

The Family Physician And Ethics At The Bedside

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Abstract: Background: Clinical ethics and ethics committees are a real phenomenon in medicine and play an important role in improving patient care by enhancing the decision-making process between patients and their physicians and thus strengthening this special bond. This article reviews the evolving qualifications of the clinical ethics consultant and compares them with the traditional knowledge, skills, attitudes, and values of the family physician.

Methods: Material for this comparison was gathered from a review of the pertinent literature of the past 10 years on the development of clinical ethics and the addition of ethics to the medical curriculum and from personal observations and literature commentary on family practice as a distinct entity.

Results and Conclusions: Family physicians are uniquely qualified to serve as ethics consultants, particularly with additional training in moral philosophy and health care law. It is hoped that family physicians will become increasingly involved in this growing field to serve as future teachers, researchers, institutional leaders, and policy makers in clinical ethics. More importantly, faculty role models are needed to train family practice residents in ethical decision making at the bedsides of their patients. (J Am Board Fam Pract 1993; 6:49-54.)

Medicine is inherently a moral enterprise.¹ The practice of medicine involves determining what is both good and right for the individual patient. For many generations this concept was accepted by physicians and their patients, and the result was a trusting, personal, one-on-one, physician-patient relationship. In the recent past, however, the exponential development of technology, the consequent specialization of medical practice, the entry of third-party payers, increased governmental regulation, and the proliferation of litigation have changed the face of medicine. One of the unfortunate results of this evolution has been an erosion of the physician-patient relationship.²⁻⁴

Theologians and philosophers were the first to recognize the detrimental effects of these changes. More than a quarter century ago, they coined the term *bioethics*. Their focus was primarily on the principles of biomedical ethics, most of which had been operative for centuries without being clearly articulated or studied. These same principles have more recently been transposed from the textbooks to the patient's bedside, giving rise to the growing

field of clinical medical ethics. Clinical ethics has attempted to improve patient care by enhancing the decision-making process between patients and their physicians, thereby helping to strengthen and restore the patient-physician bond. So important has this transformation become that the teaching of clinical ethics is now an integral part of most medical school curricula across the country⁵ with postgraduate programs rapidly developing.

There is urgent need for all clinicians to be trained in the principles of clinical ethics so they can apply them at the bedside of their patients.⁶ There is also great need for physicians to be further trained in ethics to serve as teachers, researchers, policy makers, leaders of ethics committees, and ethics consultants. Practicing physicians and house staff rank clinical ethics education as an inadequately emphasized set of clinical skills.⁷⁻¹⁰ Ethics consultation has been shown to have a significant impact on patient care.^{11,12} Hospitals and nursing homes struggle to develop difficult institutional policies, and courts have supported the role of ethics committees and consultants in helping resolve difficult ethical dilemmas in patient care while minimizing legal intrusion into the clinical decision-making process.¹³

The scope of clinical ethics,¹⁴ including the need for ethics consultations,¹⁵ has been outlined by others. Debates continue whether such consultations should be done by philosophers or cli-

Submitted, revised, 18 August 1992.

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nicians¹⁶ or ethics committees or ethics consultants.^{17,18} The primary issue, however, is not who should perform such service, but rather what are the qualities and qualifications needed to perform ethics consultation.

It is our contention that with additional training, especially in moral philosophy and health law, the family physician as a primary care specialist is uniquely qualified to serve in such a capacity. In this paper the goals, knowledge, skills, and attitudes that have been articulated for the clinical ethicist are compared with those of the family physician. We hope that such comparison will encourage family physicians to become more involved in this developing field and further assist in the transformation of ethics to the bedside of our patients.

Methods

Material for this comparison was gathered from a review of the pertinent literature of the past 10 years on the development of clinical ethics and the addition of ethics to the medical curriculum and from personal observations and literature commentary on family practice as a distinct entity.

Goals of Clinical Ethics

The goals of clinical ethics have been outlined and discussed by others.^{19,20} Clinical ethics should enhance the standard and quality of medical care and should thus improve patient outcomes. Ethics consultations should promote shared decision making among patients, families, and members of the health care team. Clinical ethics should help medical professionals recognize, analyze, and resolve moral dilemmas that arise in the care of individual patients. The clinical ethicist should help educate physicians in ethical decision making and reaffirm rather than undermine the professional responsibilities of the primary care physician.

Clinical ethics plays an important role in the delivery of high-quality medical care. Whereas the goals of clinical ethics are shared in principle by most clinicians, the family physician is the specialist who has incorporated more clearly those goals into practice.^{21,22} "Family physicians have carried a torch for a number of ideals in medical care, each of which has been more or less problematic for mainstream medicine."²³ Those ideals include generalism, continuity of care, access to

care, family and behavioral orientation, cost effectiveness, and personalized medicine. It is often the family physician who exemplifies Peabody's²⁴ admonition that "The secret of the care of the patient is caring for the patient" and who understands and accepts the physician's responsibility in decision making.²⁵

Qualifications of Clinical Ethicists

The qualifications of an ethics consultant have likewise been discussed by others.^{20,26,27} These can be summarized as requirements of knowledge, skills, and attitude (Table 1). We believe that many family physicians are particularly well qualified in each of these areas.

Knowledge

Clinical ethicists should be competent clinicians and should have adequate knowledge of moral reasoning, ethical decision making, health care law, and institutional policy. They should also be able to view the patient longitudinally within a broad social context.

Family physicians, even without additional training in ethics, have a much broader clinical experience than most other specialists. They see patients of all ages with problems in any and all organ systems. They are comfortable in all medical care settings including office, hospital ward,

Table 1. Qualifications of Ethics Consultants.

Knowledge	Clinical medicine
	Moral reasoning
	Ethical decision making
	Health care law
	Institutional policy
Skills	Communication
	Negotiation
	Education
	Coordination
	Facilitation
	Assessment of decision-making capacity
Attitude	Ethical analysis
	Common sense
	Empathy
	Objectivity
	Advocacy
	Patience
	Humility
	Team approach
	Comfort talking about death
	Comfort with uncertainty
	Comfort with challenge

emergency department, intensive care unit, operating room, delivery suite, newborn nursery, nursing home, and the patient's home. Within these treatment settings, family physicians must have a working knowledge of the diagnostic evaluation, prognosis, and therapeutic options of most of the commonly experienced medical problems. Because of the diversity of their clinical exposure, family physicians have experienced many of the same ethical dilemmas confronting clinicians from many specialties within these settings.

Family practice offers comprehensive, continuous care within the context of the family structure. This approach incorporates the bio-psycho-socio-spiritual approach to health care and often leads to a better understanding of the patient's personal values and the impact of illness on the family. Combining clinical judgment with a long-term patient relationship is one of the strengths of family practice.

Skills

The ethics consultant must be able to review the medical record, gather complex information from the chart, and interview patients, families, and other health care professionals to analyze a case appropriately. The ethicist must be able to assess patient decision-making capacity, elicit patient values, and help the patient choose desired goals of therapy from those goals that are possible. This process can be facilitated by encouraging good communication and education among patients, staff, and family, which frequently takes place in the family conference, where discussion and negotiation of treatment goals and options can occur. The ethics consultant needs to frame the ethical questions, determine which options are ethically permissible, and make recommendations and at the same time not undermine the authority of the attending physician. The ethics consultant occasionally acts as a coordinator of the care plan after decisions have been made.

Communication is an essential skill of family physicians. They continually communicate with patients and families. They advocate for the patient in dealing with the family or the health care system, and likewise they advocate for the family with both the patient and the system. They often act as an intermediary between their patients and other subspecialists. Family physicians commonly use a family conference as a forum for education

and negotiation. Family physicians are often placed in the role of health educator and in that role are involved with individual patients, families, and the community. Because family physicians' practices are primarily office based, they are likely to be familiar with available community services, such as home health agencies and hospices. They are well equipped, therefore, to suggest management options for patients with complex needs and to coordinate and facilitate implementation of the patient's choice.

Attitudes

Clinical ethicists must possess a great deal of practical wisdom. They need to be empathic and have the ability to understand how patients experience illness from their own perspective. Clinical ethicists must strive for objectivity and minimize personal bias. Ethics consultants should be strong advocates of patient rights and individual autonomy. They must be comfortable discussing issues surrounding death and dying. They must also be able to deal with both moral and clinical uncertainty and be humble enough to recognize their own limitations in determining what is right or wrong for the patient. They must be willing to work within a team setting and seek additional consultation when necessary to clarify prognosis and treatment options. They must be patient and willing to spend a great deal of time in resolving some of the most challenging ethical dilemmas.

Family physicians have traditionally been practical, empathic clinicians who are strong advocates for patients and families. They tend to take a common-sense approach that emphasizes prevention and cost effectiveness more than technological feasibility. In exchanging depth of knowledge for breadth, family physicians are frequently humbled when reaching the limit or uncertainty of their clinical abilities. They provide continuity of care in the office, hospital, nursing home, and home hospice settings. They follow families throughout the life span, provide care for the dying, and often provide family support after a patient's death.²⁸

Most family physicians have several of these qualifications, including adequate clinical knowledge, pertinent interpersonal skills, and appropriate attitudes toward patients. Most do not have sufficient background in moral philosophy, ethical decision making, health law, or health policy,

however, to serve as a clinical ethicist without further training.

Case Report

A hospice nurse called a family physician ethicist and requested an ethics consultation. The patient was a 45-year-old widowed man with rapidly progressive amyotrophic lateral sclerosis who was being cared for at home by his 3 young-adult children. He had decided that the burdens of his progressive disease had become great enough that he did not want his life prolonged by having a tracheostomy and ventilator assistance, and he also wanted to discontinue the nasal continuous positive airway pressure that he had been using for 2 months. Although it had brought him relief from dyspnea at first with night-time use only, he was now using it more than 20 hours per day and was still symptomatic. His hospice caregivers and his pulmonologist were somewhat uncomfortable with discontinuing current therapy and thus hastening his death.

The ethicist discussed the clinical situation with the nurse, the pulmonologist, and the home mechanical ventilator team who had assessed the patient. He then visited the patient at home and met with him and all 3 children and 2 of their spouses. It was apparent that they were a close, caring family and that all 3 children shared the patient's values regarding life, health, spiritual matters, and death. The physician believed that the patient had decision-making capacity, was adequately informed, was not clinically depressed, and felt under no pressure from his family or others in the course he had chosen. His family was supportive of his decision.

He then discussed the ethical issues and the legal precedents with the hospice nurse and the pulmonologist and submitted a written report to them. They also considered the clinical implications of the decision and options for symptom control for the patient. All parties were subsequently comfortable with their continued involvement with the patient until he died a few days later.

Barriers

Though we have argued that many family physicians are uniquely qualified to train and serve as ethics consultants, their experience and capabilities could be detrimental in two aspects of ethics

consultation. First, they are accustomed to making decisions, instituting therapy, and providing continuity of care in all settings. It could be more difficult for a family physician-ethicist to perform a consultation, make recommendations, and leave the decisions and follow-up care to others.

Second is the problem of "keeping up." All clinicians and all ethicists face the problem of staying abreast of new developments and trends in the literature. Because the scope of family medicine is so broad, keeping up is particularly acute for the family physician. Family physicians also serving as ethics consultants must strive to stay current with a broad range of clinical medicine, as well as the burgeoning literature in clinical ethics.

Conclusions

The goals of clinical ethics are congruent with the goals of family medicine. The knowledge, skills, and attitudes possessed by most family physicians are closely aligned with those required of the clinical ethicist. In a sense, clinical ethics attempts to restore the eroding patient-physician bond, sharing strong common values with the family physician.

Teachers of family medicine should be encouraged to expand the curriculum for their residents to include ethics and health law. Basic curricular goals for the teaching of medical ethics have been developed by a national committee of prominent ethicists and educators.²⁹ Plans for teaching ethics to residents^{30,31} and specifically to family practice residents^{32,33} have also been published. Such matters as valid consent, assessment of decision-making capacity, confidentiality, limitation of treatment plans, management of the patient who refuses the physician's recommendation or who demands interventions believed to be inappropriate can be taught by using either didactic or case-based methods. Initiating such a curricular change could require additional faculty with training and expertise in clinical ethics, moral philosophy, and health care law. With the development of proper role models, family practice residents will come to understand the process of sound ethical decision making at the bedside of their patients. The result could be a decreased need for assistance from an ethics consultant in their future practices.

Experienced family physicians who already possess breadth and depth of clinical practice might be better suited than most other specialists to

undertake postgraduate training programs in ethics in preparation for a service or academic career in clinical ethics. Such programs are varied in depth and scope. Several universities offer doctoral programs in philosophical ethics. Several foundations (Charles E. Culpepper Foundation, Robert Wood Johnson Foundation, Rockefeller Foundation, and Woodrow Wilson National Fellowship Foundation) have supported postgraduate scholars in the medical humanities. In the last few years, several institutions have developed non-degree programs in clinical ethics, including 1- or 2-year fellowships (University of Chicago, University of Pittsburgh, Dartmouth, Cleveland Clinic) and part-time 2- or 3-year community-based faculty training programs (Lutheran General Hospital, Park Ridge, IL). The University of Illinois at Chicago offers shorter term fellowships. There are also a few intensive short courses in applied medical ethics, such as the regularly scheduled courses at the Kennedy Institute of Ethics (Georgetown) and the University of Washington in Seattle, plus occasional offerings at other institutions, such as Loma Linda, Loyola Marymount, and Michigan State.

In seeking postdoctoral training in clinical ethics, physicians should find a program that meets their particular needs. They should find out whether the program has adequate formal instruction from moral philosophers, theologians, health care attorneys, clinicians, and social scientists and whether it can provide sufficient clinical material to enable them to gain experience in bedside clinical ethics consultations. There is a great need for faculty trained in this growing field, and the participation of family physicians should be encouraged.

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