



Evolving medical ethics

STEPHEN BOLSIN AND KYM SAUNDERS

Have doctors ignored or abandoned their ethical code at the cost of decreasing influence in healthcare management? Professor Bolsin proposes that wise, conscientious, brave and moderate medical input should always be valued in planning and managing better healthcare for patients.

Hippocrates is often referred to as the 'father of western medicine', but he would have lived for more than 300 years if all the teachings attributable to him were actually his. It is far more likely that the sayings emanated from a school of thought that was heavily influenced by the much older Ayurvedic schools from the Indian subcontinent.

Many people consider the Hippocratic Oath to be the basis for current ethical standards in medicine. In fact, some medical schools still ask medical graduates to swear a version of the Hippocratic Oath on graduation, but the practice is by no means universal.

Important shortcomings of the early forms of the Hippocratic Oath include no mention of female doctors (important in an era when more than half of medical graduates are female), absolute patient confidentiality (challenged in a time of international terrorism) and absolute loyalty to the profession (indefensible when medical error contributes to thousands of deaths and billions of pounds of waste annually in the NHS and the USA).^{1,2} Although some of these deficiencies in the Hippocratic principles can be easily remedied, others may be more difficult to reconcile with the Bronze Age Greek teachings in which they were codified.

This was the problem that confronted the Georgetown conference convened in 1973, the year after the disclosure, by social

scientist Peter Buxton, of the 'Tuskegee experiment' conducted by the US Public Health Service (forerunner of the Center for Disease Control).

THE 'TUSKEGEE EXPERIMENT'

The now infamous Tuskegee experiment or 'Tuskegee study of untreated syphilis in the negro male', to give it its full title, had been running for 40 years when Peter Buxton informed the press of its existence and the fact that there were no plans to end the grossly unethical study.

The experiment was conceived in the 1930s when there was no cure for syphilis. The poorest county in Alabama was deliberately chosen to identify and observe the natural course of the disease in only black sufferers. The study had no consent process but required that recruits undergo blood tests, annual lumbar punctures and mandatory postmortem examination; a fact that relatives were often told only after the subjects' deaths.³

Even when penicillin became the recognised successful treatment for syphilis, the subjects were not told if they had the condition or offered the cure, but given a placebo that turned out to be aspirin. Furthermore, updates of the study had been published in well-respected medical journals, presumably with the approval of reviewers and editors, which confirmed the medical profession's ongoing complicity in this awful experiment.⁴

This article has been modified, with permission, from Bolsin S, Colson M. Evolving medical ethics. *Anaesthetic Life* July/August 2011;60–3.

Stephen Bolsin, BSc, MB BS, FRCA, FANZCA, MHSM, DLitt (Hon), Adjunct Professor, Monash University; Specialist Anaesthetist, Geelong Hospital, Victoria, Australia; Kym Saunders, MB BS, FANZCA, Anaesthetic Registrar, Geelong Hospital, Victoria, Australia

The Tuskegee experiment was a highly unethical research project under any ethical regimen, but it was not explicitly covered by Hippocratic principles and was very embarrassing for the USA after they had completed the prosecution of Nazi war criminals at Nuremberg on charges of 'crimes against humanity' for cruelty to another human race.

Interestingly, doctors had also been guilty of war crimes in Nazi Germany and Japan, in spite of the ethical principles contained in the Hippocratic Oath, and it seemed likely that a new ethical framework to cover research and medical practice was required. Bill Clinton belatedly provided a presidential apology to the surviving victims of the Tuskegee experiment in 1997, 25 years after the initial disclosure, which indicates the time it took for the profession to come to terms with the atrocity.⁵

FOUR PILLARS OF MEDICAL ETHICS

In 1973 the Georgetown conference came up with what is now regarded as the four pillars of medical ethics for the modern doctor:

- beneficence (a duty to do good)
- non-maleficence (a duty to do no harm)
- autonomy (a duty to respect a patient's wishes)
- justice (a duty to deal equitably with patients and resources).

In many ways the first two principles may be an overstatement of the same goal, but the conference delegates obviously wanted to confirm the requirement (to do good) in the wake of the recent events. Although these were originally proposed as the principles for medical research, they quickly became adopted as principles of medical practice.⁶

Many would argue that this stepwise evolution of ethical values for the profession as a result of the Georgetown conference has served the medical profession well and could continue to serve the profession into the future. However,

the four principles have failed to deal with some important aspects of healthcare, including performance monitoring, incident reporting and whistleblowing, to name a few of current interest to the profession.

If we deal with these issues in turn we can examine the influence, if any, of the 'four pillars' on the reasoning associated with each issue and any omissions or improvements that could be achieved by employing different reasoning: in this case, applying the four primary virtues of virtue ethics: conscience, wisdom, courage and temperance.⁷

PERFORMANCE MONITORING

There is now a considerable body of evidence confirming that the collection and analysis of performance data and feedback of the results to individual clinicians and units can improve performance. A reduction in risk-adjusted mortality by as much as 40 per cent for coronary artery bypass graft surgery has been identified in two separate studies.^{8,9} Other specialties have also described similar results, but the profession remains largely reluctant to embrace this method of quality improvement.¹⁰

Conscience and wisdom, two primary virtues of virtue ethics, would provide an ethical impetus to improve healthcare outcomes in this way.¹¹ The third primary virtue of courage would also align with those clinicians brave enough to adopt such an approach to quality improvement.¹² Furthermore, performance monitoring is not an extreme process to implement and would conform to the fourth primary virtue of temperance or a moderate view.¹²

INCIDENT REPORTING

Adverse events contribute significantly to the cost, mortality and morbidity of complex healthcare systems, but reliable incident reporting and implementation of strategies to prevent recurrence have been

demonstrated to reduce the frequency of adverse events in Australia.¹³

Once again, the process of incident reporting is supported by the four primary virtues, being wise, conscientious, brave professional behaviour and not an extreme act. The bravery is illustrated by the fact that many UK doctors will not report adverse events because of their fear of the consequences. Thus virtue ethics again aligns itself with an activity that improves outcomes but is not supported or endorsed by current ethical behaviour, although it has been successfully achieved in an Australian hospital using a supportive environment.^{12,14}

WHISTLEBLOWING

In many ways, this represents the ultimate action for virtue ethics, conforming to all of the primary virtues but with courage as the first requirement.^{15,16} The fact that

'The difference between doctors and managers (especially medical managers) is sometimes only their ethical code. Having the right one is important.'

whistleblowing is regarded with such hostility by the medical profession with current ethical values is best demonstrated by the reduction in reporting of poor care that occurs during medical training in the context of a revised ethics curriculum in a UK medical school.^{17,18} Unfortunately, this unofficial learning is well recognised in medicine and attributed to the 'hidden curriculum' of medicine.

USE OF TECHNOLOGY FOR PERFORMANCE MONITORING

It has been suggested that changing these behaviours in medical graduates will take a generation. However, this may be the wishful thinking of those in the profession who do not want to change, because the evidence suggests otherwise. When in Geelong we introduced a personal digital assistant-based programme for performance monitoring and

incident reporting, accredited registrars were prepared to record their performance for analysis and feedback, as well as reporting incidents at the highest rate recorded in the medical literature, 97–100 per cent.^{14,19} This response was identified as practical virtue ethics, aided by portable digital technology and with the trainees 'blowing the whistle' on their own performance.¹² The project was a world first, conforming to the highest standards of medical and ethical practice.²⁰

FOCUSING ON PATIENTS, NOT BUDGETS

One question that must always be asked of a proposed change in ethical principles is 'What relevance does it have to current medical practice?' We hope that the improvement in outcomes for patients, professionals and organisations is evident. However, there may be an even more important consideration. If medical professionals are to deal with the current emphasis on healthcare management as the solution to reduced funding in the presence of rising healthcare costs, we must have a reasoned, systematic response to the argument of budgetary primacy in healthcare planning and delivery. Ethical considerations, particularly virtue ethics, are capable of providing that reasoned systematic response that will restore the patient, the doctor and the health professional to the centre of healthcare planning and delivery.^{7,15}

The ethical framework of the medical practitioner is one of the most important distinctions between him or her and the medical manager. This ethical framework should provide considerable extra weight to the opinions of the medical profession in considerations of healthcare delivery and planning. Budgetary considerations should be subjugated to values derived from medical ethics when they differ, although they will often be aligned.

During a senior management meeting held to discuss cuts to patient services and medical staffing, a wise, brave and conscientious consultant (the only doctor present) said: 'You must all remember that

very few patients attend this hospital specifically to see a manager'. The comment certainly helped to redefine the direction the meeting took and focused the considerations on patients and their services, not budgets.

I suspect that doctors have too easily ignored or abandoned their ethical code at the cost of decreasing influence in healthcare management. The difference between doctors and managers (especially medical managers) is sometimes only their ethical code. Having the right one is important. Managers may not even have Hippocrates or the four pillars, let alone virtue ethics, and therefore cannot be relied on to make the correct decisions in delivering and developing healthcare for patients. Wise, conscientious, brave and moderate medical input should always be valued, and valuable, in planning and managing better healthcare for patients.

Declaration of interests: none declared.

REFERENCES

- Kohn LT, Corrigan JM, Donaldson MS, et al. *To err is human. Building a safer health system.* Washington: Institute of Medicine, National Academy Press, 2000;1–16.
- Vincent C. Incident reporting and patient safety. *BMJ* 2007;334:51.
- Jones HJ. *Bad blood: the Tuskegee syphilis experiment.* New York: Free Press, 1993.
- Rockwell DH, Yobs AR, Moore MB. The Tuskegee study of untreated syphilis: the 30th year of observation. *Arch Intern Med* 1964;114:792–8.
- Chelala C. Clinton apologises to the survivors of Tuskegee. *Lancet* 1997;349:1529.
- Beauchamp TL, Childress JF. *Principles of biomedical ethics.* New York: Oxford University Press, 1973.
- Oakley J. A virtue ethics approach. In: Khuse H, Singer P, eds. *A companion to bioethics.* Oxford: Blackwell, 1998:86–97.
- Hannan EL, Kilburn H, Racz M, et al. Improving the outcomes of coronary artery bypass surgery in New York State. *JAMA* 1994; 271:761–6.
- O'Connor GT, Plume SK, Olmstead EM, et al. A regional intervention to improve the hospital mortality associated with coronary artery bypass graft surgery. The Northern New England Cardiovascular Disease Study Group. *JAMA* 1996;275:841–6.
- Bolsin SN, Freestone L. Report cards and performance monitoring. In: Clarke S, Oakley J, eds. *Informed consent and clinician accountability,* 1st edn. Cambridge: Cambridge University Press, 2007:91–105.
- Clarke S, Oakley J. Informed consent and surgeon's performance. *J Med Philos* 2004;29:11–35.
- Bolsin S, Faunce T, Oakley J. Practical virtue ethics: healthcare whistleblowing and portable digital technology. *J Med Ethics* 2005;31:612–18.
- Wolff AM, Bourke J, Campbell IA, et al. Detecting and reducing hospital adverse events: outcomes of the Wimmera clinical risk management program. *Med J Aust* 2001;174:621–5.
- Freestone L, Bolsin S, Colson M, et al. Voluntary incident reporting by anaesthetic trainees in an Australian hospital. *Int J Qual Health Care* 2006;18:452–7.
- Faunce T. Developing and teaching the virtue-ethics foundation of healthcare whistleblowing. *Monash Bioeth Rev* 2004;23:41–55.
- Faunce T, Bolsin S, Chan W-P. Supporting whistleblowers in academic medicine: training and respecting the courage of professional conscience. *J Med Ethics* 2004;30:40–43.
- Bolsin SN. Whistle blowing. *Med Educ* 2003;37:294–6.
- Goldie J, Schwartz L, McConnachie A, et al. Students' attitudes and potential behaviour with regard to whistle blowing as they pass through a modern medical curriculum. *Med Educ* 2003;37:368–75.
- Bent P, Creati B, Bolsin SN, et al. Professional monitoring and critical incident reporting using personal digital assistants. *Med J Aust* 2002;177:496–9.
- Bolsin S, Colson M. IT benefits in healthcare performance and safety. In: Dwivedi A, ed. *Handbook of research on information technology management and clinical data administration in healthcare.* IGI Global, 2009;798–813.