Editorials

Clinical Ethics And The Family Physician

In this issue of *The Journal*, Orr and Moss[1] present an intriguing proposal that urges family physicians to join the evolving field of clinical medical ethics. They correctly recognize that theologians and philosophers first recognized that the medical ethics of the past was inadequate for a new world of respirators, Medicare, and patients' rights. These founders started the new field of "bioethics."

Bioethics today comprises two overlapping parts: philosophical medical ethics and clinical medical ethics. Comparing various views about suicide, mercy-killing, and euthanasia is encompassed by the former; discussing how to keep patients free of pain, trading-off such freedom for consciousness, evaluating hospice referrals, planning discharge of terminal patients, and ensuring home nursing care concern the latter. Medicine needs both.

Orr and Moss focus on ethics consultation, proposing that family physicians are uniquely positioned for such roles. For them, "clinical ethics should help medical professionals recognize, analyze," and most importantly, "resolve moral dilemmas that arise in the care of individual patients." To fulfill this role, they say, such physicians will need knowledge, skills, and correct attitudes.

It is with this first prerequisite, knowledge, that I have my first caveat with their proposal. Most of the problematic cases that bother medical teams, especially those that come to hospital ethics committees, involve patients who are comatose. In a talk at the University of Alabama Medical Center in Birmingham, neurologist Ronald Cranford said most cases to date at Hennepin County Medical Center at Minneapolis-St. Paul involved such patients. Such cases also generate demands for ethics consultation. Given that fact, are family physicians uniquely or even best qualified to be clinical ethicists?

Neurologists would seem to be the most plausible candidates, at least as long as the caseload continues to have such a great number of cases of coma. Perhaps, if family physicians aspire to this role, they could take specialized training in neurology.

I do agree with Orr and Moss that family physicians encounter a much broader range of patients' problems than do hospital-based physicians, and the strengths of family physicians for clinical ethics here are obvious. Too often, care for patients with terminal conditions meets the cruel dilemma of intensivist overkill or abandonment. Family care offers a golden mean, especially in ensuring continuity of care with administrators, education of family members, home visits, and perhaps most important, someone who takes charge and whom the family trusts. Too often in tertiary-care hospitals, patients and families meet only specialists. Sometimes these specialists change every month, as in university hospitals. One of the loudest and most reasonable complaints of patients and families is that they get lost in this process. A caring family physician would be a welcome addition to this maze.

Orr and Moss perspicaciously predict two problems for the family physician as clinical ethicist: first, the transition from decision maker to advisor; second, the problem of mastering a growing, diverse field. Both merit comment.

Many persons attracted to the study of ethics, be it academically based or clinical ethics, have strong feelings and beliefs about current ethical problems. These persons can function well in clinical medical ethics only if they can keep private such feelings and beliefs. When they wish to persuade, they must let evidence, information, compassion, and patience convince a disagreeing physician. This more passive role will be extremely difficult to fulfill for some physicians, especially if they strongly disagree with decisions repeatedly taken in opposition to their advice.

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In their description of what a consultant does in clinical ethics, Orr and Moss also speak of "solving" problems. Solving problems, especially those ethical problems involving costs, can be more wish than reality. To be especially resisted is the concept that the family physician in the role of clinical ethicist enters as consultant with "the" right answers. Whether communicated verbally or nonverbally, this attitude guarantees failure.

Another problem Orr and Moss perceive for family physicians in clinical ethics is mastering a new field and keeping abreast of its new developments. This problem is important. Medical ethics has become a legitimate field of medical scholarship since its inception 25 years ago. It is neither a hobby nor something for which one can retrain by going off for 2 weeks to take a course. The best persons in this field have accumulated a large knowledge of medicine, law, history of medicine, and ethical theory and reasoning, as well as the interesting history of medical ethics itself.

Take this last item. Twenty-five years ago, Barnard prematurely transplanted the first human heart, raising many issues about technology, death, and quality of life. This transplant was followed in the early 1970s by the revelation of a half-dozen examples of questionable medical research, e.g., the Tuskegee study. In 1973 abortion was legalized, and in 1975 assisted reproduction helped produce Louise Brown. Were the controversies about frozen embryos and experimentation on live-born aborted fetuses then not enough, 1976 brought America the Quinlan case, which changed forever a long-held but antiquated tradition about removing care. The following years then brought controversies about removing food and water, Elizabeth Bouvia, and most recently, aid-in-dying.

All these new issues in medical ethics came before the new ethical crises of the 1980s: acquired immunodeficiency disease (AIDS) and uncontrollable medical costs. Each of these gigantic ethical issues contains hundreds of subissues, as any practicing physician knows. Beyond these issues, we have continuing controversies about Baby Does, involuntary commitment, animal experimentation, anencephalic cardiac donors, surrogate mothers, and not least, how to prevent the million teenage pregnancies in the US that have occurred each year for the last 20 years. And on the horizon but swiftly coming to the foreground are the real, practical implications of the Human Genome Project and such innovations as single-cell embryo diagnosis of genetic disease.

For the practicing ethicist, the above are merely the core issues of medical ethics proper and do not include knowledge of constitutional and federal law, regulations by the National Institutes of Health, Centers for Disease Control, and Health and Human Services, and the specific laws of one's own state about advance directives, brain death, refusal of care, and abortion, as well as other core topics. Moreover, to all this is needed general knowledge of medical history, public policy, and general culture. To become informed about all these issues and, more importantly, to do it well becomes a lot of work.

Add to these problems those of fully understanding a specific case. A full-fledged controversial case in a modern hospital, with divided teams of residents, nurses, attending physicians, and administrators, can easily consume all parties for many days, even weeks or months. In the past, when physicians or professors consulted in such cases, it was largely without compensation, but a growing trend has been to bill for consultation. Physicians in clinical ethics have argued that, inside medicine, what is not reimbursed is perceived as not valuable. At present, and with efforts of health maintenance organizations and the federal government to control costs, the status of such reimbursement is uncertain. Will lack of reimbursement affect the readiness of family physicians to consult?

Finally, Orr and Moss fail to emphasize one aspect of what having good "attitudes" means for the consulting clinical ethicist. Medical ethics is inseparably linked with the patient rights movement, and to be an ethicist in a hospital or community is inevitably to be perceived by physicians as an advocate for patients. That said, it is also true that some physicians perceive patient rights as "antiphysician." That perception could challenge family physician ethicists, as it has past ethicists.

Family physicians can indeed be good clinical ethicists. Howard Brody at Michigan State, one of the founders of bioethics, is a family physician who combines the highest standards of philo-

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sophical scholarship with clinical expertise. Dr. Brody today is one of the bright lights in the field. Let us hope that family medicine gives us many more like him.

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References

1. Orr RD, Moss R. The family physician and ethics at the bedside. J Am Board Fam Pract 1993; 6:49-54

Why Can't A Man Be More Like A Woman?

The medical interview is the family physician's principal tool for both diagnosis and treatment. Residency-trained family physicians have already received more detailed instruction and feedback regarding interview skills than have most other specialists, but we must nevertheless continue to explore ways in which we can enhance the therapeutic potential of the interview. Two recently presented studies are therefore of great interest to family physicians. The first suggests that women physicians display certain valuable interviewing skills more frequently than men. The second suggests that practicing physicians can enhance these sorts of skills following a brief and focused intervention and that measurable patient improvement results.

Charon and colleagues[1] have developed a narrative model of medical encounters that fundamentally looks at the medical interview as an example of reading the meaning of a text (i.e., the patient's story). Previous work on gender differences in the reading of literary texts suggests that women read differently from men — specifically, women more readily enter into the world of the text and identify emotionally with it, while men remain more distant from the text and see it as a source of facts to be abstracted. Applying this model to the medical interview, the authors elaborated some hypotheses: women physicians would demonstrate more interest in the patient's life narrative, would exercise less control over the interview content or process, would provide more comprehensive information to the patient, would show more receptivity toward the patient, and would spend more time and display more mutual behavior. (All of these interviewing behaviors have been shown in other research to be positively linked to improved therapeutic outcomes.[2])

Using a comprehensive and previously validated instrument that combines features of both quantitative and qualitative research methods, the authors studied 5 women and 6 men internists in the outpatient clinic of an Eastern, urban tertiary-care hospital. The results confirmed all hypotheses but one: women exercised as much control as men did over the structure of the interview. In the other four areas, women displayed the predicted behavior more frequently and at a statistically significant level.

Contrary to the assumptions of those who are suspicious of feminist agendas, Charon and colleagues have no interest in using their research as a club with which angry women can beat men physicians. Instead, they wish to use a novel research approach to focus attention upon behaviors that could have been neglected in earlier studies and that could readily be used by all physicians regardless of gender. How this approach might work is suggested in a separate study by Roter and Hall.[3]

Roter and Hall wished to demonstrate how primary care physicians could better respond to patients' psychosocial distress. They randomized to three groups 69 Baltimore-area primary care physicians representing a wide variety of practice settings. Two groups received 8 hours of continuing education on responding to emotional problems; in one group, training focused upon skills in handling emotion during the interview, while in the other group, training focused more on cognitive problem-solving skills. The third group served as a control. Approximately 10 patient encounters were then audiotaped for each physician; one-half the encounters were with patients who showed emotional distress on the General Health Questionnaire, and the other half were with nondistressed patients. Both

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