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Conflicting clinical duties

Michael J Selgelid, *Associate Editor*

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The first three articles in the Clinical Ethics section of this issue of *Journal of Medical Ethics* address potential conflicting duties of physicians. The first paper, by Niklas Juth and Niels Lynøe (see page 215, Editor's choice), reports results of an empirical study of Swedish physicians' attitudes regarding the provision of virginity certificates or hymen restorations requested by women, often from the Middle East, concerned with "honour-related threats". Such requests may be motivated by the aim to avoid "honour killings [which] are triggered by allegations of extramarital sexual relations and are considered a way of restoring a family's honour". While virginity certificates are meant to confirm a woman's lack of sexual experience, hymen restorations may be sought in order to "produce red spots on the sheets during the wedding night," and thus play a similar role.

Because Sweden lacks guidelines about how such requests should be managed, Juth and Lynøe conducted a survey designed to demonstrate Swedish general practitioners' (GPs) and gynaecologists' willingness, or lack thereof, to provide such services. A small majority of physicians indicated they would be willing to provide such services under certain circumstances, but a large minority indicated unwillingness to provide them under any circumstances.

Juth and Lynøe explain the unwillingness of many physicians to provide virginity certificates or hymen restorations by drawing parallels with zero tolerance policies regarding other practices considered to be unacceptable. Though provision of clean syringes to IV drug users may have various benefits, for example, many oppose needle exchange programs due to concerns that they signal acceptance of a practice (i.e., IV drug use) for which there should be zero tolerance. Likewise, according to Juth and Lynøe, despite the obvious benefits virginity certificates or hymen reconstructions might provide to women in danger, those unwilling to provide them under any circumstances most commonly explained their reluctance by saying that "doing these things would be to support or express patriarchal oppressive norms".

Juth and Lynøe, however, argue that intolerance for patriarchal norms does not provide good reason to refuse to assist women requesting virginity certificates or hymen reconstructions. First, they note that

there is no empirical evidence that provision of the services in question would actually increase patriarchal oppression. Second, they ask: Why should provision of such services be thought to condone patriarchal norms—as opposed to repudiation of such norms—in cases where the purpose of a virginity certificate or hymen reconstruction is actually to deceive purveyors of such norms?¹ A further problem, according to Juth and Lynøe, is that "a zero tolerance policy makes it difficult to conduct follow-up and assess whether or not different strategies are effective and safe".

In the second article, Roger Crisp examines physicians' duty of benevolence to their patients from a virtue ethics perspective (see page 220). What, he asks, should a virtuous physician do in cases where she has been instructed by superiors to provide an inferior drug, because it is cheaper, to certain kinds of patients? One might be tempted to think that the virtue of benevolence requires a doctor to always do what is best for her patients—and thus disobey instructions of her superiors in a case like this. According to Crisp, however, the virtue of benevolence is bounded by other virtues—such as professional responsibility (i.e., doing one's job) and justice (i.e., with regard to other patients' rights to healthcare, which might be compromised in the case of prescription practices which are not cost effective). Rather than necessarily always doing what is best for one's patient, therefore, according to Crisp, a virtuous physician will do what is best for her patient "in the circumstances".

Examining such issues from the perspective of Aristotelian virtue ethics—where virtue is a mean between two vices—Crisp refines the case by further specifying that the difference in effectiveness between the two drugs is slight, and that the doctor has been given strict instructions to prescribe the cheaper drug. Ignoring instructions and prescribing the more expensive (and only slightly better) drug in a case like this, according to Crisp, would not only fail to

¹e.g., in the case of false virginity certificates—or nonfraudulent "diplomatic" virginity certificates, which merely state that it could not be proven that the woman in question was not a virgin—and/or hymen reconstruction, for which the intention is presumably usually deceptive.

accommodate the virtues of professional responsibility and justice, it would also involve failure within "the sphere of benevolence or kindness" itself. Prescription of the more expensive drug in such circumstances, that is, would involve the vice of "excessive care".

Considering a case where a physician is merely requested, rather than instructed, to provide the cheaper drug—and where there are significant, though not great, differences in both cost and effectiveness between drugs—Crisp argues that "there would be something lacking in any doctor who was not, in such cases, inclined to give priority to the interests of the patient in front of her" and that the virtue of "patient-centred benevolence requires the doctor to give priority to the patient in front of her".

Crisp concludes by arguing that the virtue-based conception of patient-centred benevolence he advocates is compatible with both consequentialist and deontological approaches to ethics. Consequentialists, for example, will recognize benefits in terms of "the doctor-patient relationship itself, and the trust engendered by it, and indeed in the incentives it provides to the doctor to make medical decisions with care and attention to the medical condition of the patient as well as her wishes and needs". And deontologists, according to Crisp, are "likely to allow room for a principle of patient-centred beneficence which requires giving of appropriate priority to the interests of the patient".

The third article, by Thomas D. Harter (see page 224), argues that physician's with conscientious objections can meet professional obligations to patients via advance notification of their unwillingness to perform certain kinds of procedures (e.g., abortion, or surgery that might risk the life of a fetus) in the form of public disclosure.

Harter defines conscientious objection "as the opposition and refusal by a healthcare professional to provide certain treatments because the individual believes that helping to provide those treatments would violate personal core ethical tenets in a way that compromises his or her moral integrity". Despite its moral importance, conscientious objection may "conflict with healthcare professionals' obligation of patient non-abandonment" and potentially compromise patient welfare if access to legitimate care is denied or delayed as a result. While the compromise of

professional obligations or patient welfare might be mitigated in cases of conscientious objection via advance notification thereof, Harter argues that advance notification via public disclosure would have three main benefits.

First, according to Harter, “public disclosure generates the highest degree of advance notification”—and is thus most likely to enable avoidance of circumstances where patients are referred to physicians unwilling to provide desired interventions. Second, although the details of a public disclosure system still need to be worked out, Harter argues that “public disclosure is probably the cheapest and easiest way to generate consistent advanced notice” of a physician’s conscientious objection to certain kinds of procedures—which is not to say that public disclosure should replace direct disclosure to patients as part of informed

consent processes. Third, “public disclosure is already being used to manage [potential conflicts of interest associated with] physician’s “financial relationships with industry”—i.e., so this is an understood/accepted kind of practice, and providing models from which an implementation system for public disclosure of conscientious objection might be developed. Regarding both financial interests and conscientious objection, according to Harter, [p]ublic disclosure highlights, a priori, the physician’s potential conflicts of interest, thereby allowing those who may be affected to decide for themselves the substantiality of the potential conflicts, and, in the case of conscientious objections, precludes necessarily forcing physicians to provide treatments they morally oppose.

After countering objections that (requiring) public disclosure of conscientious

objection would involve an undue invasion of privacy, Harter concludes by flagging potentially challenging issues that will require further deliberation. These include concerns that there might be “backlash against non-disclosing physicians” (e.g., Catholic priests might be put under pressure to publicly express opposition to abortion by disclosing conscientious objection thereto); potential employment discrimination against conscientious objectors; and “the possibility that some physicians may be unfairly characterized strictly in terms of their conscientious objection”. While the latter concern is that physicians may receive fewer referrals from those with different moral outlooks, Harter argues that this might be balanced by an increased number of referrals from others who “admire those physicians for their conscientious objections”.