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MEDICAL WRITINGS

Putting Ethics into the Medical Record

The medical record is a sensitive indicator of how care is administered, reflecting not only the structure of clinical thinking but also the values embedded in medical practice. Ostensibly, the medical record identifies all the existing clinical issues, assesses each individually, and then integrates these issues to ensure that the patient receives thorough care. But the aspiration toward integrated, comprehensive health care remains, and the medical chart continues to be piecemeal and, more telling perhaps, incomplete—clearly revealing lingering frustrations facing patients and their health care providers. Physicians are in the midst of a self-conscious reappraisal of how care can be administered more effectively and, at the same time, with more empathy (1, 2). From this perspective, I offer my proposal.

Consider an addition to the medical record—one that heretofore was implicitly present but now must be made explicit: Insert a section called *Ethical Concerns.* It will be integrated into the medical chart, starting with the admission note and then the progress notes and, finally, the discharge summary. *Ethical,* in this context, refers to the deliberations concerning all matters related to the value-based decisions that are constantly made when caring for a patient. Broadly speaking, value judgments inform and guide implementation of knowledge. The scientific and technological tools of clinical medicine are applied in a context of complex personal and social factors. In short, medical decisions are made and implemented in a "moral space" of patient values. Thus, beyond the exercise of their knowledge of clinical science, physicians must draw on their empathy and moral understanding to address the myriad challenges that arise in the exercise of effective care. These matters, as crucial as they might be, are rarely voiced in the medical record and thus remain conspicuously muted.

THE MEDICAL RECORD: A REFLECTION OF VALUES

In an Ethical Concerns section of the medical record, a synthesis of personal, social, and moral issues related to patient care would expressly address these complex matters. Here, physicians would address problems ranging from decision making in crisis to the mundane details of support for patients during the hospital stay and after discharge. I maintain that only by making deliberate efforts to identify such questions does the physician effectively address the concerns that are often closest to the patient's own experience of illness. Most physicians believe that they function with moral sensitivity, but, clearly, some are more naturally attuned to moral concerns. Here, I propose that an entrance be provided into a domain that has hitherto remained obscured by the vapors of good intentions. Constructing such a portal will require a reorientation, or better, an expansion of the assembly of all the components of the clinical case. More than a scientific and legal document, the medical record might then become a more comprehensive construction of a person's illness.

The medical record can be seen as a type of narrative (3): It tells a story of disease. The contents of that story formulate, structure, and thereby interpret. With its emphasis on clinical problems, the medical record exposes an ethos, revealing both the accepted mode of care and the logic underlying practice. The structure of record keeping reflects and may even determine the kind of care given. When the moral concerns of the patient are specifically addressed as part of the medical encounter, a formal means for considering these matters is established. This is a simple, yet crucial, revision of current medical record keeping. When the busy physician is required to attend to this dimension of patient care, the empathy assumed to be embedded in the character of the caregiver is reinforced, and concerns of the ill that are too often bypassed or forgotten are explicitly emphasized.

IMPLEMENTATION

What might an "ethical work-up" section of the medical record entail? Where should it appear? Should a series of specific questions be asked or a prescribed format followed? What are the limits of such an inquiry or, more clearly, how comprehensive should the attempt to address such concerns be? Clearly, different patients have different requirements, and different questions dominate different clinical settings. Whatever the specific characteristics of a given case, a conscious effort must be made to consider the patient's values. No less important, physicians must understand the values that

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Table 1. **Fourfold Ethics Evaluation***

1. Medical indications: Define clinical problems, goals of treatment, probabilities of success, and plans for care if therapy fails; delineate cost–benefit ratios of care.
2. Patient preferences: Maintain patient's right to choose by determining preferences for care; assess patient's competence and ability to adhere to medical treatment; if incompetent, is there health care proxy or advance directives?
3. Quality of life: Specify prospects, with or without treatment, of patient's recovery; define physical, mental, and social consequences of treatment success; and explore plans for care if treatment fails.
4. Contextual features: Clarify family or provider issues, including allocation of resources, financial constraints, and religious or cultural factors, that may influence clinical decisions; describe possible legal implications of treatment decisions (e.g., informed consent in clinical research or teaching settings); and establish the scope of confidentiality.

* Adapted with permission from Jonsen et al. (9).

guide their own choices and actions. I offer no formula, but I do advocate an approach.

Defining the value structure of the patient and physician and making the structure explicit provide the basis by which the clinical encounter can be a consensual and cooperative effort. Because the moral space is constructed by a complex confluence of values, sometimes in perfect alignment and sometimes not, an ethical work-up must enunciate and, ultimately, encompass the values of the patient *and* the values of the clinician in the setting in which he or she operates. In other words, there is an ongoing negotiation as to what *can* be done and what *should* be done for each patient (4). I am advocating that we should make this deliberation explicit—that we should articulate the basic ethics that guide and inform clinical decision making.

In this formulation, the ethical examination is directed not only at the usual source of inquiry, the patient, but also at the physician. This is, perhaps, the most radical aspect of this proposal. Physicians have not been trained in self-reflection; in the scientific model, the medical gaze has been designed to be directed outward, to attain objectivity. It is crucial that physicians not only fully explain therapeutic options to their patients but also clearly delineate the ethical norms and meta-ethical assumptions (the basis on which one value is selected over another) that are the foundation of their medical opinions. To determine mutually agreed upon therapeutic goals, the physician must be aware that the decision is an adjudication of perspectives from which embedded values often silently determine what is seen, what is believed, and what is advised. The point of the exercise is to deliberately address potential conflicts of values *before* they arise and, as in any negotiation, to understand both points of view.

It is surprising that scant attention has been given to formulating a comprehensive "ethics work-up," although both general guidance (5) and specific protocols have been devised for certain problems, such as palliative care (6, 7). This is partially the result of competing systems of medical ethics (for example, axiomatic, consequentialist, consensual, or pragmatic ethics [8]), the sheer complexity of the issues involved, and the restrictions imposed by the specific characteristics of individual cases. Nevertheless, a fourfold practical approach (**Table 1**), which offers an orderly review of the ethical issues in any case, has been devised (9). **Table 2** outlines a deliberative procedure for determining a patient's moral profile and an ethical decision within this format (10). Implicit to this exercise is gathering facts, that is, obtaining clinical and psychosociologic data—a process that is already routine, or should be. The key modification lies in taking these facts and examining them not only in the accepted fashion (principally within the narrow pathophysiologic context) but also in the context of a coordinate system that includes both the values of the patient *and* the physician. Thus, the ethics work-up is directed toward understanding the patient's needs, resources, and values and then coordinating these elements with the physician's efforts, which are themselves directed by a set of personal and institutional values and priorities. The self-reflective elements of the ethics work-up make this portion of the clinical portrait fundamentally different from the rest of the chart, which is oriented from the perspective of the examining physician toward the patient. Here, a true dialogue is embraced.

Because the deliberation just described requires a comprehensive understanding of the case, I suggest that the Ethical Concerns section become the penultimate segment of the initial medical admission note, or first clinic encounter, placed just before the final Impression and Plan sections.

A likely question, given that medical practice already addresses the psychosocial setting of the patient's experience of illness, is why this modification in record keeping is

required. Simply stated, the clinical priorities, as a function of the wider life concerns of the patient, are rarely described. Perfunctory notes about marital status and employment constitute an acceptable social history, and only ancillary narratives from psychiatrists or social workers provide a comprehensive picture of the patient in the home setting. I propose deliberately addressing this aspect of care by compelling physicians to define the moral space within which they administer care. If this is done, medical ethics will have a precisely defined place in the medical chart and will thereby powerfully direct and justify our mode of professional behavior.

Most cases require little or no ethical reflection (11). For those facing end-of-life decisions, resuscitation orders, living wills, autopsy requests, and health care proxies are already routine, and their enactment rarely presents an ethical problem in the sense of being unidentified. The dramatic settings of transplantation, in vitro fertilization, and abortion, for example, hardly need comment here, because the ethical concerns of such decision making are integral to these clinical encounters. The "extremes" of the medical spectrum are not my primary concern; my focus is the more ordinary cases in which the choices presented by the physician must take into account patient values that are not easily articulated and are often overlooked.

Medical ethics is not applied only in crisis management. In one report, almost one in seven patients had moral dilemmas that went unrecognized by the ward team (11). Although much depends on the population examined and the moral "index" adopted, I suspect further study will reveal this figure as conservative. Whatever the actual incidence, however, illness demands that extraordinary choices be made, and value-laden decisions require identification and deliberation. The physician has a crucial role to play in this determination.

There are compelling administrative rationales for recognizing ethical issues proactively (for example, obtaining resuscitation directives), but I am also advocating a certain ethos of caring to be integrated with the more typical clinical concerns of patient management. By emphasizing the legitimacy of moral deliberations, I seek another mechanism by which empathy is declared and exercised as a guiding principle of medicine. There is no available formula to address this humane dimension of care. To a large extent, empathy is, or should be, implicit in the character of all health care providers, and I would not dispute the essential good will of those who enter the healing professions. I do, however, seek a means to fortify the claims of empathy by embedding them in an increased sensitivity to moral concerns. In the harried climate of the busy clinic, a self-conscious effort to place such issues high on the agenda of care requires vigilant efforts. Simply put, physicians would benefit from support that stresses both empathy (a psychological attribute) and ethical reflection (a moral endeavor).

THE DEBATE

Physicians are expected to understand the multidimensional character of disease and the diverse cognitive and moral faculties required to be effective health care providers. While I appreciate that medical practice involves keeping a delicate balance between competing interests and the establishment of priorities, I believe a more sustained effort is necessary to maintain the humane elements in clinical care; to do so, deliberate efforts must be made. Those who regard this proposal negatively often argue along one of two lines. The first objection is related to economics, that is, the economics of time and professional priorities. According to this view, physicians are already overcommitted and do not have the resources to offer patients the requisite time to obtain the information called for here. The second objection is related to a deeper and thus more difficult

Table 2. **Presentation of Ethical Decision Making***

Step 1. Identify the significant human factors in the case: Demographics (e.g., age, occupation, education, family status, and home setting), behavior history (e.g., psychiatric profile, criminal record, and substance abuse), and religious and political attitudes relevant to health and medical care.
Step 2. Explicitly define value factors (medical, professional, and human) related to the patient, the health care professional, and other relevant persons involved in the case.
Step 3. Delineate all ethical choices and major value conflicts.
Step 4. Set priorities for conflicting values and give reasons for holding a position.
Step 5. Identify the criteria by which a decision is made, considering underlying ethical norms and meta-ethical assumptions (How was *this* decision, based on *that* value, moral?).
Step 6. Critique the assumptions underlying the decision made in step 5 and present the final opinion and strategy for dealing with the moral issues identified.

* Based on Thomasma (10).

issue: Although physicians may wish to be humane, they by and large function as technocrats and thus are rarely called on to exercise moral sensitivity. Consequently, the patient in the typical setting does not expect to discuss values and beliefs, and only in the most pressing circumstances do such deliberations take place. I sympathize with these complaints but believe that the naysayers should carefully consider my rejoinder.

As for the first concern, the economics of time and commitments divide the professional day by certain expectations and standards of conduct. If physicians were expected to devote more professional effort to getting to know their patients, the time required to accomplish this objective would be acknowledged as important and would be factored into daily practice. Denying priority to this issue not only provides telltale evidence of the problem but serves as an indictment of our health care system. Only by alerting both the professional and lay communities to the shortchanging that is obviously occurring can the medical profession begin to adopt formal standards that will eventuate in change.

But now the second objection looms menacingly before my proposal: Perhaps devoting more effort to establishing the moral relationship between physician and patient is unnecessary. Why should the physician move beyond serving as technocrat to serving as a more thorough caregiver? After all, is not medicine ultimately a scientific discipline, ever more beholden to technological applications? From this viewpoint, technical proficiency is paramount, and attention to humane values will come into play only as required and in a minimal expression. Others on the health care team—including nurses, social workers, clergy, and psychiatrists—can deal with ethical complications as they arise.

Here is the heart of the matter: From my perspective, medicine is fundamentally a moral commitment, that is, the care of the *person.* Science and technology serve that responsibility (12). *Patients* entrust their care to physicians, who exercise their medical skills to resolve a clinical problem. But *people* experiencing illness have a diseased body *and* a ruptured sense of selfhood. The patient knows little about disease but intimately experiences illness. Where is the boundary drawn between *patient* and *person*? As a scientific object, the boundary is quite evident; as a moral agent, there is no division. Indeed, the patient–person distinction exists as an ethical dilemma and testifies to a profound fragmentation. Failure to specifically address mending this divide ignores the complaints of those who rightly feel that their bodies may be adequately attended to but that their personhood is left to be rejoined catch-as-catch-can.

Medical ethics is more than judicial directives, risk management, and academic debate. It is the very foundation of medicine—the moral substrate on which clinical care is built (12). One might see most choices and actions, even the most mundane, as the enactment of some underlying value system, but such reflection is not ordinarily part of clinical praxis. In adopting serious measures to ensure that medical ethics does not become another subspecialty but rather flourishes as an integral part of every physician's training, conduct, and practice, the profession must embed moral self-awareness in the medical record and thereby make moral deliberation explicit and routine. To that end, including an Ethical Concerns section of the medical chart that specifically addresses how well the physician has recognized the patient's experience of illness and incorporated that perspective in decision making is another step in improving efforts to ensure empathetic and ethical care.

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