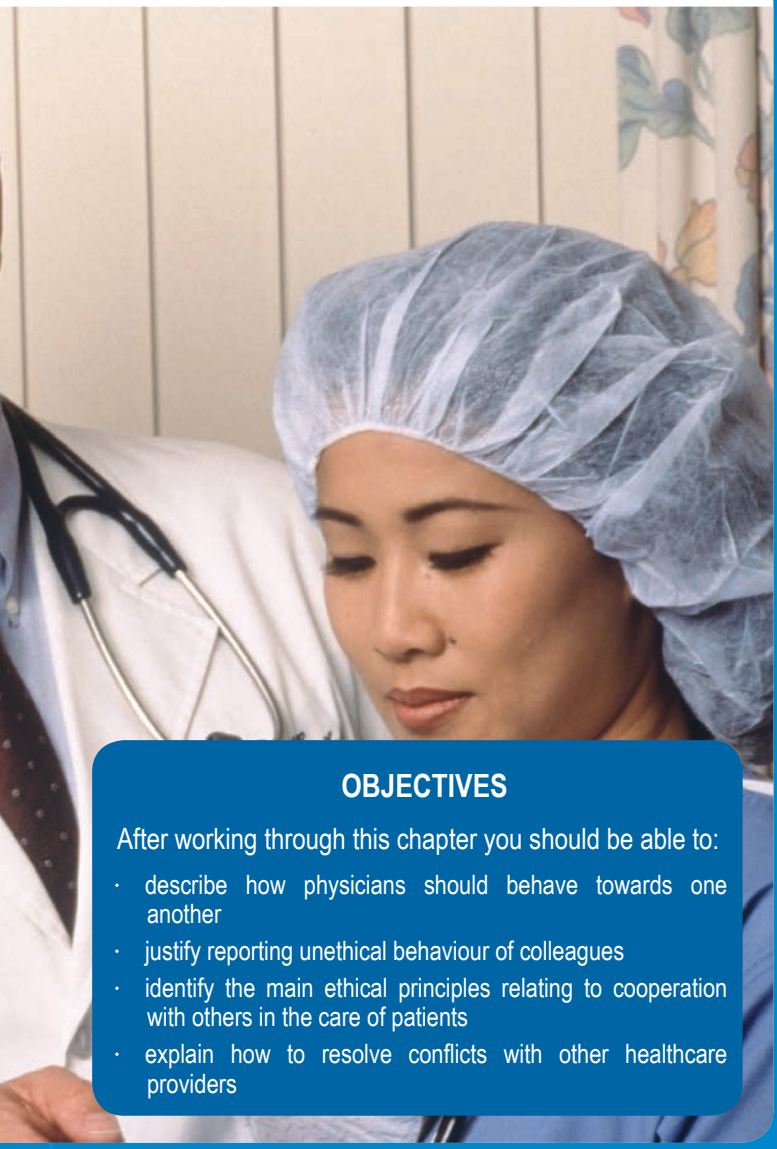
CHAPTER FOUR – PHYSICIANS AND COLLEAGUES

Medical team going over a case



OBJECTIVES

After working through this chapter you should be able to:

- describe how physicians should behave towards one another
- justify reporting unethical behaviour of colleagues
- identify the main ethical principles relating to cooperation with others in the care of patients
- explain how to resolve conflicts with other healthcare providers

CASE STUDY #3

Dr. C, a newly appointed anaesthetist in a city hospital, is alarmed by the behaviour of the senior surgeon in the operating room. The surgeon uses out-of-date techniques that prolong operations and result in greater post-operative pain and longer recovery times. Moreover, he makes frequent crude jokes about the patients that obviously bother the assisting nurses. As a more junior staff member, Dr. C is reluctant to criticize the surgeon personally or to report him to higher authorities. However, he feels that he must do something to improve the situation.

CHALLENGES TO MEDICAL AUTHORITY

"Physicians belong to a profession that has traditionally functioned in an extremely *hierarchical* fashion"

Physicians belong to a profession that has traditionally functioned in an extremely *hierarchical* fashion, both internally and externally. Internally, there are three overlapping *hierarchies*: the first differentiates among specialties, with some being considered more prestigious, and better remunerated, than others; the second is within specialties, with academics being more influential than those in private or public practice; the third relates to the care of specific patients, where the primary caregiver is at the top of the hierarchy and other physicians, even those with greater seniority and/or skills, serve simply as consultants unless the patient is transferred to their care. Externally, physicians have traditionally been at the top of the hierarchy of caregivers, above nurses and other health professionals.

This chapter will deal with ethical issues that arise in both internal and external hierarchies. Some issues are common to both; others are found only in one or the other. Many of these issues are relatively new, since they result from recent changes in medicine and health-care. A brief description of these changes is in order, since they pose major challenges to the traditional exercise of medical authority.

With the rapid growth in scientific knowledge and its clinical applications, medicine has become increasingly complex. Individual physicians cannot possibly be experts in all their patients' diseases and potential treatments and they need the assistance of other specialist physicians and skilled health professionals such as nurses, pharmacists, physiotherapists, laboratory technicians, social workers and many others. Physicians need to know how to access the relevant skills that their patients require and that they themselves lack.

As discussed in Chapter Two, medical paternalism has been gradually eroded by the increasing recognition of the right of patients to make their own medical decisions. As a result, a cooperative model of decision-making has replaced the authoritarian model that was characteristic of traditional medical paternalism. The same thing is happening in relationships between physicians and other health professionals. The latter are increasingly unwilling to follow physicians' orders without knowing the reasons behind the orders. They see themselves as professionals with specific ethical responsibilities towards patients; if their perception of these responsibilities conflicts with the physician's orders, they feel that they must question or even challenge the orders. Whereas under the hierarchical model of authority, there was never any doubt

"…a cooperative model of decision-making has replaced the authoritarian model that was characteristic of traditional medical paternalism."

about who was in charge and who should prevail when conflict occurred, the cooperative model can give rise to disputes about appropriate patient care.

Developments such as these are changing the 'rules of the game' for the relationships of physicians with their medical colleagues and other health professionals. The remainder of this chapter will identify some problematic aspects of these relationships and suggest ways of dealing with them.

RELATIONSHIPS WITH PHYSICIAN COLLEAGUES, TEACHERS AND STUDENTS

As members of the medical profession, physicians have traditionally been expected to treat each other more as family members than as strangers or even as friends. The WMA **Declaration of Geneva** includes the pledge, "My colleagues will be my sisters and brothers." The interpretation of this requirement has varied from country to country and over time. For example, where fee-for-service was the principal or only form of remuneration for physicians, there was a strong tradition of 'professional courtesy' whereby physicians did not charge their colleagues for medical treatment. This practice has declined in countries where third-party reimbursement is available.

Besides the positive requirements to treat one's colleagues respectfully and to work cooperatively to maximize patient care, the WMA **International Code of Medical Ethics** contains two restrictions on physicians' relationships with one another: (1) paying or receiving any fee or any other consideration solely to procure the referral of a patient; and (2) stealing patients from colleagues. A third obligation, to report unethical or incompetent behaviour by colleagues, is discussed below.

In the Hippocratic tradition of medical ethics, physicians owe special respect to their teachers. The **Declaration of Geneva** puts it this way: "I will give to my teachers the respect and gratitude that is their due." Although present-day medical education involves multiple student-teacher interactions rather than the one-on-one relationship of former times, it is still dependent on the good will and dedication of practising physicians, who often receive no remuneration for their teaching activities. Medical students and other medical trainees owe a debt of gratitude to their teachers, without whom medical education would be reduced to self-instruction.

"...teachers have an obligation to treat their students respectfully and to serve as good role models in dealing with patients."

For their part, teachers have an obligation to treat their students respectfully and to serve as good role models in dealing with patients. The so-called 'hidden curriculum' of medical education, i.e., the standards of behaviour exhibited by practising physicians, is much more influential than the explicit curriculum of medical ethics, and if there is a conflict between the requirements of ethics and the attitudes and behaviour of their teachers, medical students are more likely to follow their teachers' example.

Teachers have a particular obligation not to require students to engage in unethical practices. Examples of such practices that have been reported in medical journals include medical students obtaining patient consent for medical treatment in situations where a fully qualified health professional should do this, performing pelvic examinations on anaesthetized or newly dead patients without consent, and performing unsupervised procedures that, although minor (e.g., I-V insertion), are considered by some students to be beyond their competence. Given the unequal power balance between students and teachers and the consequent reluctance of

"Students concerned about ethical aspects of their education should have access to such mechanisms where they can raise concerns"

students to question or refuse such orders, teachers need to ensure that they are not requiring students to act unethically. In many medical schools, there are class representatives or medical student associations that, among their other roles, may be able to raise concerns about ethical issues in medical education. Students concerned about ethical aspects of their education should have access to such mechanisms where they can raise concerns without necessarily being identified as the *whistle-blower,* as well as access to appropriate support if it becomes necessary to take the issue to a more formal process.

For their part, medical students are expected to exhibit high standards of ethical behaviour as appropriate for future physicians. They should treat other students as colleagues and be prepared to offer help when it is needed, including corrective advice in regard to unprofessional behaviour. They should also contribute fully to shared projects and duties such as study assignments and on-call service.

REPORTING UNSAFE OR UNETHICAL PRACTICES

Medicine has traditionally taken pride in its status as a self-regulating profession. In return for the privileges accorded to it by society and the trust given to its members by their patients, the medical profession has established high standards of behaviour for its members and disciplinary procedures to investigate accusations of misbehaviour and, if necessary, to punish the wrongdoers. This system of self-regulation has often failed, and in recent years steps have been taken to make the profession more accountable,

for example, by appointing lay members to regulatory authorities. The main requirement for self-regulation, however, is wholehearted support by physicians for its principles and their willingness to recognise and deal with unsafe and unethical practices.

This obligation to report incompetence, impairment or misconduct of one's colleagues is emphasised in codes of medical ethics. For example, the WMA **International Code of Medical Ethics** states that "A physician shall…report to the appropriate authorities those physicians who practice unethically or incompetently or who engage in fraud or deception." The application of this principle is seldom easy, however. On the one hand, a physician may be tempted to attack the reputation of a colleague for unworthy personal motives, such as jealousy, or in retaliation for a perceived insult by the colleague. A physician may also be reluctant to report a colleague's misbehaviour because of friendship or sympathy ("there but for the grace of God go I"). The consequences of such reporting can be very detrimental to the one who reports, including almost certain hostility on the part of the accused and possibly other colleagues as well.

Despite these drawbacks to reporting wrongdoing, it is a professional duty of physicians. Not only are they responsible for maintaining the good reputation of the profession, but they are often the only ones who recognise incompetence, impairment or misconduct. However, reporting colleagues to the disciplinary authority should normally be a last resort after other alternatives have been tried and found wanting. The first step might be to approach the colleague and say that you consider his or her behaviour unsafe or unethical. If the matter can be resolved at that level, there may be no need to go farther. If not, the next step might be to

"…reporting colleagues to the disciplinary authority should normally be a last resort after other alternatives have been tried and found wanting"

discuss the matter with your and/or the offender's supervisor and leave the decision about further action to that person. If this tactic is not practical or does not succeed, then it may be necessary to take the final step of informing the disciplinary authority.

RELATIONSHIPS WITH OTHER HEALTH PROFESSIONALS

Chapter Two on relationships with patients began with a discussion of the great importance of respect and equal treatment in the physician-patient relationship. The principles set forth in that discussion are equally relevant for relationships with co-workers. In particular, the prohibition against discrimination on grounds such as "age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor" (WMA **Declaration of Geneva**) is applicable in dealings with all those with whom physicians interact in caring for patients and other professional activities.

Non-discrimination is a passive characteristic of a relationship. Respect is something more active and positive. With regard to other healthcare providers, whether physicians, nurses, auxiliary health workers, etc., it entails an appreciation of their skills and experience insofar as these can contribute to the care of patients. All healthcare providers are not equal in terms of their education and training, but they do share a basic human equality as well as similar concern for the well-being of patients.

As with patients, though, there are legitimate grounds for refusing to enter or for terminating a relationship with another healthcare provider. These include lack of confidence in the ability or integrity of the other person and serious personality clashes. Distinguishing these from less worthy motives can require considerable ethical sensitivity on the physician's part.

COOPERATION

Medicine is at the same time a highly individualistic and a highly cooperative profession. On the one hand, physicians are quite possessive of 'their' patients. It is claimed, with good reason, that the individual physician-patient relationship is the best means of attaining the knowledge of the patient and continuity of care that are optimal for the prevention and treatment of illness. The retention of patients also benefits the physician, at least financially. At the same time, as described above, medicine is highly complex and specialized, thus requiring close cooperation among practitioners with different but complementary knowledge and skills. This tension between individualism and cooperation has been a recurrent theme in medical ethics.

The weakening of medical paternalism has been accompanied by the disappearance of the belief that physicians 'own' their patients. The traditional right of patients to ask for a second opinion has been expanded to include access to other healthcare providers who may be better able to meet their needs. According to the WMA **Declaration on the Rights of the Patient**, "The physician has an obligation to cooperate in the coordination of medically indicated care with other healthcare providers treating the patient." However, as noted above, physicians are not to profit from this cooperation by fee-splitting.

"The weakening of medical paternalism has been accompanied by the disappearance of the belief that physicians 'own' their patients."

These restrictions on the physician's 'ownership' of patients need to be counterbalanced by other measures that are intended to safeguard the primacy of the patient-physician relationship. For example, a patient who is being treated by more than one physician,

which is usually the case in a hospital, should, wherever possible, have one physician coordinating the care who can keep the patient informed about his or her overall progress and help the patient make decisions.

Whereas relationships among physicians are governed by generally well-formulated and understood rules, relationships between physicians and other healthcare professionals are in a state of flux and there is considerable disagreement about what their respective roles should be. As noted above, many nurses, pharmacists, physiotherapists and other professionals consider themselves to be more competent in their areas of patient care than are physicians and see no reason why they should not be treated as equals to physicians. They favour a team approach to patient care in which the views of all caregivers are given equal consideration, and they consider themselves accountable to the patient, not to the physician. Many physicians, on the other hand, feel that even if the team approach is adopted, there has to be one person in charge, and physicians are best suited for that role given their education and experience.

Although some physicians may resist challenges to their traditional, almost absolute, authority, it seems certain that their role will change in response to claims by both patients and other healthcare providers for greater participation in medical decision-making. Physicians will have to be able to justify their recommendations to others and persuade them to accept these recommendations. In addition to these communication skills, physicians will need to be able to resolve conflicts that arise among the different participants in the care of the patient.

A particular challenge to cooperation in the best interests of patients results from their recourse to traditional or alternative health providers (‘healers’). These individuals are consulted by a large proportion of

the population in Africa and Asia and increasingly so in Europe and the Americas. Although some would consider the two approaches as complementary, in many situations they may be in conflict. Since at least some of the traditional and alternative interventions have therapeutic effects and are sought out by patients, physicians should explore ways of cooperation with their practitioners. How this can be done will vary from one country to another and from one type of practitioner to another. In all such interactions the well-being of patients should be the primary consideration.

CONFLICT RESOLUTION

Although physicians can experience many different types of conflicts with other physicians and healthcare providers, for example, over office procedures or remuneration, the focus here will be on conflicts about patient care. Ideally, healthcare decisions will reflect agreement among the patient, physicians and all others involved in the patient's care. However, uncertainty and diverse viewpoints can give rise to disagreement about the goals of care or the means of achieving those goals. Limited healthcare resources and organisational policies may also make it difficult to achieve consensus.

"...uncertainty and diverse viewpoints can give rise to disagreement about the goals of care or the means of achieving those goals."

Disagreements among healthcare providers about the goals of care and treatment or the means of achieving those goals should be clarified and resolved by the members of the healthcare team so as not to compromise their relationships with the patient. Disagreements between healthcare providers and administrators with regard to the allocation of resources should be resolved within the facility or agency and not be debated in the presence of the

patient. Since both types of conflicts are ethical in nature, their resolution can benefit from the advice of a clinical ethics committee or an ethics consultant where such resources are available.

The following guidelines can be useful for resolving such conflicts:

- Conflicts should be resolved as informally as possible, for example, through direct negotiation between the persons who disagree, moving to more formal procedures only when informal measures have been unsuccessful.
- The opinions of all those directly involved should be elicited and given respectful consideration.
- The informed choice of the patient, or authorized substitute decision-maker, regarding treatment should be the primary consideration in resolving disputes.
- If the dispute is about which options the patient should be offered, a broader rather than a narrower range of options is usually preferable. If a preferred treatment is not available because of resource limitations, the patient should normally be informed of this.
- If, after reasonable effort, agreement or compromise cannot be reached through dialogue, the decision of the person with the right or responsibility for making the decision should be accepted. If it is unclear or disputed who has the right or responsibility to make the decision, mediation, arbitration or adjudication should be sought.

If healthcare providers cannot support the decision that prevails as a matter of professional judgement or personal morality, they should be allowed to withdraw from participation in carrying out the decision, after ensuring that the person receiving care is not at risk of harm or abandonment.

BACK TO THE CASE STUDY

Dr. C is right to be alarmed by the behaviour of the senior surgeon in the operating room. Not only is he endangering the health of the patient but he is being disrespectful to both the patient and his colleagues. Dr. C has an ethical duty not to ignore this behaviour but to do something about it. As a first step, he should not indicate any support for the offensive behaviour, for example, by laughing at the jokes. If he thinks that discussing the matter with the surgeon might be effective, he should go ahead and do this. Otherwise, he may have to go directly to higher authorities in the hospital. If they are unwilling to deal with the situation, then he can approach the appropriate physician licensing body and ask it to investigate.