

# MEDICAL ETHICS 1

## HEALTH CARE PROFESSIONAL'S PATIENT RELATIONSHIP

### ABSTRACT

#### OBJECTIVES

After working through this course you should be able to:

- explain why all patients are deserving of respect and equal treatment;
- identify the essential elements of informed consent and;
- more



#### WHAT'S SPECIAL ABOUT THE HEALTH CARE PROFESSIONALS-PATIENT RELATIONSHIP?

The health care profession-patient relationship is the cornerstone of medical practice and therefore of medical ethics. The Declaration of Geneva requires of the health care profession that "The health of my patient will be my first consideration," and the International Code of Medical Ethics states, "A health care profession shall owe his patients complete loyalty and all the resources of his science." The traditional interpretation of the health care professional-patient relationship as a paternalistic one, in which the health care professional made the decision and the patient submitted to them, has been widely rejected in recent years, both in ethics and in law. Since many patients are either unable or unwilling to make decisions about their medical care, however, patient autonomy is often very problematic.

This on-line course will deal with two topics that pose particularly vexing problems to Health Care Professionals in their daily practice: respect and equal treatment, communication and consent.

#### RESPECT AND EQUAL TREATMENT

The belief that all human beings deserve respect and equal treatment is relatively recent. In most societies

disrespectful and unequal treatment of individuals and groups was accepted as normal and natural. Slavery was one such practice that was not eradicated in the European colonies and the USA until the 19<sup>th</sup> century and still exists in some parts of the world. The end of institutional discrimination against non-whites in countries such as South Africa is much more recent. Women still experience lack of respect and unequal treatment in most countries. Discrimination on the basis of age, disability or sexual orientation is widespread. Clearly, there remains considerable resistance to the claim that all people should be treated as equals.

In the 20<sup>th</sup> century there was considerable elaboration of the concept of human equality in terms of human rights.

One of the first acts of the newly established United Nations was to develop the Universal Declaration of Human Rights (1948), which states in article 1, "All human beings are born free and equal in dignity and rights." Many other international and national bodies have produced statements of rights, either for all human beings, for all citizens in a specific country, or for certain groups of individuals ('children's rights', 'patients' rights', consumers' rights', etc.).

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The medical profession has had somewhat conflicting views on patient equality and rights over the years. On the one hand, health care professionals have been told not to “permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient” (Declaration of Geneva). At the same time health care professionals have claimed the right to refuse to accept a patient, except in an emergency. Although the legitimate grounds for such refusal include a full practice, (lack of) educational qualifications and specialization, if health care professionals do not have to give any reason for refusing a patient, they can easily practice discrimination without being held accountable. A health care professional's conscience, rather than the law or disciplinary authorities, may be the only means of preventing abuses of human rights in this regard.

Even if health care professionals do not offend against respect and human equality in their choice of patients, they can still do so in their attitudes towards and treatment of patients. Case study #1 described on page 4 illustrates this problem. Compassion is one of the core values of medicine and is an essential element of a good therapeutic relationship. Compassion is based on respect for the patient's dignity and values but goes further in acknowledging and responding to the patient's vulnerability in the face of illness and/or disability. If patients sense the health care professional's compassion, they will be more likely to trust the health care professional to act in their best interests, and this trust can contribute to the healing process.

### ENDING A PATIENT RELATIONSHIP WITH HEALTH CARE PROFESSIONAL

The trust that is essential to the health care professional-patient relationship has generally been interpreted to mean that health care professionals should not desert patients whose care they have undertaken. The WMA's International Code of Medical Ethics implies that the only reason for ending a health care professional-patient relationship is if the patient requires another health care professional with different skills: “A health care professional shall owe his patients complete loyalty and all the resources of his science. Whenever an examination or treatment is beyond the health care professional's capacity he should summon another health care professional who has the necessary ability.”

Many health care professionals, especially those in the public sector, often have no choice of the patients they treat. Some patients are violent and pose a threat to the health care professional's safety. Others can only be described as obnoxious because of their antisocial attitudes and behavior. Have such patients forsaken their right to respect and equal treatment, or are health care professionals expected to make extra, perhaps even heroic, efforts to establish and maintain therapeutic relationships with them? With such patients, health care professionals must balance their responsibility for their own safety and well-being and that of their staff with their duty to promote the well-being of the patients. They should attempt to find ways to honor both of these obligations. If this is not possible, they should try to make alternative arrangements for the care of the patients

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### HIV/AIDS

Another challenge to the principle of respect and equal treatment for all patients arises in the care of



infectious patients. The focus here is often on HIV/AIDS, not only because it is a life-threatening disease but also because it is often associated with social prejudices. However, there are many other serious infections including some that are more easily transmissible to healthcare workers than HIV/AIDS. Some health care professionals hesitate to perform invasive procedures on patients with such conditions because of the possibility that they, the health care professionals, might become infected. However, medical codes of ethics make no exception for infectious patients with regard to the health care professional's duty to treat all patients equally. The **World Medical Association's (WMA's) Statement on the Professional Responsibility of Health Care Professionals in Treating AIDS Patients** puts it this way:

*AIDS patients are entitled to competent medical care with compassion and respect for human dignity.*

*A health care professional may not ethically refuse to treat a patient whose condition is within the health care professional's current realm of competence, solely because the patient is seropositive.*

*Medical ethics do not permit categorical discrimination against a patient based solely on his or her seropositivity. A person who is afflicted with AIDS needs competent, compassionate treatment. A health care professional who is not able to provide the care*

*and services required by persons with AIDS should make an appropriate referral to those health care professionals or facilities that are equipped to provide such services. Until the referral can be accomplished, the health care professional must care for the patient to the best of his or her ability.*

### SEXUAL ATTRACTION

The intimate nature of the health care professional-patient relationship can give rise to sexual attraction. A fundamental rule of traditional medical ethics is that such attraction must be resisted. The Oath of Hippocrates includes the following promise: "Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male person...." In recent years many medical associations have restated this prohibition of sexual relations between health care professionals and their patients. The reasons for this are as valid today as they were in Hippocrates' time, 2500 years ago. Patients are vulnerable and put their trust in health care professionals to treat them well. They may feel unable to resist sexual advances of health care professionals for fear that their treatment will be jeopardized. Moreover, the clinical judgment of a health care professional can be adversely affected by emotional involvement with a patient.

### TREATING FAMILY MEMBERS

This latter reason applies as well to health care professionals treating their family members, which is strongly discouraged in many medical codes of ethics. However, as with some other statements in codes of

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ethics, its application can vary according to circumstances. For example, solo practitioners working in remote areas may have to provide medical care for their family members, especially in emergency situations.

### COMMUNICATION AND CONSENT

Informed consent is one of the central concepts of present-day medical ethics. The right of patients to make decisions about their healthcare has been enshrined in legal and ethical statements throughout the world.



The WMA **Declaration on the Rights of the Patient** states:

*“The patient has the right to self-determination, to make free decisions regarding himself/herself.*

*The health care professional will inform the patient of the consequences of his/her decisions. A mentally competent adult patient has the right to give or withhold consent to any diagnostic procedure or therapy. The patient has the right to the information necessary to make his/her decisions. The patient should understand clearly what the purpose of any test or treatment is, what the results would imply, and what would be the implications of withholding consent.”*

A necessary condition for informed consent is good communication between health care professional and patient. When medical paternalism was normal, communication was relatively simple; it consisted of the health care professional's orders to the patient to

comply with such and such a treatment. Nowadays communication requires much more of health care professionals. They must provide patients with all the information they need to make their decisions. This involves explaining complex medical diagnoses, prognoses and treatment regimes in simple language, ensuring that patients understand the treatment options, including the advantages and disadvantages of each, answering any questions they may have, and understanding whatever decision the patient has reached and, if possible, the reasons for it. Good communication skills do not come naturally to most people; they must be developed and maintained with conscious effort and periodic review.

As from 2010 a written informed consent for cervical manipulation and Dry Needling is mandatory. The following text for your assessment forms is recommended.

**Hereby I agree to any physical examination and treatment [including needling and manipulation] on which the therapist decides after having discussed the possible effects with me. I also agree that the therapist may report back to the referring medical doctor or physiotherapist [if applicable].**

**SIGNED:** .....

**DATE:** .....

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### CASE STUDY #1

Dr P, an experienced and skilled surgeon, is about to finish night duty at a medium sized community hospital. A young woman is brought to the hospital by her mother, who leaves immediately after telling the intake nurse that she has to look after her other children. The patient is bleeding vaginally and is in a great deal of pain. Dr P examines her and decides that she has had either a miscarriage or a self-induced abortion. He does a quick dilatation and curettage and tells the nurse to ask the patient whether she can afford to stay in the hospital until it is safe for her to be discharged. Dr Q comes in to replace Dr P, who goes home without having spoken to the patient.

**Do you think that Dr P's conduct was deficient in any way? To learn more see question section.**

understand the diagnosis and treatment options provided by their health care professional. In such circumstances health care professionals should make every reasonable effort to probe their patients' understanding of health and healing and communicate their recommendations to the patients as best they can.

If the health care professional has successfully communicated to the patient needs and wants to know about his or her diagnosis, prognosis and treatment options, the patient will then be in a position to make an informed decision about how to proceed. Although the term 'consent' implies acceptance of treatment, the concept of informed consent applies equally to refusal of treatment or to choice among alternative treatments. Competent patients have the right to refuse treatment, even when the refusal will result in disability or death.

### OBSTACLES TO GOOD COMMUNICATION

Two major obstacles to good health care professional-patient communication are differences of language and culture. If the health care professional and the patient do not speak the same language, an interpreter will be required. Unfortunately, in many settings there are no qualified interpreters and the health care professional must seek out the best available person for the task. Culture, which includes but is much broader than language, raises additional communication issues.



Because of different cultural understandings of the nature and causes of illness, patients may not

### CASE STUDY #2

#### A competent patient refuses treatment

Mrs X is 35 and is in need for Dialysis. She is refusing treatment because she is scared of the treatment which she believes is invasive. She has been counselled about the nature of the treatment- there are no alternatives that would be of practical benefit. She is competent to make treatment decisions. She understands if she refuses dialysis she will die. She has a daughter of 15 years who lives at home. The clinician believes very strongly that she should receive dialysis, but despite numerous attempts to persuade her she refuses.

**Can the clinician treat her? To learn more see questions section.**

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Evidence of consent can be explicit or implicit (implied). Explicit consent is given orally or in writing. Consent is implied when the patient indicates a willingness to undergo a certain procedure or treatment by his or her behavior. For example, consent for venipuncture is implied by the action of presenting one's arm. For treatments that entail risk or involve more than mild discomfort, it is preferable to obtain explicit rather than implied consent.

### **THERE ARE TWO EXCEPTIONS TO THE REQUIREMENT FOR INFORMED CONSENT BY COMPETENT PATIENTS:**

- Situations where patients voluntarily give over their decision making authority to the health care professional or to a third party. Because of the complexity of the matter or because the patient has complete confidence in the health care professional's judgment, the patient may tell the health care professional, "Do what you think is best." Health care professionals should not be eager to act on such requests but should provide patients with basic information about the treatment options and encourage them to make their own decisions. However, if after such encouragement the patient still wants the health care professional to decide, the health care professional should do so according to the best interests of the patients.
- Instances where the disclosure of information would cause harm to the patient. The traditional concept of 'therapeutic privilege' is invoked in such cases; it allows health care professionals to withhold medical information if disclosure would be likely to result in serious physical, psychological or

emotional harm to the patient, for example, if the patient would be likely to commit suicide if the diagnosis indicates a terminal illness. This privilege is open to great abuse, and health care professionals should make use of it only in extreme circumstances. They should start with the expectation that all patients are able to cope with the facts and reserve nondisclosure for cases in which they are convinced that more harm will result from telling the truth than from not telling it.

In some cultures, it is widely held that the health care professional's obligation to provide information to the patient does not apply when the diagnosis is a terminal illness. It is felt that such information would cause the patient to despair and would make the remaining days of life much more miserable than if there were hope of recovery. Throughout the world it is not uncommon for family members of patients to plead with health care professionals not to tell the patients they are dying. Health care professionals do have to be sensitive to cultural as well as personal factors when communicating bad news, especially of impending death. Nevertheless, the patient's right to informed consent is becoming more and more widely accepted, and the health care professional has a primary duty to help patients exercise this right.

### **ABUSING MEDICAL RESOURCES**

In keeping with the growing trend towards considering healthcare as a consumer product and patients as consumers, patients and their families not infrequently demand access to medical services that, in the considered opinion of health care professions, are not appropriate.

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Examples of such services range from antibiotics for viral conditions to intensive care for brain-dead patients to promising but unproven drugs or surgical procedures.

Some patients claim a 'right' to any medical service that they feel can benefit them, and often health care professions are only too willing to oblige, even when they are convinced that the service can offer no medical benefit for the patient's condition. This problem is especially serious in situations where resources are limited and providing 'futile' or 'non-beneficial' treatments to some patients means that other patients are left untreated.

### CASE STUDY #3

Dr. A is becoming increasingly frustrated with patients who come to her, either before or after consulting another Health Practitioner for the same ailment. She considers this to be a waste of health resources as well as counter-productive for the health of the patients. She decided to tell these patients that she will no longer treat them if they continue to see other practitioners for the same ailment. She intends to approach her medical association to lobby the government to prevent this form of misallocation of health care resources.

**Is Dr. A right to consider the impact on society of her patient's behavior. Is she also right to approach a Medical association? To learn more see question section.**

### FUTILE AND NON-BENEFICIAL TREATMENTS

**Futile** and **non-beneficial** can be understood as follows. In some situations a health care profession can

determine that a treatment is 'medically' futile or non-beneficial because it offers no reasonable hope of recovery or improvement or because the patient is permanently unable to experience any benefit. In other cases the utility and benefit of a treatment can only be determined with reference to the patient's subjective judgment about his or her overall well-being. As a general rule a patient should be involved in determining futility in his or her case. In exceptional circumstances such discussions may not be in the patient's best interests. The health care profession has no obligation to offer a patient futile or non-beneficial treatment.

The principle of informed consent incorporates the patient's right to choose from among the options presented by the health care profession. To what extent patients and their families have a right to services not recommended by health care professions is becoming a major topic of controversy in ethics, law and public policy. Until this matter is decided by governments, medical insurance providers and/ or professional organizations, individual health care professions will have to decide for themselves whether they should accede to requests for inappropriate treatments. They should refuse such requests if they are convinced that the treatment would produce more harm than benefit. They should also feel free to refuse if the treatment is unlikely to be beneficial, even if it is not harmful, although the possibility of a placebo effect should not be discounted. If limited resources are an issue, they should bring this to the attention of whoever is responsible for allocating resources.

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### FOR YOUR INTEREST ONLY

This case study will consolidate your knowledge and clarify concepts discussed earlier. No questions to be asked from this case study.

#### WHO SHOULD HAVE THE INTENSIVE CARE BED?

Case discussion on resource allocation in ICU

#### WHO SHOULD HAVE THE INTENSIVE CARE BED?

Barry is a 32 year old man with meningitis and is brought into the A&E department of hospital A. He is unconscious with an extremely low blood pressure and evidence of renal failure. His condition is grave and without intensive care support he is almost certain to die. With intensive care support he may make a full recovery. Until this illness he has been fit and well. The Intensive Care Unit (ICU) in hospital A is full, with some patients critically ill and some in a relatively stable condition but for who optimum care would still require the facilities of an ICU. There is evidence that moving a patient from an ICU early increases their chances of complications and may increase mortality. There is an available bed in an ICU in hospital B, which is fifty miles away. The intensive care consultant on call must decide if Barry should be moved to hospital B or if a patient already in ICU should be transferred to allow Barry to be admitted. The clinical ethics committee is asked to review the case retrospectively and advise on how such cases should be approached in the future.



### QUESTIONS

#### 4 TO CONSIDER

1. Does the clinical team, or the institution, owe an equal duty of care to both patients?
2. If each patient is owed the same duty of care, should the aim be to maximise the chance that both patients live, or minimise the chance that both patients die.
3. In contrast to 2, should the sickest patient be given any greater priority in receiving best possible care?
4. If the patient in ICU is owed a greater duty of care, is this **sufficient** to justify the decision not to admit the other patient, given the foreseeable probable outcome?
5. Is patient autonomy relevant in this situation?

Keep in mind that it is not possible to provide the best care to both patients

#### DISCUSSION OF THE ISSUES.

The first step in considering such a dilemma is to establish the clinical facts and clarify the concepts used. This is an important part of the process of any ethical discussion, but is particularly important in issues of resource allocation when underlying ethical principles include terms such as benefit and need that may be open to interpretation. Thus information such as what will be the benefit of a certain course of action, and to whom it will accrue, and the relative need of the individuals involved, is essential to inform the ethical debate.



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### MAXIMISING BENEFIT

One way of looking at the dilemma would be to consider the relative benefit of different courses of action. The benefit to Barry of being admitted to ICU is clear; he will die if he is not given intensive care. However, the actual benefit will depend on the likelihood of his surviving even with intensive care. If his chances of making a full recovery are 80% the potential benefit will be greater than if his chance of surviving, even with intensive care, is 10%. The effect of transferring Barry to another hospital on his likely survival would also be important.

For a patient already in ICU in hospital A, there can be no benefit from moving them out of ICU and transferring them to another hospital. The assessment here would be of the possible risk of such a move and the likely effect on their long-term recovery. If the risk is small, and the risk of moving Barry is great, then a utilitarian calculation of the overall benefit may support the transfer of a stable patient in hospital A to provide a bed for Barry. However, a greater risk of transfer for patients already in ICU combined with only a small chance of benefit to Barry from admission (a high likelihood that he will not survive even with treatment) may give a different answer if the criterion for the decision is overall benefit.

### RESPONDING TO NEED

Another way of looking at this dilemma is from the point of view of the relative need for intensive care treatment. Barry is in urgent need because without intensive care treatment he will die. One can argue that we have a moral responsibility to respond to such urgent need even if the chances of success are small and it involves a small risk of potential harm to others.

### RESPECTING AUTONOMY

Respecting a patient's autonomous wishes is an important ethical principle in health care. What weight should be given to the refusal of a patient, or their relatives, to agree to a transfer to another hospital to allow a very sick patient to have their bed? What about the autonomous wish of the patient in the casualty department to have appropriate care in the hospital to which they have been brought? In terms of acceding to patients' or relatives' wishes, the principle of autonomy is not particularly helpful in this situation.

### DUTY OF CARE

Health professionals in an ICU have a duty of care to their patients and must act in their patients' best interests. Therefore it may be very difficult for them to make a decision that is not entirely in their patient's best interest. The question arises as to whether the intensive care team also has a duty of care to a patient who is currently physically elsewhere in the hospital but who is in need of intensive care treatment.

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Faculty Lecturer (part-time), Faculty of Religious  
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Principal Research Associate, Center for Bioethics,  
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Research Associate Professor (Chercheur agrégé),  
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Lecturer (part-time), Department of Religion, Concordia  
University, Montreal (1989-90)

Adjunct Professor, Department of Religion, Concordia  
University (1991-92)

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## **REFERENCES**

### **BEGINNING-OF-LIFE ISSUES**

Human cloning - [www.who.int/ethics/topics/cloning/en/](http://www.who.int/ethics/topics/cloning/en/)  
Assisted reproduction – [www.who.int/reproductive-  
health/infertility/report\\_content.htm](http://www.who.int/reproductive-health/infertility/report_content.htm)

### **END-OF- LIFE ISSUES**

Resources – [www.nih.gov/sigs/bioethics/endorlife.html](http://www.nih.gov/sigs/bioethics/endorlife.html)  
Education in Palliative and End-of-life Care –  
[www.epec.net/EPEC/webpagars/index.cfm](http://www.epec.net/EPEC/webpagars/index.cfm)  
Opposition to euthanasia – [www.euthanasia.com](http://www.euthanasia.com)

### **HIV/AIDS**

UNAIDS –  
[www.unaids.org/eb/PolicyAndPractice/default.asp](http://www.unaids.org/eb/PolicyAndPractice/default.asp)

### **RELATIONS WITH COMMERCIAL ENTERPRISES**

Educational resources – [www.ama-  
assn.org/ama/pub/category/5689.html](http://www.ama-assn.org/ama/pub/category/5689.html)

### **RESEARCH ON HUMAN SUBJECTS**

Guidelines and resources –  
[www.who.int/ethics/research/en/](http://www.who.int/ethics/research/en/)  
Harvard School of Public Health, ethical issues in  
international health research course  
[www.hsph.harvard.edu/bioethics/](http://www.hsph.harvard.edu/bioethics/)  
Training and Resources for Research Ethics  
Evaluation – [www.trree.org/site/en\\_home.phtml](http://www.trree.org/site/en_home.phtml)

UNESCO Chair in Bioethics informed consent case  
studies – <http://research.haifa.ac.il/mediaw/> (UNESCO  
Chair)

Uk Clinical Ethics Network case studies:  
[www.ethics-network.org.uk/case-studies/](http://www.ethics-network.org.uk/case-studies/)

Harvard School of Public Health international health  
research case studies:  
[www.hsph.harvard.edu/research/bioethics/cases/](http://www.hsph.harvard.edu/research/bioethics/cases/)