

Tacit components of medical ethics: Making decisions in the clinic

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When a patient visits his doctor there is, as well as a spoken dialogue, also an unspoken, or tacit, dialogue between them. This may not be evident unless that dialogue breaks down when the psychological or moral terms of reference of each are seen to be different. The author of this paper tries to elucidate the framework in which physician and patient think, and in so doing allow an understanding of why the physician may appear to be rigid and authoritarian in his dealing with his patients and the patient uncooperative.

'... I distrust the universals that are not reached by way of profound respect for the significant features and outcomes of human experience as found in human institutions, traditions, impelling interests and occupations.'

JOHN DEWEY

Much of the current work in medical ethics proceeds under a major, unexamined assumption. The assumption is that ethical reasoning can appeal to the physician as a person. I shall argue that no such appeal can be made without special consideration of how in making decisions physicians are influenced by the clinical context and by the values of this professional framework.

Ethicists' paradigm of medical ethics

The theologian Paul Ramsey claims that his work is addressed to 'patients as persons' and to 'physicians . . . who are persons', with the general understanding that 'the question, "What ought the doctor to do?" is only a particular form of the question, "What should be done?"'¹ Ramsey is not sufficiently aware of just how particular this medical form of the moral question can be. His moral analysis is brilliant but thin in its appreciation of medical sensibilities. It underestimates the power of the medical ethos to shape both the context of making decisions and the value predilections of decision makers.

In a similar fashion Harmon Smith has offered his thoughtful contribution to medical ethics on the premise that the 'shared *de facto* Judeo-Christian heritage' between physicians and laymen is sufficient to provide a common framework for moral dialogue².

By contrast, my contention is simply that the shared Judeo-Christian heritage is pluralistic in its implications. While this heritage may contain a common sense of moral obligation between persons, the moral obligations obtaining between medical professionals and their patients is less clear and often problematical. The assumption that there exists between physicians and patients an anchor of common reference in which moral reasoning is grounded is an unwarranted generalization.

The conventional approach to medical ethics, exemplified at its best by Ramsey and by Smith, focuses upon the application of rules or principles to particular cases. This approach takes it for granted that the task of ethics is the delineation and clarification of choices; it is essentially the task of interpreting rules or principles in such a way as to illuminate the various moral implications which different choices involve. Such a process is, of course, fundamental to ethics. Yet this particular understanding of ethics does not do justice to the moral life as experienced in the clinic. In particular, this conventional approach excludes some important dimensions of the doctor-patient relationship, the loyalties and values espoused by each, and especially the preunderstandings or tacit components which inform medical professionalism³.

Medical professionalism and moral values

Philosophers and theologians are prone to argue that moral reasoning must appeal to men *as men*, that is, as members of the human community. This is an important argument, but an unrealistic expectation within a medical context. Hiatt⁴ describes an 'invisible line' in the career of a doctor 'where he no longer views himself primarily as a member of society, but foremost as a physician . . .'. This strong sense of professional identity, and its accompanying preoccupations, are part of the context of moral decision making in medicine which the conventional approach does not fully recognize. Others from within medicine and from without have argued that the forms of professional education and professional work play a major role in the physician's ethical sensibility^{5,6}. These professional influences help to shape the physician's self image as a healer and his/her expectations of patients.

These factors are not a part of explicit ethical deliberation but give shape to how and when ethical issues are raised. Whether one chooses to call these tacit factors 'moral', 'psychological', or 'sociological', is of small concern. These components comprise a part of the context of medical ethical decision making which is often neglected.

Divergent views of decision making

Ethical decision making is the process of bringing moral sensibilities to bear in choosing a specific action. It can be used in a pejorative sense by those who feel that laws or principles prescribe real-life decisions without sufficient appreciation of their complexity. A decision-making process which is too rigid in its interpretation of how rules are to be applied becomes a moral taxonomy and forfeits its usefulness. Such rigidity does not assist decision making but replaces it. Other thinkers are more sensitive to the opposite danger in which looseness in the interpretation of rules leads to a wholly relative ethical position. This end of the polarity rightly asserts that ethics is more than taste or opinion. Aesthetic analogies do not do justice to the precision and objectivity that is possible in ethical analysis. Whether acknowledged as such or not, every situation of moral choice embodies an effort to interpret the meaning of rules, principles, codes or laws for that situation in some way. Yet the conventional models of decision making tend to exclude professional value components of the medical context. These components make a difference in our actual choosing. In short, the conventional approach to ethics has been successful in dealing with theoretical elaborations upon ethical problems, as these problems are defined by ethicists, theologians or other specialists in the humanities. Yet this approach has not been as successful in assisting the practitioner to cope with mundane value conflicts, viewed from within the daily routines of patient care. For the clinician, ethics is a practical, not a theoretical, discipline, rooted in the culture and traditions of medicine. For the philosopher or theologian, ethics is a field populated with quite different figures. And neither perspective may approximate to the moral decision making of patients. The divergence is not just a matter of who defines the problems, but of what paradigms are invoked, what customs pertain and what authorities are cited. This divergence is exemplified in the following situations.

Two clinical situations

Consider the typical case of an elderly female patient, hospitalized for an extended period, who one morning refuses to submit to any further blood tests. The physician faced with this situation has a choice of respecting the patient's wishes and no

longer drawing blood, or of finding some way of persuading her to continue. Assuming that the reading of blood gases is central to monitoring her condition and evaluating her course of therapy, her refusal may not be seen by the physician as a simple desire to forego further pain and inconvenience. Rather, it may be taken as a positive challenge to his authority or the effectiveness of his present course of treatment. The proliferation of articles in medical journals on 'non-compliant behaviour' is one index of the scope of clinicians' concern with this 'problem'.

While a typical ethical analysis of such a situation is likely to revolve around issues of patients' rights to refuse treatment, self determination and mutual contractual obligations between physicians and patients, clinicians may tend to see other issues as central. Non-compliance is viewed not only as a threat to the patient's life or health, but as an abridgement of the physician's authority and as a threat to his identity as a healer. Such a professional commitment has a definite bearing on the choices made. The clinician will not be likely to see this situation as one in which the appropriate action is to reason morally with his patient as one human being to another. 'Non-compliant behaviour' reflects a professional, medical judgment; this judgment can shape the moral choices to be entertained. Often the acceptance of non-compliance is interpreted as 'giving up' on a patient. Hence, such replies as 'As long as you're my patient, you're going to do as I say' are not seen by the physician as coercive or abusive. They are viewed as legitimate professional responses necessitated by the doctor's choice to push ahead with his patient's care. The patient can, of course, exercise his or her authority by absolutely refusing any further treatment, and this may or may not be a choice made out of a commitment to self determination, even at the cost of health or life. My point in all of this is that the physician and the patient are not here adjudicating a moral dispute as between one person and another, but as physician and patient, with all the special assumptions that that relationship embodies in our culture. Because the conventional ethical analysis of such a situation does not probe into the value components of professional training and practice, clinicians rarely get an adequate hearing for their mode of decision making.

It should not seem surprising that physicians think about ethics through such phrases as 'improved patient care', and describe the context of ethical deliberation as 'on the firing line', or 'in the trenches'. Parables of moral decisions are often, for clinicians, 'war stories'. These phrases emerge from the patterns of training and practice in medicine; they make sense within this professional frame of reference. Rather than stressing a common *de facto* Judeo-Christian cultural heritage between physicians and patients, it seems best to acknowledge that the clinical encounter is subtle and complex. Physicians

and patients are apt to read situations of moral choice differently, and to exercise different modes of decision making, quite often without being aware of it.

Another clinical situation in which expectations and preunderstanding conflict is the preoperative conference, especially when a malignant tumour is suspected. Patients, or their families, are frequently very inquisitive and always anxious. Yet their questions can easily be interpreted by the physician as probes to assess his diagnostic or therapeutic expertise. Such situations are complicated by the fact that the surgeon may be unable to answer these questions until he is well into the operation, when no judgment can be made by the patient. Patients who feel they have a right to know how much pain and disfigurement to expect will feel rebuffed by the physician who, sensing he is being asked the impossible, responds abruptly that he will 'do whatever is necessary'.

Sociologists of medicine have been interested in such clinical encounters for some time, interpreting them within sociological categories such as 'affective norms' and 'behavioural patterns'. Ethicists have been less interested in the fine detail of such encounters and usually focus exclusively on the explicit decision-making process. Yet clinical encounters such as the two depicted above disclose value agendas within the behavioural patterns. They disclose modes of moral reasoning which often remain at a tacit level, precisely because these encounters comprise the routines of clinical medicine. They constitute the substance of the physician's professional life and for this reason are not subject to frequent examination.

Three layers in the perspectives of physician and patient

A recent article in the *Journal of the American Medical Association* typifies the conventional view. It asserts that since there now appear to be 'systematic ethical differences between the layman and the professional', even at the theoretical level, 'the physician must learn to understand and accept the views and decisions of patients'.⁷ Such a view assumes that the layman's perspective is normative. No mention is made of any reciprocal responsibility laymen might have to understand and accept the views of their doctors. It is presumably on the terms of the lay norms alone that any conflict of opinion must be adjudicated.

I agree that there *are* ethical differences between physicians and laymen, but these differences are not surface differences of opinion. They are rather differences in custom and tradition, differences in sources used for ethical insight, and differences based in diverse understandings of the ritual dramas in which patients and doctors find meaning in their work, their illness and their therapies. It should not

be assumed *a priori* that one mode of ethical reasoning is superior. It may well be that conflicts in values between physicians and patients should be adjudicated with a bias toward the patient's perspective, yet no such general principle should be established or practised until there is greater effort to map the decision-making process which is enacted in the clinic. By assuming that our commonality as persons should and will override all differences, ethicists have excused themselves from the hard work and the cultural shock of clinical exposure. At a minimum, clarification and adjudication of value conflicts in medicine depend upon appreciation of and respect for the diverse modes of decision making between doctors and patients at a variety of levels.

Decision making in medical ethics is comprised of three identifiable levels or layers: 1) the weighing of alternative choices, the process of choosing; 2) the explicit deliberation of the implications of choices in terms of codes, rules or principles; and 3) the formulation of the issues through value assumptions. For example, a physician could decide not to tell his cancer patient of a discouraging diagnosis (level 1), because he doesn't want to take away the patient's hope on the principle, *primum non nocere* (level 2), and he may formulate the choice - to tell or not to tell - out of his sense of himself as an independent and controlling healer (level 3). As is evident, a different professional self-image would lead to different modes of formulating the moral choices and the process of deliberation. If patients are to take part in the process of decision making there must be some consonance between doctor and patient at level 3, as well as at levels 1 and 2.

The conventional approach to ethical problems in medicine has succeeded admirably in delineating the first two layers of this process. The level of value assumptions has been given less attention, partly because the values which function at this level are transmitted informally and are part of the customs and habits in the life of the culture and the professions. Confusion arises when these value assumptions are not shared between doctor and patient, since in these cases there is not only disagreement about what should be done, but about what is at stake, what choices are possible and what those choices signify. As illustrated above, refusal of a blood test, which to a patient may signify a desire for increased autonomy, to a physician may signal a non-compliant patient.

In endeavouring to illumine this tacit layer of values in ethical decision making in medicine I do not suggest that ethicists have been mistaken. I do argue that an inquiry into the tacit level of professional and cultural value components is an important complement to their work and will enrich both the process of ethical decision making and our understanding of ourselves as moral agents.

References

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