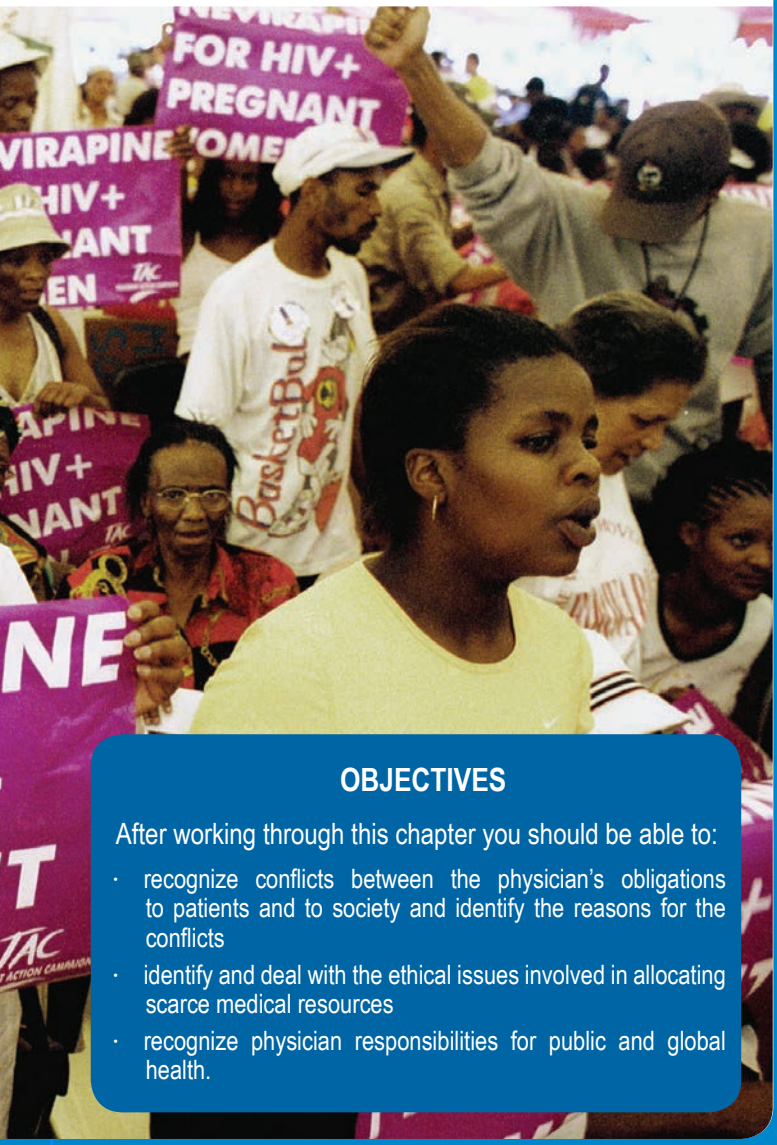
CHAPTER THREE – PHYSICIANS AND SOCIETY

Looking AIDS in the Face
© Gideon Mendel/CORBIS



OBJECTIVES

After working through this chapter you should be able to:

- recognize conflicts between the physician's obligations to patients and to society and identify the reasons for the conflicts
- identify and deal with the ethical issues involved in allocating scarce medical resources
- recognize physician responsibilities for public and global health.

CASE STUDY #2

Dr. S 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 decides 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 national medical association to lobby the government to prevent this form of misallocation of healthcare resources.

WHAT'S SPECIAL ABOUT THE PHYSICIAN-SOCIETY RELATIONSHIP?

Medicine is a profession. The term 'profession' has two distinct, although closely related, meanings: (1) an occupation that is characterized by dedication to the well-being of others, high moral standards, a body of knowledge and skills, and a high level of autonomy; and (2) all the individuals who practise that occupation. 'The medical profession' can mean either the practice of medicine or physicians in general.

Medical professionalism involves not just the relationship between a physician and a patient, as discussed in Chapter Two, and relationships with colleagues and other health professionals, which will be treated in Chapter Four. It also involves a relationship with society. This relationship can be characterized as a 'social contract' whereby society grants the profession privileges, including exclusive or primary responsibility for the provision of certain services and a high degree of self-regulation, and in return, the profession agrees

to use these privileges primarily for the benefit of others and only secondarily for its own benefit.

"Medicine is today, more than ever before, a social rather than a strictly individual activity."

Medicine is today, more than ever before, a social rather than a strictly individual activity. It takes place in a context of government and corporate organisation and funding. It relies on public and corporate medical research and product development for its knowledge base and treatments. It requires complex healthcare institutions for many of its procedures. It treats diseases and illnesses that are as much social as biological in origin.

The Hippocratic tradition of medical ethics has little guidance to offer with regard to relationships with society. To supplement this tradition, present-day medical ethics addresses the issues that arise beyond the individual patient-physician relationship and provides criteria and processes for dealing with these issues.

To speak of the 'social' character of medicine immediately raises the question – what is society? In this Manual the term refers to a community or nation. It is not synonymous with government; governments should, but often do not, represent the interests of society, but even when they do, they are acting **for** society, not **as** society.

Physicians have various relationships with society. Because society, and its physical environment, are important factors in the health of patients, both the medical profession in general and individual physicians have significant roles to play in public health, health education, environmental protection, laws affecting the health or well-being of the community, and testimony at judicial proceedings. As the WMA **Declaration on the Rights of the Patient** puts it: "Whenever legislation, government action or any other administration

or institution denies patients [their] rights, physicians should pursue appropriate means to assure or to restore them." Physicians are also called upon to play a major role in the allocation of society's scarce healthcare resources, and sometimes they have a duty to prevent patients from accessing services to which they are not entitled. Implementing these responsibilities can raise ethical conflicts, especially when the interests of society seem to conflict with those of individual patients.

DUAL LOYALTY

When physicians have responsibilities and are accountable both to their patients and to a third party and when these responsibilities and accountabilities are incompatible, they find themselves in a situation of 'dual loyalty'. Third parties that demand physician loyalty include governments, employers (e.g., hospitals and managed healthcare organizations), insurers, military officers, police, prison officials and family members. Although the WMA **International Code of Medical Ethics** states that "A physician shall owe his/her patients complete loyalty," it is generally accepted that physicians may in exceptional situations have to place the interests of others above those of the patient. The ethical challenge is to decide when and how to protect the patient in the face of pressures from third parties.

"...physicians may in exceptional situations have to place the interests of others above those of the patient."

Dual loyalty situations comprise a spectrum ranging from those where society's interests should take precedence to those where the patient's interests are clearly paramount. In between is a large grey area where the right course of action requires considerable discernment.

At one end of the spectrum are requirements for mandatory reporting of patients who suffer from designated diseases, those deemed not fit to drive or those suspected of child abuse. Physicians should fulfil these requirements without hesitation, although patients should be informed that such reporting will take place.

At the other end of the spectrum are requests or orders by the police or military to take part in practices that violate fundamental human rights, such as torture. In its 2007 **Resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment of which They are Aware**, the WMA provides specific guidance to physicians who are in this situation. In particular, physicians should guard their professional independence to determine the best interests of the patient and should observe, as far as possible, the normal ethical requirements of informed consent and confidentiality. Any breach of these requirements must be justified and must be disclosed to the patient. Physicians should report to the appropriate authorities any unjustified interference in the care of their patients, especially if fundamental human rights are being denied. If the authorities are unresponsive, help may be available from a national medical association, the WMA and human rights organizations.

"Physicians should report to the appropriate authorities any unjustified interference in the care of their patients, especially if fundamental human rights are being denied."

Closer to the middle of the spectrum are the practices of some managed healthcare programmes that limit the clinical autonomy of physicians to determine how their patients should be treated. Although such practices are not necessarily contrary to the best interests of patients, they can be, and physicians need to consider carefully whether they should participate in such programmes. If

they have no choice in the matter, for example, where there are no alternative programmes, they should *advocate* vigorously for their own patients and, through their medical associations, for the needs of all the patients affected by such restrictive policies.

A particular form of a dual loyalty issue faced by physicians is the potential or actual conflict of interest between a commercial organization on the one hand and patients and/or society on the other. Pharmaceutical companies, medical device manufacturers and other commercial organizations frequently offer physicians gifts and other benefits that range from free samples to travel and accommodation at educational events to excessive remuneration for research activities (see Chapter Five). A common underlying motive for such company largesse is to convince the physician to prescribe or use the company's products, which may not be the best ones for the physician's patients and/or may add unnecessarily to a society's health costs. The WMA's 2009 **Statement Concerning the Relationship between Physicians and Commercial Enterprises** provides guidelines for physicians in such situations and many national medical associations have their own guidelines. The primary ethical principle underlying these guidelines is that physicians should resolve any conflict between their own interests and those of their patients in their patients' favour.

"...physicians should resolve any conflict between their own interests and those of their patients in their patients' favour. "

RESOURCE ALLOCATION

In every country in the world, including the richest ones, there is an already wide and steadily increasing gap between the needs and desires for healthcare services and the availability of resources to

provide these services. This gap requires that the existing resources be rationed in some manner. Healthcare rationing, or 'resource allocation' as it is more commonly referred to, takes place at three levels:

- At the highest ('macro') level, governments decide how much of the overall budget should be allocated to health; which healthcare expenses will be provided at no charge and which will require payment either directly from patients or from their medical insurance plans; within the health budget, how much will go to remuneration for physicians, nurses and other heath care workers, to capital and operating expenses for hospitals and other institutions, to research, to education of health professionals, to treatment of specific conditions such as tuberculosis or AIDS, and so on.
- At the institutional ('meso') level, which includes hospitals, clinics, healthcare agencies, etc., authorities decide which services to provide; how much to spend on staff, equipment, security, other operating expenses, renovations, expansion, etc.
- At the individual patient ('micro') level, healthcare providers, especially physicians, decide what tests should be ordered, whether a referral to another physician is needed, whether the patient should be hospitalised, whether a brand-name drug is required rather than a generic one, etc. It has been estimated that physicians are responsible for initiating 80% of healthcare expenditures, and despite the growing encroachment of managed care, they still have considerable discretion as to which resources their patients will have access.

The choices that are made at each level have a major ethical component, since they are based on values and have significant consequences for the health and well-being of individuals and communities. Although individual physicians are affected by

decisions at all levels, they have the greatest involvement at the micro-level. Accordingly, this will be the focus of what follows.

As noted above, physicians were traditionally expected to act solely in the interests of their own patients, without regard to the needs of others. Their primary ethical values of compassion, competence and autonomy were directed towards serving the needs of their own patients. This individualistic approach to medical ethics survived the transition from physician paternalism to patient autonomy, where the will of the individual patient became the main criterion for deciding what resources he or she should receive. More recently, however, another value, justice, has become an important factor in medical decision-making. It entails a more social approach to the distribution of resources, one that considers the needs of other patients. According to this approach, physicians are responsible not just for their own patients but, to a certain extent, for others as well.

"…physicians are responsible not just for their own patients but, to a certain extent, for others as well. "

This new understanding of the physician's role in allocating resources is expressed in many national medical association codes of ethics and, as well, in the WMA **Declaration on the Rights of the Patient**, which states: "In circumstances where a choice must be made between potential patients for a particular treatment that is in limited supply, all such patients are entitled to a fair selection procedure for that treatment. That choice must be based on medical criteria and made without discrimination."

One way that physicians can exercise their responsibility for the allocation of resources is by avoiding wasteful and inefficient practices, even when patients request them. The overuse of

antibiotics is just one example of a practice that is both wasteful and harmful. Many other common treatments have been shown in randomized clinical trials to be ineffective for the conditions for which they are used. Clinical practice guidelines are available for many medical conditions; they help to distinguish between effective and ineffective treatments. Physicians should familiarize themselves with these guidelines, both to conserve resources and to provide optimal treatment to their patients.

"One way that physicians can exercise their responsibility for the allocation of resources is by avoiding wasteful and inefficient practices, even when patients request them. "

A type of allocation decision that many physicians must make is the choice between two or more patients who are in need of a scarce resource such as emergency staff attention, the one remaining intensive care bed, organs for transplantation, high-tech radiological tests, and certain very expensive drugs. Physicians who exercise control over these resources must decide which patients will have access to them and which will not, knowing full well that those who are denied may suffer, and even die, as a result.

Some physicians face an additional conflict in allocating resources, in that they play a role in formulating general policies that affect their own patients, among others. This conflict occurs in hospitals and other institutions where physicians hold administrative positions or serve on committees where policies are recommended or determined. Although many physicians attempt to detach themselves from their preoccupation with their own patients, others may try to use their position to advance the cause of their patients over others with greater needs.

In dealing with these allocation issues, physicians must not only balance the principles of compassion and justice but, in doing so, must decide which approach to justice is preferable. There are several such approaches, including the following:

- **LIBERTARIAN** – resources should be distributed according to market principles (individual choice conditioned by ability and willingness to pay, with limited charity care for the destitute);
- **UTILITARIAN** – resources should be distributed according to the principle of maximum benefit for all;
- **EGALITARIAN** – resources should be distributed strictly according to need;
- **RESTORATIVE** – resources should be distributed so as to favour the historically disadvantaged.

As noted above, physicians have been gradually moving away from the traditional individualism of medical ethics, which would favour the libertarian approach, towards a more social conception of their role. For example, the WMA **Statement on Access to Health Care** says that "No one who needs care should be denied it because of inability to pay. Society has an obligation to provide a reasonable subsidy for care of the needy, and physicians have an obligation to participate to a reasonable degree in such subsidized care." Even if the libertarian approach is generally rejected, however, medical ethicists have reached no consensus on which of the other three approaches is superior. Each one clearly has very different results when applied to the issues mentioned above, that is, deciding what tests should be ordered, whether a referral to another physician is needed, whether the patient should be hospitalised, whether a brand-name drug is required rather than a generic one, who gets the organ for transplantation, etc. The utilitarian approach is probably the most difficult for individual physicians to practise,

"…choice …will depend on the physician's own personal morality as well as the socio-political environment in which he or she practises."

since it requires a great deal of data on the probable outcomes of different interventions, not just for the physician's own patients but for all others. The choice between the other two (or three, if the libertarian is included) will depend on the physician's own personal morality as well as the socio-political environment in which he or she practises. Some countries, such as the U.S.A., favour the libertarian approach; others, e.g., Sweden, are known for their egalitarianism; while still others, such as South Africa, are attempting a restorative approach. Many health planners promote utilitarianism. Despite their differences, two or more of these concepts of justice often coexist in national health systems, and in these countries physicians may be able to choose a practice setting (e.g., public or private) that accords with their own approach.

In addition to whatever roles physicians may have in allocating existing healthcare resources, they also have a responsibility to advocate for expansion of these resources where they are insufficient to meet patient needs. This usually requires that physicians work together, in their professional associations, to convince decision-makers in government and elsewhere of the existence of these needs and how best to meet them, both within their own countries and globally.

"…physicians …have a responsibility to advocate for expansion of these resources where they are insufficient to meet patient needs."

PUBLIC HEALTH

20th century medicine witnessed the emergence of an unfortunate division between 'public health' and other healthcare (presumably 'private' or 'individual' health). It is unfortunate because, as noted above, the public is made up of individuals, and measures designed to protect and enhance the health of the public result in health benefits for individuals.

Confusion also arises if 'public health' is taken to mean 'publicly-funded healthcare' (i.e., healthcare funded through a country's taxation system or a compulsory universal insurance system) and seen as the opposite of 'privately-funded healthcare' (i.e., healthcare paid for by the individual or through private health insurance and usually not universally available).

The term 'public health', as understood here, refers both to the health of the public and also to the medical specialty that deals with health from a population perspective rather than on an individual basis. There is a great need for specialists in this field in every country to advise on and advocate for public policies that promote good health as well as to engage in activities to protect the public from communicable diseases and other health hazards. The practice of public health (sometimes called 'public health medicine' or 'community medicine') relies heavily for its scientific basis on **epidemiology**, which is the study of the distribution and determinants of health and disease in populations. Indeed, some physicians go on to take extra academic training and become medical epidemiologists. However, all physicians need to be aware of the social and environmental determinants that influence the health status of their individual

"all physicians need to be aware of the social and environmental determinants that influence the health status of their individual patients."

patients. As the WMA **Statement on Health Promotion** notes: "Medical practitioners and their professional associations have an ethical duty and professional responsibility to act in the best interests of their patients at all times and to integrate this responsibility with a broader concern for and involvement in promoting and assuring the health of the public."

Public health measures such as vaccination campaigns and emergency responses to outbreaks of contagious diseases are important factors in the health of individuals but social factors such as housing, nutrition and employment are equally, if not more, significant. Physicians are seldom able to treat the social causes of their individual patients' illnesses, although they should refer the patients to whatever social services are available. However, they can contribute, even if indirectly, to long-term solutions to these problems by participating in public health and health education activities, monitoring and reporting environmental hazards, identifying and publicizing adverse health effects from social problems such as abuse and violence, and advocating for improvements in public health services.

Sometimes, though, the interests of public health may conflict with those of individual patients, for example, when a vaccination that carries a risk of an adverse reaction will prevent an individual from transmitting a disease but not from contracting it, or when notification is required for certain contagious diseases, for cases of child or elder abuse, or for conditions that may render certain activities, such as driving a car or piloting an aircraft, dangerous to the individual and to others. These are examples of dual-loyalty situations as described above. Procedures for dealing with these and related situations are discussed under 'confidentiality' in Chapter Two of this Manual. In general, physicians should attempt to find ways to minimise any harm that individual patients might suffer as a result of meeting public health requirements. For example, when reporting

is required, the patient's confidentiality should be protected to the greatest extent possible while fulfilling the legal requirements.

A different type of conflict between the interests of individual patients and those of society arises when physicians are asked to assist patients to receive benefits to which they are not entitled, for example, insurance payments or sick-leave. Physicians have been vested with the authority to certify that patients have the appropriate medical condition that would qualify them for such benefits. Although some physicians are unwilling to deny requests from patients for certificates that do not apply in their circumstances, they should rather help their patients find other means of support that do not require unethical behaviour.

GLOBAL HEALTH

The recognition that physicians have responsibilities to the society in which they live has been expanded in recent years to include a responsibility for global health. This term has been defined as health problems, issues and concerns that transcend national boundaries, that may be influenced by circumstances or experiences in other countries, and that are best addressed by cooperative actions and solutions. Global health is part of the much larger movement of globalization that encompasses information exchange, commerce, politics, tourism and many other human activities.

"The failure to recognize and treat highly contagious diseases by a physician in one country can have devastating effects on patients in other countries."

The basis of globalization is the recognition that individuals and societies are increasingly interdependent. This is clearly evident with regard to human health, as the rapid spread of diseases such as influenza and SARS has shown. Such epidemics require international action

for their control. The failure to recognize and treat highly contagious diseases by a physician in one country can have devastating effects on patients in other countries. For this reason, the ethical obligations of physicians extend far beyond their individual patients and even their communities and nations.

The development of a global view of health has resulted in an increasing awareness of health disparities throughout the world. Despite large-scale campaigns to combat premature mortality and debilitating morbidity in the poorest countries, which have resulted in certain success stories such as the elimination of smallpox, the gap in health status between high and low-income countries continues to widen. This is partly due to HIV/AIDS, which has had its worst effects in poor countries, but it is also due to the failure of many low-income countries to benefit from the increase in wealth that the world as a whole has experienced during the past decades. Although the causes of poverty are largely political and economic and are therefore far beyond the control of physicians and their associations, physicians do have to deal with the ill-health that is the result of poverty. In low-income countries physicians have few resources to offer these patients and are constantly faced with the challenge of allocating these resources in the fairest way. Even in middle- and high-income countries, though, physicians encounter patients who are directly affected by globalization, such as refugees, and who sometimes do not have access to the medical coverage that citizens of those countries enjoy.

Another feature of globalization is the international mobility of health professionals, including physicians. The outflow of physicians from developing to highly industrialized countries has been advantageous for both the physicians and the receiving countries but not so for the exporting countries. The WMA, in its **Ethical Guidelines for the International Migration of Health Workers**, states that physicians should not be prevented from leaving their home or adopted country

to pursue career opportunities in another country. It does, however, call on every country to do its utmost to educate an adequate number of physicians, taking into account its needs and resources, and not to rely on immigration from other countries to meet its need for physicians.

Physicians in the industrialized countries have a long tradition of providing their experience and skills to developing countries. This takes many forms: emergency medical aid coordinated by organizations such as the Red Cross and Red Crescent Societies and Médecins sans Frontières, short-term surgical campaigns to deal with conditions such as cataracts or cleft palates, visiting faculty appointments in medical schools, short- or long-term medical research projects, provision of medicines and medical equipment, etc. Such programmes exemplify the positive side of globalization and serve to redress, at least partially, the movement of physicians from poorer to wealthier countries.

PHYSICIANS AND THE ENVIRONMENT

A major threat to both public health and global health is the deterioration of the environment. The 2006 WMA **Statement on the Role of Physicians in Environmental Issues** states that "The effective practice of medicine increasingly requires that physicians and their professional associations turn their attention to environmental issues that have a bearing on the health of individuals and population." These issues include air, water and soil pollution, unsustainable deforestation and fishing, and the proliferation of hazardous chemicals in consumer products. But perhaps the most serious environmental challenge to health is climate change. The 2009 WMA **Declaration of Delhi on Health and Climate Change** notes that "Climate change currently contributes to the global burden of disease and premature deaths….. At this early stage the effects are small but are projected to progressively increase in all countries

and regions." The document encourages individual physicians and medical associations to educate patients and communities about the potential consequences of global warming for health and to lobby governments and industries to significantly reduce carbon emissions and other contributors to climate change.

BACK TO THE CASE STUDY

According to the analysis of the physician-society relationship presented in this chapter, Dr. S is right to consider the impact on society of her patient's behaviour. Even if the consultations with the other health practitioner occur outside of the health system in which Dr. S works and therefore do not entail any financial cost to society, the patient is taking up Dr. S's time that could be devoted to other patients in need of her services. However, physicians such as Dr. S must be cautious in dealing with situations such as this. Patients are often unable to make fully rational decisions for a variety of reasons and may need considerable time and health education to come to an understanding of what is in the best interests of themselves and of others. Dr. S is also right to approach her medical association to seek a societal solution to this problem, since it affects not just herself and this one patient but other physicians and patients as well.