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Words

Clinical freedom

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'Freedom versus order is one of the oldest of all political antagonisms and today it is at the very heart of politics.'

Plato – *Republic*

It is hardly necessary to quote Plato to remind us that the concept of freedom is a topic as old as time – and has always been relative. Stuck in rush-hour traffic we may envy the cave-man his freedom to roam the hills, or hunt for food. But cave-man was also free to starve – and no more free from responsibilities for rearing his young, and ensuring the continuation of the species, than we are individually or collectively today. This balance between freedom and order, liberty and constraint, is basic to human life.

Definition

Freedom is not a word that even a dictionary can define, other than by use of a sliding scale of synonyms, from 'liberty' at one end to 'license' at the other and hence emphasises the relative quality implicit in the term. Liberty is positive when it implies the ability to do what a person wishes and negative when it represents an absence of interference by others with the activities of an individual man or woman.

The United Nations describes the 'inalienable' rights of all members of the human family, which it perceives as the 'formulation of freedom, justice and peace in the world'. One has to start somewhere. Even then the first article in the *Universal Declaration of Human Rights* begins 'all human beings are born free and equally in dignity and rights' and this statement could itself be questioned. It's all very nebulous; all too reminiscent of those who don't know about Art but know what they like. We have a concept which everyone understands, but which defies definition.

The geneticist C H Waddington conveys the secret reservations implied in the term when he says that 'freedom is a very troublesome concept for the scientist to discuss partly because he is not convinced that in the last analysis there is such a thing.' (1).

The lawyers are in no doubt. Jeremy Bentham is reputed to have said that every law is an infraction of liberty. For him laws only existed to maintain the balance between the individual and the rest – so that 'my freedom to' should not extend so far as to reduce 'your freedom from' – without which there is anarchy and might equals right. Freedom is a valued entity perceived as essential for the preservation of the species and function of any social group which can only be safeguarded by its own restriction or loss. A paradox. Pursuit of this conflict as a philosophical debate seems to lead down a blind alley. In considering the more precise topic of clinical freedom it is essential to appreciate that this balance and conflict is enshrined in any form of freedom – be it political, personal, or ideological.

Source of the problem

Turning specifically to clinical freedom it may help to look at the origin of the issue. History shows that aspects of medical care make it a service which from earliest days has been concerned with the protection of freedom – both of the patient and the physician. It is worth lingering over the factors which cause such concern. From the patient's point of view his, or her, complaints may be of an intimate nature, concerning bodily functions which come under varying degrees of taboo as topics of every-day conversation. His condition may convey social implications attached to its cause, or social consequences implicit in the diagnosis – all regarded as private to the individual unless he waives the assumption of confidentiality. At the same time – though he might at first wish to preserve this privacy – the combined effect of a deteriorating condition, and the information gap between the lay person and those with special expertise in the end forces recourse to a professional adviser. The individual's liberty is sacrificed because of his vulnerable position, and it becomes the transferred responsibility of the professional to preserve it.

In the retail trade 'the customer is always right'. But in his relationship with a doctor the patient is not a customer but a client, distinguished by a relative sus-

Key words

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pension of critical judgment and with the onus on the professional adviser not to take advantage of his privileged position.

The physician has power. Hidden knowledge is always power. The doctor has knowledge in depth of the clinical condition, the likely diagnosis, the preferred treatment and probably of prognosis. And this knowledge pertains to a subject which is personal and private. So the doctor has powers of life and death; powers to influence and shape a person's life-span and life-style; powers to treat or to harm. Faced with such a loaded adviser the patient's vulnerability needs protecting and he should certainly be protected against any abuse of this power.

The doctor in turn also needs protection. He is human and fallible too. At best he will try to ensure that his knowledge is adequate and his practice competent. He cannot have superhuman knowledge; and the practice of his craft may carry inherent risks. So he must be protected against any unfortunate outcome being attributed to malpractice, provided he has taken all reasonable steps to reach a sound judgment – and he must be guarded from unfounded accusations which damage his professional reputation and in turn his ability to serve other patients. It is a complex interlocking of relationships which together ensure a more favourable outcome than would occur as a result of an unrestricted free-for-all without any agreed code.

Professionalism

From the starting point of personal freedom we seem to have strayed into the field of professionalism. It may illuminate our understanding of the conflict (hidden or overt) which surrounds 'clinical freedom' if this aspect is explored a little further. A profession is defined by a number of characteristics (2).

A profession:

1) Is based on technical expertise; and requires the exercise of judgment in carrying out its responsibilities.

2) Has an elaborate code of ethics, with peer review machinery for disciplining members who offend against the code.

3) Controls entry; and is able to reject would-be members who lack the qualifications which the profession itself deems necessary.

4) Accepts accountability for its own standards.

5) Ensures that training includes a programme of socialisation which reinforces the subsequent practice of the professional role.

6) In its ideal form is motivated by a tradition of service.

The practice of medicine meets these criteria in a way that is rivalled by few other occupations. Indeed the responsibility for maintaining standards is protected by the force of law so that those not 'qualified' by the profession's own standards are in breach of the law if they attempt to undertake its practice.

The programme of socialisation is very subtle, persuasive and powerful. Despite the cynics, those who embark on a medical training usually start with genuine concern and may question their own temerity at hoping to acquire sufficient expertise to practise the craft. It is seen by the budding student as difficult, useful, and perhaps hazardous because of the responsibility. The professional code is regarded as helpful to the aspiring clinician, supportive to the practising doctor, and imperceptibly leads to the assumption that it, the code itself, is morally right and a good thing.

The next step to a benevolent paternalism ('rice pudding is good for you') is taken unconsciously. There is assumed to be a right to give the consumer, not what he says he wants, but what the profession judges he needs. Colleagues rather than users of the service must judge the appropriateness and competence of skills applied, and the client is regarded as unable to evaluate the calibre of services he receives.

For those programmed by the training it becomes particularly difficult to appreciate that such a worthwhile arrangement can ever be questioned – that others from different backgrounds and with varying outlooks can doubt the benefit, and challenge the values.

Professional responsibilities

Cocooned within the code and confident that he is on the right path the doctor happily shoulders his many responsibilities – or what the profession itself perceives as his responsibilities. After all, during his isolated and protected training no one has offered alternatives – suggested that patients, people, may wish to retain options; make their own decisions, prefer to go to hell their own way or refuse the attention offered.

We need to look closer at these responsibilities. We need to focus clearly on the ill-health or dysfunction which led the patient to seek professional advice in the first place. He sought the doctor's expertise.

Indeed he pays either directly or indirectly, for this service – for the answer to his question as to why he has developed a rash or is experiencing pain, or why a lump is developing or a bodily function altered. In response to this the doctor has a legal duty to exercise a reasonable degree of care and skill, harm resulting from negligence being actionable, in the way he advises or treats the patient.

This exchange is to take place within the context of the doctor-patient relationship. In his explanation of the law on these matters Speller defines this as 'the relationship which arises whenever a person seeking medical advice or treatment from a doctor is advised or treated by him, this whether or not the doctor is paid for his services' (3). With both sides protected by the relationship the doctor tries to answer the patient's question.

The patient's position

The patient is further protected by the common law rule that a person's body must not be interfered with

without his consent; and the doctor is under an obligation at no time 'improperly to disclose anything he may have learned about the patient and his affairs by reason of a professional relationship with him present or past.' (3).

Described in this way the patient's role is very passive. Reinforced by the blinkers that social class may bring to the relationship it is all too easy for the articulate doctor not to notice that the patient has views of his own. Vulnerable because of his ill-health and having approached the doctor in the first place, the patient has not however, necessarily abrogated responsibility for taking decisions. It is, after all, his life and health at stake.

There are those who choose to apply other criteria than length of life when told that they have a fatal disease and alternative treatments are offered. Women who question the advantage to be gained from radical surgery or radiotherapy for breast cancer complain that health professionals (doctors and nurses) reject them when they decline standard treatments.

The right, the freedom, of the patient to accept or reject the advice offered may need as much protection as the patient's body from physical assault. Patients find it increasingly unacceptable when they are treated like children, decisions (however well intentioned) are taken from them, and jargon is used to obscure what could be explained in terms that offer a genuine opportunity for comment or decision.

Sources of conflict

First, there is often confusion about the consultation. The patient cannot automatically be assumed to be seeking advice on matters outside the doctor's expertise. He has not asked for and may not want a moral judgment, ethical advice, or help with the full range of life's social and behavioural problems. He cannot be presumed to want a free lecture based on the doctor's own moral code or personal attitudes. The doctor is not trained, and is certainly not expert, in these matters. The patient will be mistaken if he thinks that the doctor is. The doctor is certainly mistaken if he believes that he has a prerogative of wisdom in areas that are clearly outside his professional field. If this aspect of the consultation was made more explicit to both sides doctors could become less defensive on the topic of clinical freedom. Only the misinformed are likely to question their rights and duty to prescribe on strictly clinical matters. It is at the heart of the consultation. But doctors are as vulnerable as any other amateurs outside their technical range and it is unfortunate if their process of training and socialisation obscures their perception of their role.

Secondly, there is conflict at the margin – when a clinical topic has moral or social implications; where confidentiality concerning knowledge gained at a consultation threatens the physician's duty as a citizen; where actions taken in good faith on behalf of one patient may be to the detriment of others. In these areas it is misguided for the doctor to be so blinkered by his own view of his professional role that he fails to perceive the validity of genuinely held differing views. Professionalism may be a code and a way of life that stems from the highest motives, but well founded motivation does not automatically ensure absolute wisdom. It is a method of protecting the interests of all parties rather than a divine and irrefutable authority.

It may help to illustrate the scope for misunderstanding by considering a few examples. A woman's request for termination of a pregnancy is an obvious topic. Such a procedure is safest if undertaken by the skilled professional gynaecologist. Certainly an opinion that continuation of her pregnancy may be harmful in respect of the woman's health is properly the physician's concern. He may be of the view that it will cause permanent damage to her kidney function or result in the deterioration of some other condition from which she suffers. It is his obvious professional duty to explain the problem and outline his estimate of the consequences of bearing the child. He should also hold an opinion and advise the parents accordingly if the child is likely to be harmed by the process of birth or has a high probability of being malformed. In this way he is responding with expert knowledge to the woman seeking advice, and should recommend the treatment he thinks appropriate.

The fact that he holds a different moral view on the sanctity of human life, or has a different attitude to sexual behaviour should not intrude on his forming a clinical opinion, or colour his advice – which will be received in good faith by the patient. It is all too easy for a punitive element to creep in. Because the patient's behaviour or its consequences are seen as harmful in the physician's eyes, and his professionalism has exaggerated the parental aspect of his judgment, he may easily justify the feeling that he is entitled to make an example of her misfortune – 'she'll think twice another time'. I am not making a plea for promiscuity – but simply giving an example of a matter on which clinical judgment can readily be clouded by the doctor's personal bias. For it is an abuse of clinical freedom if the 'treatment' is dictated pre-eminently by a moral judgment, and the doctor should not be surprised if his views outside the specific health issue are challenged in the same way as those of any other citizen would be.

Again at the margin there is a problem with confidentiality. This can be a 'grey area'. The law helps on this one. In the last resort information must be disclosed to a court of law. After all, ultimately we would survive a shorter time in a community that lacked a rule of law than in one devoid of doctors and the treatment they offered. While it is necessary to have a good doctor-patient relationship so that the patient may be confident of his doctor's total discretion, this should not be interpreted as requiring the doctor to conceal knowledge of a crime or of potential harm to others from the proper authority. There can't be an exact cut-off point, a dividing line which separates the two duties. The doctor should remember that he has been

trained and is expected to use judgment as a fundamental part of his role.

It is perhaps when one patient's interests conflict with those of others awaiting treatment, or even still unidentified, that the arguments become most extreme. The issue of kidney transplants in the treatment of renal failure epitomises the problem. A clinician's recommendation for such an operation may be based on his appraisal of the benefit which will be derived from such treatment and his estimate of the patient's condition. He will apply his professional experience and judgment in making the diagnosis and reaching the decision. Indeed he would be failing in his duty and negligent of his responsibilities, if he did not advise his patient to the best of his ability.

It only becomes a problem if the financial expense associated with the treatment is so great that implementing the operation exhausts the funds provided for the total population of patients seeking care from this particular crock of gold. It is in the interest of a greater number of people that a range of views are sought on the proper distribution of resources. Any one individual can easily be too prejudiced to make a balanced judgment. The allocation of finite resources depends ultimately on values, and the public's respect for the doctor's professional knowledge ensures that doctors' opinions rate high on any priority list of values.

However, allocating funds to transplant surgery is not solely a clinical matter if that allocation deprives an elderly patient of a hip replacement or prevents the appointment of another doctor skilled, say, in pain-relief techniques. It is not an encroachment on clinical freedom for a community to reserve a share of resource for care of the dying. The clinician would do well to recognise the validity of this position in a real world of finite resources. It is appropriate to look for alternate sources of funds, to suggest that less vital matters take a higher proportion of any cuts that, come hard times, have to be made. But it is an abuse of the doctor's privileged position in society for him to assume that he can make the final authoritative judgment on the relative merits and entitlement to preferential treatment of any one patient. He is entitled to hold a personal view. Society is entitled to hold a range of views which may differ from, or conflict with, that of the physician. Doctors do themselves a disservice and can be criticised for a blinkered approach when they give the impression that a single perspective is the only just one.

Yet another source of conflict may be the doctor's contract of employment. When no longer an entrepreneur, a doctor may on occasion find that he has divided loyalties. This explains the way the term 'clinical freedom' only became a battle-cry when Lloyd-George initiated discussions with the profession on the subject of state health care. In the armed forces a doctor is likely to remain with the wounded and would find it difficult to desert the sick for the sake of the battalion as a whole. In the prison service doctors eventually resisted instructions to participate in forced feeding of those on hunger strike. A social system whose doctors succumb to inhuman instructions and participate in barbaric abuse of their role, inflicting physical or psychological torture, is a perverted and degenerate social system.

Boundaries

So perhaps if we haven't been able to define the term we have been able to discover the parameters of clinical freedom. It is a responsibility to prescribe confidential treatment in response to a patient's request for advice about his health. The exchange takes place within the setting of the doctor-patient relationship. The consultation is controlled by the doctor's professional ethic – and the intra-professional constraints derived from this. It does not preclude the doctor's responsibilities as a law-abiding citizen; it may be threatened by the doctor's contract of service; and, when clinical matters overlap with moral or social problems it is valid for others to hold contrary views on those aspects which are outside the professional physician's expertise.

Why then does the term 'clinical freedom' arouse such hostility? Why does it cause such emotive and differing reactions in people? To the doctor who practises under its umbrella it is an obvious and self-explanatory concept. He may fail to appreciate that his training has perhaps enhanced his medical judgment and ability to make prescriptive decisions at the expense of sensitivity to alternative viewpoints. He may take for granted the benefits which go with his privileged social status and confuse constructive paternalism with the right to dictate the actions of others.

Those who are critical of the authority exercised by the doctor should consider whether it is his judgment or his attitude that they question. Suspicion that he is abusing his power – extending its use beyond its legitimate range – will justifiably rouse resentment and hostility. But their own reaction may be coloured by an element of 'sour grapes' – envy of the professionalism and the benefits it so obviously brings to the practitioner – rather than genuine doubt at the competence shown.

There can be frustration when the doctor's actions are perceived as counter-productive to the common good. When the critic in turn has opinions to which he is entitled by virtue of his own training, experience, or position in society he should not feel intimidated by the opposing professional aura from expressing them. This should enhance the decision reached and does not denigrate the clinical view.

In the end it is fair to ask whether in fact we as patients could do without it.

References

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