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Clinical ethics and the duty of care

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Scholarly inquiry into medical ethics should inform and guide those involved in making challenging ethical decisions.[1] It should strive to be integral to the work of health care professionals and health care institutions[2] and clinical relevance seems essential for this to happen.

To acknowledge the importance of clinical relevance for medical ethics, the *Journal of Medical Ethics* has introduced a regular Clinical Ethics section at the beginning of each issue. Papers that we think are likely to be of particular interest and relevance to clinicians will be placed in this section of the journal.

One way in which a paper can be framed for a more clinical audience is by organising it around a scenario that healthcare professions might face. The paper published in this issue's Clinical Ethics section considers a dilemma about whether an egg donor should be contacted to help diagnose a condition that the resulting child might have.[3] While egg donation has become more common, the complexities presented by this scenario might appear removed from those which most health professionals face. However, the way in which genomics is becoming incorporated into healthcare means that the issues this scenario raises are relevant to all healthcare professionals. The spread of genomics into practice means that the blurring of research and clinical practice and the resulting ethical complexities require us to be more sophisticated about how we view consent.

For those nearing the end of their life and those that love them, judgments about the 'futility' of future treatment are critically important. Patients and family members expect that such judgments will be reached with the best interests of that patient being centre stage, yet at the same time all areas of publicly funded healthcare make decisions against a backdrop of scarcity and the need to use resources effectively. The emphasis given to the duty to use resources well varies depending on the healthcare system and professional body. For example, the Declaration of Geneva says, 'The health and well-being of my patient will be my first consideration',[4] while The Medical Council of New Zealand thinks that duty needs to be balanced against competing duties,

> Strive to use resources efficiently, consistent with good evidence based patient care, and balance your duty of care to each patient with your duty of care to the community and wider populations.[5]

Taken at face value, that implies that when significant resources are being expended toward the end of life, clinicians should be mindful of how this might impact on their duties to other patients and populations. Given that all healthcare professionals who work in publicly funded systems do so within resource constraints, it's timely to consider how and whether scarcity influences their assessment of futility. Close and colleagues report on qualitative research upon clinicians' perspectives about the scarcity of resources and what this means for their judgments about futility.[6] They found that many of the clinicians they spoke to from three Australian public hospitals did take resource implications into account when making decisions about someone nearing the end of their life. Some of the clinicians spoken to expressed concern that resource restrictions could be conflated with futility. Close and colleagues suggest a number of steps that might help with such situations, including greater transparency about the competing duties that clinicians can have.

The duty of care is also at the heart of the therapeutic misconception: when patients involved in clinical trials think they are being treated when they are in fact research participants.[7] One alarming implication of the well documented prevalence of therapeutic misconception is that it can occur despite research ethics review and the emphasis given to informed consent. Halpern, Paulo and Huang claim that more thought should be given to what effective consent means in the context of clinical trials and that we should not overplay the significance of some mistaken beliefs that patients might have.[8] Their argument can be summarised as follows:

1. The prevalence of therapeutic misestimation and unrealistic optimism preclude adequate informed consent.
2. Informed consent is important so as to respect agency and that occurs when agents act for reasons they think are worthwhile.
3. So, the actual motivation and 'appreciation' of those enrolling in a clinical trial is the critical determinant of whether informed consent is adequate.
4. Therefore, research on consent to clinical trials should be tailored so as to tease out actual motivation and 'appreciation' and not focus on every misunderstanding.

They suggest that a misunderstanding that is not central to consent can parsed from one that is, by investigating patient motivation for taking part in a trial. This can be done by considering whether patients have not realized 'expectable personal downsides' and by asking them what they would be giving up by participating in the trial. These points are important not only for further research on therapeutic misconception, but also for clarifying what we should aim at when seeking consent for a clinical trial.

Many medical schools have introduced discussion of the societal, legal and ethical issues associated with using cadavers for anatomy teaching into the curriculum. Understandably, medical schools have been keen to ensure that the significance of human cadaveric material is acknowledged by medical students and that such tissue is used appropriately. The duty of care that healthcare professionals owe to their patients is an important component of the ethics curriculum and some medical schools introduce the ethical duties owed to cadavers by encouraging students to refer to them as 'my first patient.' Cohen reflects on her experiences as a first year medical student and what it meant to be encouraged to view her cadaver as a patient.[9] She shows how the values that are relevant to the anatomy lab are quite different from those of clinical practice and the standard way we think of the duty of care owed to patients. This paper, along with a number of other papers in this issue of the JME highlight the importance of the duty of care, but also how we should be thoughtful about the priority we give to it, how it is weighed and the confusion that can create from its application to activities such as research and education.

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