The Review

Ethics of the ordinary:

a class response

In a previous issue of the *BJGP*, Papanikitas and Toon use a fictional narrative to illustrate the ethical components of an ordinary consultation.[1] We discussed the narrative as a class as well as the questions posed by the authors, and would like to showcase our discussion as a way to decrypt some of the moral decisions and value judgements in this case. As a set of signposts to the ethical principles we have used Gillies' *InnovAIT* paper.[2] This paper sets out key ethical frameworks in relation to RCGP curriculum statement 3.3 on ethics and values-based medicine.[3] The class consisted of five qualified GPs, one senior house officer in medicine, one bioinformatics graduate, and one researcher for a think-tank. The class were all taking part in an optional MSc module in ethics law and professionalism as part of an MSc degree in primary healthcare or a Master of Public Health degree at King's College London. We conducted the discussion by Chatham House Rule, so all authors contributed, but no one voice is identified here. The class facilitator was Andrew Papanikitas, one of the authors of the previous *BJGP* narrative. We are all too aware that our discussion is not comprehensive and would welcome correspondence, either with us directly (via the corresponding author) or in the pages of this Journal.

The scenario is one where the last patient on a Friday afternoon asks for a private referral to a clinic for consideration of bariatric surgery. We note that the patient would not qualify for an NHS referral, and that the GP in the scenario is in a hurry to get to a social engagement. The authors ask how the doctor reconciles his 'legitimate' (class emphasis) plans for an evening out with the needs of his patient.

'TIME' IS AN ETHICALLY RELEVANT FACTOR

In discussion we arrived at a consensus that 'time' is an ethically relevant factor. The most important resource that a doctor can offer to the patient is their time. In the scenario it is Friday afternoon, which is generally perceived to be busy. The GP cannot control or predict how much time any particular patient may require and can easily have his clinic running behind schedule, but he might try to keep a margin between his expected finishing time and personal appointments. In fact this may be prudent, as the last patient may have something that needs to be dealt with urgently. The discussion included whether doctors should feel as entitled to finish on time as anyone else. While the authors' use of the word 'legitimate' begged the question, the class acknowledged that doctors are human, humans have rights, and therefore doctors have rights, such as the same 'right' to a work–life balance as other working people. Comments were made that it is not unusual for GPs (especially partners) to still be at work after official working hours have finished, because of paperwork or additional patients. This approach has been challenged by a younger more rights-conscious generation, but simultaneously, choice of appointment time and extension of appointment times have also been justified using the language of choice and rights enshrined in NHS policies.[2]

Most GPs based in a practice have the possibility to revisit an issue, whether the doctor proposes a decision and the patient refuses or vice versa. By contrast, locum GPs may have to defer to a colleague and hospital doctors are more constrained by what Doyal and others call a 'Slice of time'.[4,5]

HONESTY, INFORMATION, AND AUTONOMY

We concluded that the GP should ask the patient to return later, when he has had time to explore her options. There was a deontological element to the consensus; the GMC *Good Medical Practice* framework tells us that care of the patient should be the doctor's first concern during consultations,[6] but also an element of virtue-ethics. Two key issues were identified by the group: firstly this GP is possibly being dishonest. Secondly not having all the facts may compromise the patient's autonomy.

The behaviour generated by the virtue of honesty would be a frank, possibly apologetic disclosure of ignorance. The class mused about possible motivation to be dishonest, including the desire to seem competent and the desire to finish quickly.

The GP in this scenario does not appear to have all the facts, and consequently the patient may not be fully informed. If time to look up guidelines and have a fuller discussion cannot take place straight away, then a suitable follow-up appointment may be prudent. Although the patient's prime concern is her weight, the GP while respecting the patient's autonomy should further explore her wishes, her prime reasons for losing weight, her expected treatment outcome, and how bariatric surgery (if provided) will affect her lifestyle. The class had the opportunity to listen to Radio 4's Inside the Ethics Committee on BBC iPlayer.[7] Those who did so commented that the serious risk and consequences of bariatric surgery are overlooked in discussions of entitlement to the service. Even where surgery goes well, repercussions for lifestyle such as not being able to eat a 'normal' meal may affect social interactions in a significant way.

GUIDELINES AND VALUES — BUT WHOSE VALUES?

Papanikitas and Toon ask, 'If you stop eating you lose weight: when is surgery appropriate for lifestyle-related diseases?'

The class dissatisfaction with the fictional GP's actions largely revolved around his perceived ignorance or referral criteria. Current NICE guidelines for bariatric surgery[8] are:

'1.2.6.1 Bariatric surgery is recommended as a treatment option for people with obesity if all of the following criteria are fulfilled:

- *they have a BMI of 40 kg/m^2 or more, or between 35 kg/m^2 and 40 kg/m^2 and other significant disease (for example, type 2 diabetes or high blood pressure) that could be improved if they lost weight*
- *all appropriate non-surgical measures have been tried but have failed to achieve or maintain adequate, clinically beneficial weight loss for at least 6 months*
- *the person has been receiving or will receive intensive management in a specialist obesity service*
- *the person is generally fit for anaesthesia and surgery*
- *the person commits to the need for long-term follow-up.*

1.2.6.7 In addition to the criteria listed in 1.2.6.1, bariatric surgery is also recommended as a first-line option (instead of lifestyle interventions or drug treatment) for adults with a BMI of more than 50 kg/m^2 in whom surgical intervention is considered appropriate.'

These guidelines are based on values. A particular BMI or combination of BMI and other risk factors has been designated 'bad enough' to warrant surgery. A certain BMI has been designated 'overweight' and another 'obese.' These values are not necessarily shared by all, as the fictional GP notes how other 'fatter' patients who have comorbidities are less concerned about their weight. And why is weight so important to the patient in the scenario, and to the husband who is referred to but absent in this case? Values-based practice is an explicit component of the RCGP curriculum statement on ethics.[3] A *BJGP* paper argues its relevance in the primary care context.[9] The class felt it would be appropriate to arrange a follow-up appointment to go through matters in greater detail and clarify the relevant values.

IS IT RIGHT TO TREAT PRIVATE AND NHS REFERRALS DIFFERENTLY?

There are two issues that were discussed by the class. The first was the anecdotal observation that there is a perceived lower threshold for referral to a private healthcare provider. The class reflected that this should not be strictly correct, as private providers may offer a speedier service and possibly a larger range of services, but the business arrangement with the person referring is that the referral should be appropriate. This makes sense when the private referral is made under insurance cover. Otherwise the implication would be that GPs either refer people privately in an inappropriate way, or restrict people's access to NHS care purely in order to safeguard healthcare resources for 'more worthy' cases. The patient in the scenario avoids this concern by offering to pay for the consultation herself. It was noted that the fact that inappropriate referral in this case seemed to be more likely because the patient wanted to go private. The class felt that the public may perceive 'private' treatment as generally 'better' in some way.

The other issue was whether a referral should take place at all. The class agreed that irrespective of whether the treatment is provided through the NHS or privately, the clinical reasoning for providing that treatment should remain the same. However, the GPs in the class acknowledged that some GPs may feel less concerned about an unnecessary private referral than an NHS one, as it would not 'waste' NHS resources. But was it the right thing to do here? Using a principlist approach as advocated in the UK by Gillon,[10] The following aspects were discussed:

- Beneficence. What benefits are there of bariatric surgery at this stage? Does the patient actually require it?
- Non-maleficence. What are the adverse effects of having bariatric surgery? If, as we suspect, no surgery will be offered, then the patient is wasting her time and money could be classified as harm minimisation. The balance of benefit against harm is reflected in the withdrawal of sibutramine (Reductil) from NHS prescribing in January 2010 on the basis that the risk of cardiovascular side effects outweighed the potential benefits. The class noted that this patient had tried Reductil.
- Respect for autonomy. Use evidence to give patient accurate information so that they can make the right decision for themselves. The GP in the scenario accedes to the patient's choice, but makes little effort to investigate what underlies it. The patient needs more time to be counselled and given the correct information in order to choose the right treatment for themselves.
- Justice. NHS and private referral criteria should be the same unless there are reasons for unequal treatment. (for example, funding issues for some treatments: is the guideline based on clinical benefits and harms or based on the availability of funding?) Papanikitas and Toon ask if the GP should spend longer with this patient, desperate about her weight, than with others with greater problems but less concern. Gillies would respond, 'Does justice require that we primarily deal with demand or with need? The first of the duties of a doctor in *Good Medical Practice* is to 'make the care of your patient your first concern'. However, it can be difficult to decide in everyday practice which patient should be your first concern'.[2]

Deontological theories argue that 'The intentions of the person in acting are seen as morally relevant.' If the GP aims to respect the patient's autonomy, and intends their benefit then this is morally more worthy, even if the outcome is total disaster. Papanikitas and Toon ask their readers to identify whose agenda dominated this consultation. Does it matter that the husband is referred to in deciding on bariatric surgery? The GP is under a duty to demonstrate efficient knowledge, skills, and effective communication in understanding this patient's values. The patient appears to get an inappropriate referral in the scenario because the GP was in a hurry.

Consequentialist theories argue that the right action in any situation is that which will produce the greatest good for the greatest number. So if patients can afford private care and they fulfil the clinical criteria for required treatment, then they should be offered private care instead of having their name on an NHS waiting list. This also reduces the wait for those who cannot afford to pay for private care. Unfortunately this overlooks the aftercare and the management of complications which may not be provided. The other cost-benefit discussion is an individual one involving the likelihood that the surgeon would refuse to do any bariatric procedure for this patient. If the GP suspects this, and knows that the patient is paying 'out of pocket' then he will increase the patient's happiness by acceding to her request. However her happiness will decrease when the surgeon refuses to operate, and charges her a couple of hundred pounds for the consultation.

The class were also aware of a number of empirical studies examining GPs' ethical decisions. Twenty years ago a major international survey suggested that British, US, and Canadian GPs tend to make ethical decisions on a case by case basis rather than prioritising patient autonomy or patient welfare when these came into conflict.[11,12] In a much smaller qualitative study Berney *et al* found that the acceptance by GPs of general moral principles does not entail clarity of coherence in the application of these principles in practice with respect to rationing decisions.[13] In her study of South Australian GPs and back pain, Wendy Rogers[14] noted that her participants were far more reluctant to give patients free choice over options perceived as relating to clinical decisions (opiate analgesia and radiological imaging) than not (alternative therapies and sick leave).

CONCLUSION

The class concluded that although the patient got a 'choice,' she did not have the option of alternatives or full information which would have made the choice autonomous. This illustrates that autonomy and choice are not necessarily synonymous. Whether or not his dominating agenda was to catch the train on time, the GP in the scenario did not probe into the matter much. One of the class quoted an Indian proverb, 'His eyes could not see what his mind did not know'. Sokol describes the ethical Cyclops,[15] the person who does not see the why an action may be ethically flawed.

Wittingly or unwittingly, GPs in the UK may have a variety of ethical approaches imposed on them. The GMC duties of a doctor are arguably deontological, the RCGP curriculum statement endorses a values-based approach, and the cost-effectiveness calculations of NICE are perceived as utilitarian.[16,17] Our discussion illustrates how a GP can decrypt the ethical component of any consultation, be it for an iMAP case, a workplace-based assessment or an appraisal. It also illustrated the benefits of a discussion to expand the issues rather than steer to one answer, something which has tended to be seen in Balint groups.[18] The lack of fora to discuss ethical aspects of cases in general practice is often bemoaned.[4,5] The class was quite critical of the GP in the scenario. This kind of ethical decryption could be uncomfortable for a real GP, whether or not a consultation was perceived to be problematic at the time. This may be evidenced by interactions between trainers and trainees up and down the country and we hope that it will be an issue raised at the 'Primary Care Ethics: Solidarity or Personal Choice?' conference in London on 1 February this year (at the Royal Society of Medicine).

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Glossary

Autonomy: the notion that people who are able to make decisions about themselves should be allowed to and where necessary, assisted in doing so.

Balint group: small group of doctors (ideally facilitated by a psychologist or someone with training in psychoanalysis) that aims to examine aspects of the doctor–patient relationship through discussion of cases. Groups meet under pre-agreed rules, such as the agreement to keep the content of the group confidential. Although not specifically designed for this purpose, ethical issues can arise out of discussion.

Bariatric: descibes anything to do with the management in healthcare of obese people.

Consequentialism: ethical framework where the best predicted outcome defines the 'rightness' of any action. Utilitarianism is a consequentialist framework based on the calculation of relative amounts of 'happiness' or 'good' and 'unhappiness' and 'bad.' The action with the greatest net benefit is the best choice.

Deontology: ethical framework based on rules and duties, where the intention of the decision-maker is more important than the predicted outcome. It is based on the ideas that one should do things that one might wish others to do as well, and that people should always be treated as ends and never purely as means.

Ethics: the study of theories of morality.

iMAP: Interim membership by assessment of practice (IMAP) is a way in which practising GPs who have not undergone the Membership of the Royal College of General Practitioners (MRCGP) examination (But have undergone the old 'summative assessment' examination) may gain the qualification 'MRCGP'.

Moral: to do with the rightness and wrongness of actions.

Values-based practice: the idea that any healthcare decision should take account of all the different values that shape opinion as to the correct course of action. Sometimes values do not appear to conflict and so we are not aware of difference unless we ask.

Virtue ethics: ethical framework based on the notion that the characteristics or dispositions of the decision maker will produce a decision. Some virtues are practical, such as physical strength or the ability to do mental arithmetic. Others are less tangible, such as courage, prudence, and compassion. One of the goals of a virtue ethicist is to have 'practical wisdom'.

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