Family Medicine and Medical Ethics—A Natural and Necessary Union

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Since many ethical dilemmas in the practice of medicine involve cases associated with tertiary care, primary care providers may feel removed from these kinds of problems. Family medicine, committed to an intellectual synergism with a variety of non-biomedical disciplines as well as being a "specialty in breadth" should develop a strong bond with medical ethics. Because of their ongoing relationships with patients and subsequent knowledge of their value systems, family physicians can provide leadership in guiding ethical decision making in intensive care settings. In addition, since a significant number of ethical dilemmas in medicine involve common problems, family physicians may be more sensitive to and feel more comfortable with this aspect of medical practice.

Some family practice residency programs have begun to provide educational experiences in medical ethics for their trainees. Although the evaluation methodology for this aspect of training is not fully developed, it seems clear that residency programs should give additional attention to these areas in planning their curricula.

Over the last decade, ethical dilemmas in the practice of medicine have become an area of increasing concern for philosophers and legal thinkers as well as practicing physicians. Essays, monographs, and texts in this area are appearing with increasing frequency, and many medical schools have developed courses designed to introduce students to the field.[1,2] A recent survey revealed that 70 percent of North American medical schools offer some formal work in medical ethics to their students (Committee on Medical Ethics and Human Values: National survey, School of Medicine, State University of New York at Buffalo 1977, unpublished). The lay press has also widely publicized material of this sort, choosing to focus its attention on some of the more dramatic cases of the day such as Karen Ann Quinlan and the test tube baby.

For many, both inside and outside the medical profession, there is often a tendency to associate ethical dilemmas in medicine with patients whose problems require highly technical, tertiary medical care and for whom life and death often hang in the balance. In particular, difficult decisions involving patients on respirators in an intensive care unit have become the classic "material" for those interested in the field. Because of this, family physicians and other primary care providers may feel that moral problems in medicine should be of more importance for those intimately involved

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with tertiary care. It is the purpose of this paper to suggest that family physicians, perhaps more than any other group, should have extensive and intensive involvement in ethical decision making with patients. In advancing this point, it will first be shown how the conceptual framework of family medicine can smoothly accommodate the discipline of medical ethics. Further, the reasons that family physicians should be at the forefront of ethical decision making in medicine will be elaborated. Finally, a brief review of two approaches that have been used to enhance this role for the family physician will be presented.

Medical Ethics in Family Medicine

Although a concise definition of the field is difficult to formulate, most attempts to do so seem to have two common threads. First, family medicine is clearly a specialty which crosses traditional disciplinary lines, "a specialty in breadth which builds on a core of knowledge derived from other disciplines—drawing most heavily on internal medicine, pediatrics, obstetrics and gynecology, surgery, and psychiatry...."[3] Secondly, most conceptual formulations of family medicine attempt to suggest that each patient and his/her problems must be viewed in more than biological terms. Knowledge of the social support system (family) in which the patient exists as well as an understanding of his value system and the community from which he comes are necessary for the proper practice of family medicine. Thus, family medicine has "much to gain from collaboration with epidemiology, sociology, psychiatry, and even anthropology."[4]

As opposed to this concept of family medicine, other medical specialties have a much narrower scope. In an important essay in *Science*, George Engel suggested that the "dominant model of disease is biomedical with molecular biology its basic scientific model."[5] As such it involved both reductionism and exclusionism. First, most medical scientists seek to *reduce* illness and patient responses to it to a molecular or cellular level. Secondly, biomedicine will seek to *exclude* those problems which cannot be reduced to that level from the legitimate concern of medical scientists. Family medicine, on the other hand, is prepared to deal both conceptually and practically with the large number of patient problems which cannot or should not be understood in biomedical terms alone.

This willingness to seek an understanding of illness in more than biomedical terms should produce family physicians prepared to accept and even investigate a variety of nonscientific disciplines which may impact on the practice of medicine or on the understanding of the nature of man. Philosophy, which seeks to understand human beings in aesthetic and moral terms, must be a necessary part of non-reductionistic, synthetic view of medicine. Although the history of medicine reveals an intimate involvement with philosophy, particularly during the time of ancient Greece, its separation from philosophy today (with a few hopeful exceptions) is almost complete.[6]

Family physicians should want to investigate the varied philosophical views of rights, duties, and values as well as the ethical principles which underlie their moral intuitions about how one *ought* to act when faced with certain difficult medical situations. Further, how patients' moral (and/or religious) values influence their perception of health and illness and their expectations of medicine seem to be legitimate concerns of the family physician. Since family medicine is committed to an intellectual synergism with a variety of other disciplines concerned with the nature of man and his socio-medical problems, a willingness to understand the well-elaborated and varied philosophical views of this seems necessary and natural. For medicine and philosophy have a unique responsibility in any synthetic view of man and "no viable contemporary humanism is possible without their closest interaction."[6]

The potentially intimate relationship between philosophy and medicine can, in the final analysis, be stated in terms of perspective. Clouser, in an essay on philosophy and medical education, puts it this way: "Anyone constantly talking only to his own kind loses perspective. Professional schools are a case in point; they can be conceptual ghettos where we are very apt to get locked into seeing the world, others, ourselves, and our own goals in one particular and narrow perspective."[7] This narrowed, biomedical perspective of man and his illnesses seems contrary to all that family medicine wants to and can be.

Given this strong conceptual bond between

family medicine and philosophy, it will be necessary to see how this union can be further enhanced within the practical framework of ethical decision making in medicine. In its broadest sense, biomedical ethics has two major areas of focus—individual and social.[8] Individual medical ethics is concerned with specific moral dilemmas faced by physicians and patients as they interact with each other in the medical encounter. Questions about "pulling the plug," informed consent to treatment, and truth telling in medicine are but some of the concerns under this broad heading. Social medical ethics, on the other hand, is concerned with institutional and community policy questions such as the right to health care, resource allocation, research on human subjects, and the philosophical basis of physician obligation and other moral imperatives in the practice of medicine.

Even though some problems in individual medical ethics often come to climax in an intensive care unit (ICU), decisions there should be made by patients *and families* as well as by health care providers, who, because of their ongoing relationship with the patients, most fully understand the value systems of the patients (and their families). In addition, providers involved in these kinds of decisions should comprehend the moral principles and their ramifications which may be relevant to the question at hand. The family physician, *not* the ICU specialist, could be the best suited for involvement in these kinds of decisions. His ongoing relationship with the patient, especially when coupled with some basic grounding in moral philosophy and logical thought, should allow him to become more intimately involved with these kinds of problems than the "intensivist," whose initial contact with the patient is under extreme conditions.

In order for the primary care physician to best function in this way, it must be understood that ongoing knowledge of the patient and his family may be a necessary but not a sufficient condition for him to thoroughly guide decision making in this area. Solid grounding in the "basic science" of moral philosophy, including study of classical ethical theories (deontological, utilitarian) as well as specific inquiry into such areas as the definition of death, theories of euthanasia, and the nature of informed consent, will allow the family physician to bring a *perspective* to these decisions which may not presently be there. Further, if the family physician is given the opportunity to "practice" the rational application of ethical principles in a case study format prior to his involvement with the care, then he might feel more comfortable in dealing with these issues. Thus, a comprehensive involvement in ethical decision making will require of the family physician time for study and investigation of the issues and their applications prior to his participation in a real-life problem.

Illustrative Cases

Case 1

The following actual case report will illustrate these points:

> Mr. S. is a 69-year-old male retired truck driver admitted to the intensive care unit for acute respiratory failure secondary to chronic obstructive pulmonary disease with superimposed pneumonia. Upon admission to the unit, the patient's PCO_2 is 70; he is conscious and refuses intubation. The primary care physician is called to advise the residents on management. Upon arrival in the unit the family physician finds the patient's wife and two children (all of whom are part of his practice) distraught and ordering him to ignore the request of Mr. S. His knowledge of the wife, who suffers periodic bouts of acute anxiety and conversion hysteria forces him to seriously consider her "side of the story" and the impact of granting Mr. S.'s request (and his subsequent death) on her health.

There are a number of issues which the family physician must consider before reaching a decision in this case. The conflicting positions of absolute respect for the patient's right to decide and what may be "best" for the patient at the expense of his personal freedom must be considered. The competing claims of the family and the patient must also be carefully weighed. In this particular case, the family physician's previous knowledge of Mr. S.'s life-style and expressed "will to live" caused him to be suspicious of his present request. Further, his understanding of the adverse effects of CO_2 intoxication on this patient's mental functions also influenced his thinking. Finally, the family physician was able to uncover the fact that Mr. S.'s real worry was that being intubated would be painful. Realizing the importance of preserving Mr. S.'s personal autonomy, the family physician was able to engage him and his family in further decision making and help him feel satisfied about

the "final" decision to intubate. Although there are a number of other issues which may be considered in this case (euthanasia, the nature of informed consent, and truth telling), its resolution by the family physician clearly demonstrates that the primary care provider (more than others) has the ability to consider the medical, psychosocial, and philosophical issues at stake in such a case and would therefore be well equipped to adequately guide decision making in problems such as this.

In addition, it is important to understand that although critical cases like Mr. S.'s often require ethical decision making, ordinary problems in medicine also have an ethical or value component to them. Robert Veatch, in collecting 100 cases in medical ethics, selects as his first one a noncontroversial, straight-forward medical problem—a broken leg.[9] In his introductory remarks, he states that "...in this particular case, which may be the single most significant case in the volume, the ethical and value foundation of the choice become quite apparent." The family physician, intimately involved with these ordinary cases, should understand that a synthetic view of every physician-patient encounter must consider its ethical component. His day-to-day activities therefore contain a wealth of rich, moral experience. What to tell patients about their problems and treatments as well as reconciling different value systems are but two obvious issues which should surface in the day-to-day practice of medicine.

Social medical ethics has another set of concerns which clearly relate to the role and practice of the family physician. Variously construed as a manager or even an "orchestrator"[10] of the delivery of all health services to his patients, the family physican should be concerned with the broader institutional questions about the nature of the health care delivery system in which he works. The achievement of high quality care for a *community* does not depend solely on the dedication of the individual practitioner. Policy questions of resource allocation and access as well as the moral bases of the professional obligations of health care providers are concerns about which a family physician should be given the opportunity to reflect. In order to develop a well-grounded position on these issues, the family physician should investigate the philosophical notions of rights, duties, and justice as well as their application to current questions about health policy.

Case 2

Mr. D. is a 38-year-old unemployed alcoholic with documented cirrhosis. He lives alone in a rooming house and is supported by welfare. Although a Medicaid patient of the family practice center for two years, he has broken two scheduled appointments in the last four months and walks into the office today complaining of being shaky and hallucinating. His primary care provider has 15 scheduled patients booked and must now decide whether to interrupt his schedule to see this patient or to send him to the Emergency Room of the county hospital.

A variety of issues must be considered in reaching a decision in this case. Does this patient's "right" to health care (as determined by his Medicaid eligibility) entitle him to any health service in any health care setting he desires, or to a "basic decent minimum" of services.[11] Further, does his physician have a duty (or even a contract) to respond to claims filed by Mr. D. based on that "right" in all circumstances? If so, does this obligation conflict with obligations to other patients? What is the nature of the responsibilities and obligations of patients in the physician-patient relationship? Does the patient's "disease" render him unable to meet those obligations?

In this case, the family physician having considered some of these questions, concluded that his "obligation" to Mr. D. was to briefly determine that he was not in immediate danger of death and to then refer him to the local Emergency Room for further evaluation. The provider believed that Mr. D.'s "right" to health care had been honored and that the rights of others in his practice deserved more consideration. He also considered that his "contract" with Mr. D. has been previously invalidated by the patient and that his decision was justified and consistent with his understanding of the patient's right to health care.

As these cases illustrate, prior consideration of the philosophical questions at the root of the dilemmas posed by the practice of medicine will not provide the family physician with unequivocal answers. Study of these issues within training programs could, however, provide the physician with a clearer view of the nature of his moral obligations in medicine, and a stronger conviction about how he "ought" to act in specific clinical situations. Further, and perhaps equally as important, the family physician, when given the opportunity to consider these issues, may be able to produce new insights into some of these dilemmas in

medicine which those more removed from the everyday arena could not develop.

Implications for Training Programs

In order for this goal to be realized, however, residency programs in family medicine must recognize the importance of training in moral philosophy and ethical decision making, and must design programs to introduce basic moral theory and its application to their students. Trainees should also be given the opportunity to discuss difficult cases with ethicists, as well as experienced clinicians. Using the case study format, residents can explore alternatives in a variety of simulated, "old," and actual cases which may be currently active in the ward or clinic. By elaborating, clarifying, and applying a variety of moral principles during his training years, the family physician can assume a leadership role in dealing with the plethora of moral decisions which permeate the everyday practice of medicine.

This type of training during the family medicine residency can have many forms. In a recent article, Keller reported on a detailed program in ethics and human values education developed in the family practice residency at the Medical University of South Carolina.[12] Using a set of six well-defined teaching objectives, this program runs throughout the entire three years and is designed to provide the resident with a variety of opportunities to fully consider and understand both individual and societal moral questions in medicine. The resident is also given the opportunity to learn how to consistently apply rules and principles to individual and social problems in medicine through the case study format.

Other programs may be less formalized. In a presentation to the Society for Health and Human Values in October 1978, an ethicist and a clinician reported on a program of "rounding" together one half-day a week on a family practice teaching floor.[13] After some initial uneasiness on the part of everyone, residents were eager to share their concerns and explore their thinking on a variety of moral problems with which they were confronted each day.

Both of these programs are examples of attempts to enable family medicine residents to develop a perspective of medical care usually not available to traditional training programs. The methodology for determining whether this kind of training achieves its objectives and enables participants to make new and "better" ethical decisions is yet to be developed. Nevertheless, these kinds of activities can only help family physicians enhance their position as the health care providers who are prepared to consider all aspects of the medical encounter from individual and societal perspectives. In addition, a more profound understanding of the moral substructure of medicine will allow the family physician to assume a leadership role in coping with the dilemmas produced by scientific medicine and to assess the impact of one's profession on all aspects of the community. Finally, training in this area can produce physicians who, while intimately involved with the daily practice of medicine, may be able to think and write creatively about the moral dilemmas which pervade it. All of these activities seem natural and necessary outgrowths from the basic concept of the family physician.

References

1. McElhinney TK (ed): Human Values Teaching Programs for Health Professionals, ed 3. Philadelphia, Society for Health and Human Values, 1976

2. Veatch R, Sollito S: Medical ethics teaching: Report of a national medical school survey. JAMA 35:1030, 1976

3. American Academy of Family Physicians: Official Document No. 303. Kansas City, Mo, American Academy of Family Physicians, 1976

4. Cassel JC: Psychosocial process and stress: Theoretical formulation. Int J Health Serv 4:471, 1974

5. Engel GL: The need for a new medical model: A challenge for biomedicine. Science 196:129, 1977

6. Pellegrino ED: Medicine and Philosophy: Some Notes on the Flirtations of Minerva and Aesculapius. Philadelphia, Society for Health and Human Values, 1974, pp 6,12

7. Self DJ (ed): The Role of the Humanities in Medical Education. Norfolk, Va, Teagle and Little, 1978, p 31

8. Veatch RM, Branson R (eds): Ethics and Health Policy. Cambridge, Mass, Ballinger, 1976, p 5

9. Veatch RM: Case Studies in Medical Ethics. Cambridge, Mass, Harvard University Press, 1977, p 17

10. Spitzer WO: The intellectual worthiness of family medicine. Pharos 40:3, 1977

11. Fried C: An analysis of equality and rights in medical care. Hastings Center Rep 6(1):29, 1976

12. Keller AH: Ethics/human values education in the family practice residency. J Med Educ 52:107, 1977

13. Carson RA: Ethics teaching on ward rounds. Presented as a workshop at the Annual Meeting of the Society for Health and Human Values, New Orleans, October 21, 1978