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Medical ethics contributes to clinical management: teaching medical students to engage patients as moral agents

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Abstract

OBJECTIVES—In order to teach medical students to engage more fully with patients, we offer ethics education as a tool to assist in the management of patient health issues.

METHODS—We propose that many dilemmas in clinical medicine would benefit by having the doctor embark on an iterative reasoning process *with* the patient. Such a process acknowledges and engages the patient as a moral agent. We recommend employing Kant's ethic of respect and a more inclusive definition of patient autonomy drawn from philosophy and clinical medicine, rather than simply presenting dichotomous choices to patients, which represents a common, but often suboptimal, means of approaching both medical and moral concerns.

DISCUSSION—We describe how more nuanced teaching about the ethics of the doctor–patient relationship might fit into the medical curriculum and offer practical suggestions for implementing a more respectful, morally engaged relationship with patients that should assist them to achieve meaningful health goals.

Keywords

clinical medicine; education; ethics; clinical; education; teaching; methods; physician–patient relations; ethics; education; medical; undergraduate; morals

INTRODUCTION

Doctors and patients ideally partner one another to promote patient health. Doctors' advice for a healthy lifestyle can dovetail effectively with patients' health behaviours to improve health status.¹ Often, however, patients do not follow their doctors' recommendations. Patient non-compliance can frustrate trainees and doctors. Although doctor–patient communication strategies such as motivational interviewing² can be helpful in overcoming patients' obstacles to participating in their own medical care, much of medical education falls short of adequately training doctors in these strategies.

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So how do students and, subsequently, clinicians elicit, understand and achieve realistic and meaningful medical goals – which might more aptly be called clinical *management* – with a patient? We argue that more nuanced teaching about the ethics of the doctor–patient relationship might improve the way that medical students learn to engage with patients and manage their health issues. We offer ethics education as a tool to assist in patient care management, describe its theoretical underpinnings, and show where it can fit into the medical curriculum.

Consider the following sample scenarios.

- As small business owners in the USA, Carol and her husband lack private health insurance. Fortunately, Carol's husband is healthy and, at 65 years of age, has Medicare coverage. Carol, aged 58 years, has diabetes and hypertension. She asks her doctor to write her expensive prescriptions in her husband's name so that his Medicare can cover them.
- Tonya, aged 27 years, is a single mother of three young children. Working full-time and taking care of her children leaves Tonya little time to prepare healthy meals. Often dinner is at the closest fast-food restaurant. At Tonya's recent physical check-up, the doctor records that she has gained 40 pounds (18 kg) in weight over the last 3 years and has a blood pressure of 150 / 90 mmHg.
- After living with Crohn's disease for 40 years, John, aged 68 years, developed colon cancer. His wife has cared for him during his Crohn's flares and now continues to do so through surgery and four rounds of chemotherapy. She doesn't complain, but he can see how tired and stressed she is. John thinks his treatments are harder on his wife than they are on him.

A student precepted by Carol's doctor might be instructed to counsel Carol to modify her lifestyle through diet and exercise so that her need for medication decreases. The attending doctor would correctly convey the information that writing prescriptions in another patient's name involves two unethical actions: insurance fraud, which is also illegal, and falsification of patient records, which represents substandard clinical care. A student working with Tonya's doctor would learn to refer her to a dietician for advice on healthy meal preparation. John's doctor could urge him to continue chemotherapy and explain to the oncology fellow that their goal should be to get John feeling well enough to take his wife on vacation.

These recommendations may provide appropriate answers to clinical questions, but they do not fully acknowledge or account for the human lives in which those dilemmas occur. Too simplistic to be effective in most clinical situations, these recommendations do not necessarily attend to the real needs, circumstances and human relationships manifested in these medical encounters. Patients' lives do not present simple dichotomous choices such as that between either following medical advice to achieve a favourable outcome or ignoring such advice to perpetuate an unfavourable condition. Such a dichotomous framework casts patients as isolated objects who do not morally engage with their loved ones, employers, fellow citizens or even their doctors.

CONTEXT

A medical student learns to employ internal dialogue to reason through and choose between treatment options. Bioethics educators teach a similar process for ethical reasoning; exercises in moral judgement offer narrow sets of choices between competing virtues, principles or laws. This strategy may be suboptimal for traversing both medical and moral terrains with a patient. We suggest that many dilemmas in clinical medicine require the doctor to embark on an iterative reasoning process *with* the patient that acknowledges and

engages the patient as a moral agent. We use the term ‘moral agent’ to denote a person who can make moral judgements and act accordingly, as long as life circumstances permit.

Involving patients as moral agents in a dialogue about the potential consequences of their requests or behaviours on themselves and others can help patients identify morally defensible solutions and motivate and equip them to shoulder their own responsibilities. The sort of iterative reasoning between doctor and patient that we advocate acknowledges that patients are embedded in social relationships and that they are accountable to and responsible for others. By fostering ethical behaviour in their patients, doctors demonstrate respect for their patients – and even for themselves – and assist their patients to realise their autonomy fully.

THEORETICAL UNDERPINNINGS

The theoretical underpinnings of such an engaged practice of medicine reside in Immanuel Kant’s (1724–1804) work on the subject of respect. Kant argued that:

‘...as rational beings who are capable of moral agency... each person is to be respected as an equal among equals... to respect others is to engage with them not as instruments or obstacles but as persons who are to be reasoned with.’³

Other philosophers have described Kant’s claims in this way:

‘...we should provide [other persons] with genuine reasons in our dealings with them rather than trying to manipulate them... we should help [others] to promote and protect what they value and to pursue their ends, provided these are compatible with due respect for other persons.’³

Nearly two decades ago, the philosopher John Hardwig also argued this point, writing that as:

‘...there is no way to detach the lives of patients from the lives of those who are close to them... it is irresponsible and wrong to exclude or to fail to consider the interests of those who are close.’⁴

He continued:

‘If, then, I am morally empowered to make decisions about “my” medical treatment, I am also morally required to shoulder the responsibility of making very difficult moral decisions. The right course of action for me to take will not always be the one that promotes my own interests... The ethics of patient decisions is most poignantly highlighted precisely when the patient is inclined to decide without considering the impact of his decision on the lives of the rest of his family... Confronting patients with tough ethical choices may be part and parcel of treating them with respect as fully competent adults.’⁴

Although Hardwig submitted that family doctors and intensivists tend to engage patients and families this way, his model is hardly widespread. In 2005, doctor Eric Cassell accepted a lifetime achievement award from the American Society of Bioethics and Humanities with these comments:

‘Ethics is about relationships... Even “autonomy” and “freedom of choice” imply relationships.’⁵

Cassell recapitulated what feminist ethicists call ‘relational autonomy’:

‘Autonomy is not an intrinsic property held or expressed by an individual, but a feature of the moral agent that comes into existence and is maintained through the agent’s interdependencies with, and responsibilities towards, others.’⁶

Ethics curricula typically do not teach strategies for implementing such paradigms of the doctor–patient relationship. Most ethics teaching and assessments of moral decision making in medicine are insufficiently nuanced to incorporate the sort of human engagement feminist ethicists describe and Hardwig and Cassell advocate.^{7,8}

Perhaps the adoption of such engagement has suffered for lack of practical examples of teaching and practising this iterative reasoning process. We submit that a doctor should pursue a morally engaged doctor–patient relationship because it facilitates the moral practice of medicine. We offer a rendition and expansion of Hardwig’s and Cassell’s ideas and suggest a taxonomy of cases in which they may be particularly useful.

CLINICAL AND EDUCATIONAL APPLICATIONS

Patients can present a broad range of requests that may seem morally problematic to their doctors (Table 1), such as in the scenario about Carol, the small business owner without health insurance. Carol’s doctor might practise thinking through options with her (as in Table 2) to play out the range of potential consequences. The doctor might ask if Carol’s husband knows she has made this request. Ultimately, Carol’s doctor should assert that, although she is willing to do all she can to help, Carol cannot expect the doctor to lie on her behalf.

Given that Carol does not have the option of using national health insurance, the doctor might suggest that Carol investigate whether her local small business association allows individual business owners to obtain group health insurance coverage together, offering to complete any required medical documentation. The doctor could ask Carol for more detail on how the financial burden of her medications impacts on her and her family, which may lead to ideas about accessing other financial resources potentially available to them. Or the doctor may learn that the situation is much worse than she had imagined, that, indeed, Carol has been going without her medication at times and that her family could use a much wider range of support than simply prescription drug coverage. She might follow up with advice about available social services and other sources of support, resources about which medical students should also be educated. These possibilities illustrate that other avenues exist. Importantly, the doctor may learn of Carol’s feelings about asking for assistance at all. If ashamed, Carol might be relieved that the doctor has declined her request. Even so, she needs help, and the doctor now understands and respects this. Such engaged, constructive dialogue with Carol offers her a more respectful attitude and is likely to yield more constructive solutions. This contrasts with the simple dichotomous choice involved in deciding whether or not to comply with Carol’s request.

Through these approaches, the doctor demonstrates awareness of the *personal consequences to the patient* of requests or behaviours in the context of family, livelihood and community. By acknowledging his or her context and responsibilities, the empowered patient makes fully informed, autonomous decisions.

WHAT HAPPENS WHEN THE PATIENT DOES NOT PARTICIPATE?

Perhaps it is presumptuous for a doctor to assume that a patient will welcome such moral engagement. If, after exploration of the moral weight of the patient’s request, the patient seems dismissive or sceptical, the doctor may need to acknowledge that he has miscalculated the patient’s receptivity. If so, the doctor could step back and re-focus, as he probably does when patients are unpersuaded about purely medical matters. A doctor’s attempts to traverse this terrain with anything but a graded course of small steps over multiple interactions may be impractical and ineffective. In the process, however, the doctor and patient may discover opportunities for negotiation about the patient’s goals.

Although we believe that most patients would prefer to be treated as moral agents rather than as objects or instruments, not all patients will. Doctors may feel that it remains worthwhile to point out the effects that patients' requests or behaviours may have on others, simply because the moral practice of medicine requires that sort of acknowledgement and consideration. For example, another patient, Ms G, may engage in self-destructive behaviour, such as cigarette smoking or alcohol dependence. She may resist her doctor's assistance in curbing or quitting those behaviours, arguing that it is her life and her body at risk and that she understands and accepts the potential future consequences. Ms G is free to make that choice. However, although Ms G's doctor may have informed her fully of her health risks, he is not yet absolved of any further responsibility. Without engaging Ms G in a dialogue about how her behaviour may impact on her role in her family or influence her loved ones' futures, the doctor does not fully acknowledge Ms G's autonomy as per Kant, Hardwig or Cassell.

Similarly, patients may consider their doctors as moral agents. Although doctors are privileged to serve and care for patients, they are not merely diagnosis- and therapy-producing machines. They have feelings and concerns that may make them more or less uncomfortable with patients' requests. Carol's doctor understandably may have felt strong conflict about Carol's appeal. How might patients respond when they are asked to see things from the doctor's perspective? They may welcome the reciprocity of an inter-subjective relationship. Alternatively, they may be surprised or respond unfavourably. At the least, the doctor will engage them, take a moral stand and then listen to their responses. In the process, the doctor may also shift her own view of what is morally defensible, a highly unlikely outcome had the dialogue never occurred.

THEORETICAL MATERIAL FOR STUDENTS

Students should understand the types of ethical reasoning that justify the approach we describe. Respect for an individual patient's autonomy is a central – perhaps *the* central – guiding principle in the practice of patient-centred medicine. Nevertheless, some medical ethical questions arise that require the consideration of more than just the individual patient's voice. Doctors may assist patients to achieve meaningful health goals using a model of reciprocity and interdependence. Such a model exemplifies the relational account of autonomy and illustrates the 'value of depending on others and being depended on'.⁹

To the extent that the doctor–patient relationship exists in a broad social context, a communitarian perspective might pertain. Yet a communitarian perspective fails to account for the moral status of the individual. Parker and Dickenson locate the notion of autonomy in a middle ground between individual and community.¹⁰ They call this consideration of individualistic and communitarian approaches to bioethics a deliberative approach:

'Both the social and the individual are together necessary and it is their combination that makes a coherent account of the moral possible... From this deliberative perspective... it is possible to begin to recognise the particular value, and indeed the necessity, of the engagement of human beings in deliberation about the moral features of their own lives.'¹⁰

Parker and Dickenson's approach allows the doctor to facilitate moral behaviour in others in much the same way that Emanuel and Emanuel suggest in their deliberative model of the doctor–patient relationship:

'...the physician and patient engage in deliberation about what kind of health-related values the patient could and ultimately should pursue... The conception of patient autonomy is moral self-development; the patient is empowered not simply to follow unexamined preferences or examined values, but to consider, through

dialogue, alternative health-related values, their worthiness, and their implications for treatment.’¹¹

This approach resonates with the Lindemann Nelsons’ connection of family–patient relationships to ethics education:

‘...we want... to ask doctors to learn to see the whole person in relationship with others’ (p 51); ‘...lives lived in common... the years of intimacy and trust... give [families] a moral claim on [a patient’s] care’ (p 72); ‘Thinking about a [moral player’s] story as part of [the patient’s] own underscores how rights can conflict with responsibilities to others’ (p 107); ‘The moral self-definition highlights the relationship between one’s moral identity and the character of intimate relationships in which one’s life is embedded.’ (p 136)¹²

IMPLEMENTATION

Engaging patients in this way would seem time-consuming. Other patients await the busy doctor’s attention. Asking a patient to assume moral agency may feel laborious or uncomfortable. Despite the limitations and likely failures of offering dichotomous responses to a patient, the perceived expedience may tempt. Having promised a practical description implementing moral engagement, we wish to counter claims that our suggestions may be unduly time-consuming. True, an exploration of the patient’s moral engagement with others over a particular clinical issue may prolong the visit. We argue that additional time spent at the outset in dialogue with patients about ‘relationships and the responsibilities and duties attendant on those affiliations and associations’⁵ might prove more efficient, productive and rewarding than time spent trying to solve conflicts later when the issues may be more polarised and contentious or when the patient returns repeatedly without having ‘complied’ with recommendations.

Adopting this communication strategy requires practice. Table 2 offers questions that may prompt a more deliberative conversation with a patient about the moral import of an issue. In medical student interviewing classes and ethics seminars with housestaff and faculty, these questions can be role-played using the sample scenarios (Table 1). Italicised text provides options for engaging with patients as moral agents in their particular situations while avoiding dichotomous, simplistic responses.

We suggest practising with several sample scenarios and real, morally troubling cases. Practising in the safety of an educational venue would give doctors and trainees confidence to apply their new skills to actual clinical situations. Stop-action video may represent an effective modality. In addition, trainees could be graded on how well their assessments and plans reflect the range of morally relevant options available to the patient, perceived and real obstacles to those options, incremental steps patients believe they can take realistically, and mechanisms for further evaluation and follow-up.

We add a caveat to this approach. The process of considering a person as a moral agent may incline doctors and students to make hasty moral judgements. However, the illness experience casts patients into vulnerable circumstances that doctors do not always grasp fully. Helping patients face their illnesses should lead doctors, with rare exceptions, to suspend moral judgements. Assisted by doctors to explore moral options for themselves, patients may arrive at choices that their doctors might not make personally. Unless these choices are beyond some range of acceptability, doctors should refrain from being judgemental, patronising or manipulative.

The theory and examples provided here can guide medical faculty towards teaching and practising a more nuanced doctor–patient relationship. Although we focus on patient

behaviour because healthpromoting behaviour is a crucial contributor to good health, we recognise that many other determinants of health are beyond a patient's control. As an intersection of clinical medicine and ethics, however, the engagement with patients as moral agents should improve the effectiveness of patient care management.

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Table 1

Sample scenarios

Issues of deception

- a. Andrea, a surgeon, develops a tremor. She urges her doctor not to report this
- b. Rita is a bus driver. She's had diabetes for 20 years and has developed peripheral neuropathy

The doctor should consider how to assist these patients to cope and counsel them to meet their professional needs in ways that will not endanger vulnerable others. Encourage Andrea to explore and pursue a different area of medicine, or Rita to obtain vocational rehabilitation. Frame these dilemmas in terms that help them to manage their responsibilities to those they serve in their professional lives

Patient–professional interactions

Scott has diabetes, hypertension and symptomatic three-vessel coronary artery disease, and smokes cigarettes. His internist knows the cardiac surgeon will only evaluate patients who have been off cigarettes for at least 6 months. Scott asks his internist to refer him anyway and to write on the referral that he quit smoking 6 months ago

As Scott probably believes bypass surgery will help him feel better and increase his lifespan, the doctor could acknowledge his desire to be seen by the surgeon. But the doctor could also explain that no matter how much he would like Scott to have those outcomes, lying is an ineffective way to achieve them. Lying would damage the doctor's relationship with the surgeon (and it is to Scott's and other patients' benefit to maintain that relationship). Seeing that his doctor could be persuaded to lie might even undermine the doctor's credibility with Scott himself in the long run. The doctor should offer to assist Scott to stop smoking and ameliorate his symptoms if possible. He could also mention that an appointment with the surgeon before Scott is ready (the surgeon might check his urine for cotinine) deprives another patient of the visit slot. Optimally, trust between doctor and patient flows in both directions. If the surgeon discovered that Scott pretended he had quit smoking, the surgeon might be less inclined to consider Scott seriously as a surgical candidate

Patient attitudes

Together, Steve and Laura smoke between three and four packs of cigarettes per day. They have a 5-year-old son with environmental allergies and they understand that they should not smoke around him. Sometimes in bad weather, however, they smoke in the house or car

Steve and Laura's family doctor could educate them about the effects of cigarette smoke on their son's allergies and the potential for further respiratory difficulties for him over time. The doctor could urge them to look critically at their behaviour in the light of a child who is regularly exposed to a known allergen. The doctor could point out the contradiction between providing doctor's visits and respiratory medications for their child, but continuing to smoke, and explore how Steve and Laura reconcile this

Patient behaviour

Bill has a stressful job as a New York stock exchange trader. When he gets home he 'needs' a drink to unwind. Unfortunately, if he has more than a couple of drinks, he can become violent. Although Bill insists that he can hold his liquor, more than once he's become intoxicated and injured his wife when she tried to discourage his sexual advances. At his doctor's office, he discloses that his stressful job triggers his drinking

Bill's doctor knows of prior episodes of violence between Bill and his wife. Referring Bill to Alcoholics Anonymous or a stress management programme, or suggesting that he blow off steam by exercising, are reasonable approaches to help Bill to control his drinking. In addition, the doctor could engage Bill by having him play out plausible scenarios of further injury to his wife or a possible restraining order, dissolution of the marriage, physical or emotional harm to their children, loss of respect within his extended family or community, and potential subsequent difficulties at work. Bill may resist these conversations, insisting that he can control his drinking and behaviour, but the dialogue about a range of plausible consequences may provide additional motivation for Bill to confront his alcohol dependence and assaults and help him to comprehend the impact of his drinking on others

Preventive medicine

Andrew, aged 90 years, is developing dementia. His 89-year-old wife, Mary, has debilitating arthritis and can no longer drive. Andrew drives to the supermarket and runs other errands, but has had several small fender-benders and near misses pulling out into traffic. Mary often accompanies him so she can 'pay attention'. Their grown daughter, Evelyn, calls her parents' doctor to find out if he can ask the Department of Motor Vehicles to take away her father's licence. However, they live in New York, where it is illegal for a doctor to violate patient confidentiality, even in this circumstance

This is a particularly difficult situation because Andrew's capacity for sound reasoning is diminishing and his wife is facilitating his unsafe behaviour. Insisting that Andrew will inevitably harm himself or his wife if he continues to drive may only engender resistance and alienate him from his doctor. The doctor might explore other ways by which Andrew could retain his independence and dignity if he were to stop serving as chauffeur, and perhaps identify how Andrew could be particularly valuable to his family or community in exchange for transportation provided by others. The potential danger he represents to innocent bystanders or his own failure to survive to see grandchildren graduate from college (for example) might persuade Andrew to relinquish the car keys. If not, it might be more productive for the doctor to engage Mary first in a discussion about potential, realistic consequences to both herself and her husband if Andrew continues to drive. Mary may reveal the couple's feelings about what life might be like after one of them dies; for them, togetherness and privacy about their life choices may trump safety. The doctor should ask about this to demonstrate respect for their autonomy as a couple and clarify how they understand their responsibilities to the rest of their family and community

Table 2

Sample questions to ask the patient

<p>How is this issue affecting your family or partner?</p> <p>Have you thought about how this will affect your family or partner?</p> <p>What do you think you can do about the effect on your family or partner?</p> <p>How can I help you address this problem?</p> <p>The choices here are difficult. Can we rethink this situation?</p> <p>How can we rethink the options we've thought of so far?</p> <p>How can we come up with other options?</p>
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