



## Implementing Medical Ethics

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**Key words:** medical ethics, medical record, moral philosophy

### Abstract

How to place medical ethics more firmly into medical practice continues to be a central concern of physician training and practice. One strategy is to make medical ethics an explicit focus of attention in the medical record. A separate section of the medical chart, one integral to clinical evaluations and ongoing progress notes, should be devised to articulate both the obvious and less apparent ethical issues pertinent to each patient. This so-called Ethical Concerns section is designed to proactively identify such problems and thereby raise these issues as part of routine evaluation and care. The historical developments and ethical challenges leading to the need for such a revision in record-keeping is reviewed.

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### The problem

The medical record not only depicts healthcare, it also has a role in structuring that care. In its narrative, the chart identifies clinical problems, the efforts to diagnose illness, and finally, records therapeutic interventions. But it also proscribes the ways each of these processes is performed. In short, the record reflects the structure of medical thought. And, perhaps less obviously, it also expresses the values embedded in clinical practice.

The medical record begs for revision. As a true mirror of healthcare, the medical chart reveals a remarkable absence of attention to medical ethics, except in the case of crisis management. But medical ethics is more than crisis decision-making, for implicit to virtually all medical interventions is a complex array of choices based on individual and cultural values. The kinds of care, the integration of diverse belief systems, the attention to the psychological reaction to illness are each representative of a vast universe of moral reckoning – *moral* in the sense that values are exercised as choices are made. In short, medicine's moral accounting must factor all those *values* that determine decisions in the clinic or hospital. Thus, medicine's scientific ethos is only one element of this calculus. Religious beliefs, personal histories, psychologies and social mores also carry weight in this calculation.

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The conspicuous absence of medical ethics in the record of clinical encounters is baffling given the current global interest in making medicine's moral commitments explicit. In an attempt to repair this situation, I recently suggested an addition to the medical record [1]: In the admission note, and thereafter in progress notes and in the discharge summary, I propose that a section called *Ethical Concerns* be inserted. 'Ethical' in this instance encompasses all those matters related to the value-based decisions that are constantly made when caring for a patient. What options are exercised and how they are implemented are more than technical decisions. Praxis must be integrated within broad social and psychological concerns. These decisions require physician guidance, and the doctor in turn, in order to negotiate effectively, should be aware of his or her own values that may be either in harmony or in conflict with those of the patient. Self-reflection and empathy thus become important moral faculties in addressing the myriad challenges that appear in the exercise of effective care.

An *Ethical Concerns* section of the medical record would provide for a synthesis of personal, social, and ethical issues related to patient care. There, physicians would self-consciously address problems, which range from decision-making in crisis to the mundane details of support for the ill during the hospital stay and after discharge. In making deliberate efforts to identify such questions, the doctor effectively addresses those concerns often closest to the patient's own experience of illness. Irrespective of individual physician moral sensitivity, an entrance must be provided into a domain that has hitherto remained obscured by vapors of good intentions. To construct such a portal will require a reorientation, or better, an expansion of the assembly of all those components that make up 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 solution

The need for a formal section in the medical record to specifically address the moral issues of patient care has been a natural extension of prominent trends in healthcare since the late 1960s. The most important in the context of this discussion is patient rights, which grew in a period of extraordinary social ferment in the United States. Two protective processes – one proactive, the other reactive – worked together at this time. The first was the enunciation of bioethical principles and the formal

affirmation of patient rights between 1968 and 1973 [2]. The other major force was not moral in a strict sense, but judicial, as witnessed most dramatically in the rise of malpractice suits and resultant awards during the 1970s and thereafter. Israel is largely immune from American medico-legal imbroglios of malpractice, and the social context is obviously different, nevertheless a newfound sensitivity to medical ethics has been shared [3].

Closely linked to a self-conscious moral acuity is a growing appreciation that the patient perspective must be factored into the care scenario. Patient narratives have increasingly been seen by medical professionals as an important element of data-gathering. But beyond reconstructing medical histories for clinical information, patient accounts reveal how disease is *experienced* and thus demonstrate the value structure within which disease is perceived [4,5]. Such phenomenologically based stories often dramatically portray the complexities of illness that were hardly apparent within traditional medical case study methods [6]. The disturbing, but hardly startling conclusion: Scientific characterization of disease is inadequate to address what are often the central concerns of the ill person. Only a more global assessment captures the complexity of disease as experienced, and when appropriately explored, patients might eloquently, and too often surprisingly, offer insights that add new requirements to care. In the patient narrative setting, comprehensive care assumes new dimensions and new meanings.

Thus we might reasonably predict that current medical records must evolve to address these newly expanded understandings of patient care. Consider the revision that occurred about thirty years ago when Lawrence Weed proposed the problem-oriented chart to organize what too often was a chaotic assemblage of clinical data. In particularizing specific problems, the new chart reflected a deliberate effort to coordinate and ultimately integrate the clinical specialties that came to dominate patient care. In the face of the rising subspecialty culture, Weed endeavored to design a chart, which was to be a "scientific manuscript" and a "creative instrument for facilitating comprehensive and highly specialized medical care" [7, p. vii]. But there was another salutary effect of this revision for those who saw this structured approach as a means to combat the fragmentation of care. By listing all the medical problems, physicians could not be satisfied with pinning Mrs. Smith's hip fracture without treating her arthritis, diabetes, hypertension, and insomnia, which would remain nagging problems long after her hospital discharge. Weed initiated a self-conscious effort to integrate care, albeit in service to a subspecialty-dominated medical practice. Much to his credit, he was successful, but new times demand new solutions as the increasing complexity of the doctor-patient relationship called for re-examination [8].

Because the medical record is a narrative of a particular sort [9], it tells a story of disease. So what is included in that story formulates, structures, and thereby interprets. Once standardized along prescribed lines, the medical chart could be perused quickly by anyone conversant with current practice. Whether in Boston or Haifa, such a document displays information uniformly, and (perhaps more subtly) the logic underlying practice – how care is thought of and ultimately delivered. But the record is more than a *reflection* of practice and thought; it is also a *determinant* of what kind

of care is given, because the record functions in structuring clinical thinking. Doctors are trained to fulfill the template of the record's divisions and subdivisions, to obtain data relevant to the particular problems that require attention, as well as to address unsuspected disease. If questions are not asked, answers cannot be given. If tests are not performed, the best-intentioned scrutiny will not suffice. Similarly, if inquiry is not made into the welfare and support of a patient, the physician will not identify potential or present problems. Pathography (testimonies of illness, disability, mental disease, death, and recovery) has shown how patient narratives reveal hidden values that structure the experience of illness [9,10]. And while there is an increasing sensitivity to glean such insight in the clinical interview, there is as yet no formal place in which to situate such information. By specifically addressing the moral concerns of the patient as part of the medical encounter, physicians will have a straightforward means to consider such matters. I regard this addition as a simple, yet crucial revision of current medical record-keeping.

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