds that they were likely to make great demands on his time, and though he would accept it as his duty to respond to those demands in a family already on his list, or indeed if the family practitioner committee allocated the family to him, he would not accept that it was his duty to accept voluntarily a family who would make heavy demands. This went beyond the realms of duty to sainthood, and he did not believe that he had a moral duty to act in a saintly fashion. In fact, he would go as far as saying that it was his duty to refer patients to the family practitioner committee for allocation because if it became known that the practice never refused a patient they would collect more than their fair share of such patients, and as their resources of time and energy are finite there would be less time to spend on others in the practice.

The second doctor, who accepted the patient as a temporary patient only in the first instance, also called on the principle of justice to justify his recommendation. He maintained that one could not judge a family by outward appearances. It would be unjust to label the family as heavy users until they had proved themselves to be. Therefore he would use their time as temporary residents as a testing period, and if they were not heavy users he would accept them onto the list permanently. If they were heavy users he would refer them to the family practitioner committee for allocation, using the same arguments as the first doctor.

The third doctor agreed with the second that it was unjust to assume that a family were heavy users without knowing them, but even if they were he felt he had no right to refuse their admission to his list. He argued on the grounds that theirs was the practice nearest the patient and as their list was not full the patient had a right to join the practice. To go elsewhere would cause some hardship to the family if only in terms of access. Furthermore, he would wish to distinguish between a family who made heavy demands because of health care needs and a family who was unreasonably demanding on the doctor's time. He felt that it was to the latter group only that one would be acting in a saintly fashion by accepting them voluntarily. He felt that as a doctor he had certain obligations, one of which was to make himself available to the sick even at his own expense, and if doctors would accept that obligation there would be no need to allocate patients except the few who were unreasonably demanding.

He was also interested in knowing how open the second doctor would be with the family when he signed them on as temporary residents. Would he explain to them that it was to be a test period? If not, he wondered what principle other than self interest he would use to justify it?

The second doctor agreed that not to tell the family would be

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dishonest. Just as important, he thought that to tell the family might put them at risk, as they might not call the doctor when medically necessary to avoid the label of "heavy user." He accepted the third doctor's distinction between "heavy users" and "unreasonable demanders" and agreed that it was for this group only that a test period was acceptable, after a full explanation to the patient. All the doctors agreed that the principle of honesty should be placed high in the doctor-patient relationship. Therefore they rejected the second option leaving options one and three open to them.

The options

The first doctor used the concepts of duty and justice and called on utilitarian theory—that is, that by accepting "heavy users" by allocation only he would free more of his time and energy to spend on other patients. Thus the total amount of good achieved would be greater. He rejected any supererogatory duties—that is, duties based on ideals.

The third doctor also used the concept of justice, together with nonmaleficence. He thought that he had certain obligations to the family because of the family's right and of a supererogatory nature based on a concept of professional ideals. In his analysis justice would follow if the medical profession would accept its supererogatory duty. He rejected the theory that ultimately one should be guided by the maximisation of good.

The two doctors are nearer in their thinking than one might suppose. They both imply that the medical profession has a duty to provide health care for the family. There is no suggestion that the family should not be on someone's list. Indeed, they imply that duty is of a supererogatory nature because they think even "unreasonable demanders" should receive care, but the burden of care should be shared by the whole medical profession. From this it is reasonable to suppose that if either doctor was the only doctor in the area each would act in the same way—that is, accept the family.

In the real world, however, there is more than one group of doctors in most areas. The question raised is really how patients should be shared between them, and the ethical issue is the doctor's autonomy versus the patient's. If the patient is to have the full right of free choice of doctor then the medical profession must agree to respect that right and to accept a loss of autonomy. To be practical it would be an impossible situation. So, there would have to be some agreed restrictions on this right. For example, a patient could not choose a doctor whose list was already full or travel more than a certain distance from her home to find a doctor. On the other hand, if the doctor's autonomy in refusing patients is to be preserved it must be recognised that this will be at the expense of a patient's rights, and even then to preserve professional ideals some loss of autonomy must be allowed for by a system of allocation.

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Diary of Urban Marks: 1880-1949

On the same evening as my appearance before the house committee Mr Gosling arrived at 5 pm. He had sent a case in during the day and was now about to visit her in hospital. He asked me if I had seen and examined her. I replied that I had done so and agreed with him that operation was necessary. He said that he would operate at 8 pm. I told him I should not be there as I was playing bridge with Corder. He remarked that he would, no doubt, manage without me. We came down into the hall and he asked me to assist him to put his coat on. He stretched himself luxuriously and remarked that he was very tired. I asked him if he ever took a holiday. He looked at me askance and smilingly said, "Marks, you are a funny fellow." I replied that I was not the only funny thing around and in Worcester. He took me by the arm and asked me to walk down the drive with him. I noticed several heads peeping out of the windows overlooking the drive and everyone was wondering what was happening. Gosling said that he had taken a fancy to me. I duly thanked him. He asked me if I would care to come to him as a locum during his holidays, but after I had told him my plans he asked me to communicate with him on my return. He then asked me to dinner with him but I firmly declined, saying that I had been in Worcester for six months, a cathedral city with bells ringing incessantly and where there was no theatre. Cinemas were of course unknown. As no one member of the honorary staff had thought it worth while to invite me out for a night I was not inclined now that I was on the point of leaving to accept invitations. I told him, however, that it would be a good thing, and a nice thing, too, to invite future housemen to dinner occasionally. It would promote good fellowship and a better understanding between the staff and residents.

Then I asked him why everyone feared Bates. He said that Bates was the original surgeon and that he (Gosling) himself had been house surgeon in previous years. As time went on and Bates grew old he became more and more a martinet and no one dared or cared to thwart him, apparently out of respect to his grey hairs. Bates had so to speak become "dug in," but when he retired things would be altered. And so we parted.

On my return from Corder's that night I was met by the matron who was greatly perturbed. She informed me that one of the staff nurses, Fairleigh by name, was in a raging delirium and was shouting that I was the father of her child. I gathered that she had suddenly collapsed and had become insane. I went to see her and as soon as she saw me she became violent and vituperative. I gave her an injection to quieten her and left her in charge of the attendants. The matron of course asked me if there was any truth in the allegation. I asked her what she thought and she was kind enough to say that

the girl was insane. In two days the nurse became saner and, in the charge of her people who had been sent for, departed.

I did not tell the matron what I knew, but the truth of the matter was this. At the lower end of the lawn there was a small cottage with four beds. These were used for very septic or isolation cases. It was in charge of a staff nurse and every night when on duty either Mac or myself had to visit the place for the nightly report, just as we had to visit every ward before going to bed. One night about six weeks before the outbreak of the nurse I had been out at Corder's and did not arrive back till very late. I went as usual to the cottage but found the door locked. I knocked but no one came. This was very unusual and I knocked incessantly until finally the door was opened by Fairleigh. I noticed that she had no cuffs nor cap on and that her hair was disarranged. I was very wroth at being kept waiting and accused her of being asleep. She denied this and said she had been attending to an obstreperous patient. I said I would see him but she said that he was now quiet and sleeping. It was therefore unnecessary. She barred my way but I pushed her aside and walked through into the kitchen. There I saw Mac sitting in the armchair with a foolish smile on his face. I remarked that I was sorry I had intruded at an inconvenient moment and hurriedly departed. The affair was never mentioned between us after this and I had forgotten all about it until it was suddenly recalled to memory on the night Fairleigh went insane. Why she did so I cannot tell. I know not. Perhaps there was a fear that Mac would never come back or perhaps he had written to her while he had been away and said a few inconvenient things in the letter. No doubt Fairleigh thought that half a loaf was better than none at all and hence tried to drag me into the matter. Years afterwards I saw a notice in a society paper of Mac's wedding and the bride was not Fairleigh.

Two days afterwards I was asked by the matron to attend a little function in the board room. By the matron I was presented with a Worcester china coffee set, which had been subscribed for by the nursing staff. Before accepting this I asked those present if anyone present believed what Fairleigh had been shouting down the four winds of Heaven. Every sister present told me that the nursing staff did not believe a word and one even hinted that she knew what had happened. I did not enlighten them and thanked them for the gift.

At Worcester I gained a good experience in rheumatic troubles especially the heart. Being on a river and misty and damp the town-people suffered from rheumatism and its effects. Dr Crowe was the senior physician and was a wise old man with plenty of common sense. Dr Reed was younger but middle aged, and from them both I learned much diagnosis and treatment. I still use some of their prescriptions in preference to some of the new drugs so widely advertised today.