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CASE AND COMMENTARY

When Is There a Duty To Inform? Commentary 2

Russell Burck, PhD

Case

For the first presentation of his radiology elective, Scott was to select a film and discuss what he saw with the other students, residents, and faculty. He selected a chest film of a 57-year-old man, Mr. Walters, who had come to the Emergency Department several days before with a cough.

Scott decided the film was consistent with a diagnosis of chronic obstructive pulmonary disease. The next time he saw the attending radiologist, Dr. Carlson, Scott asked him to look at the film with him to see whether he concurred. Dr. Carlson began working through the systematic reading of the film with Scott—soft tissue, then bones. Then he pointed to some spots on a lower left rib and asked Scott, "What are those?" "They look like mets," Scott answered, and Dr. Carlson agreed they could be.

Scott pulled Mr. Walters' chart to verify his diagnosis and see whether the bony lesions were noted in the report. The radiologist's report said only: No acute pulmonary disease. Scott read the full chart entry. Mr. Walters had been in town visiting his daughter when he developed the cough. Because of his chronic lung condition, she had prevailed upon him to go the emergency room. The physician ordered the chest X-ray to rule out pneumonia. The discharge note said that, given his underlying lung disease, Mr. Walters saw his pulmonologist every 6 months. The chart said nothing about a chest X-ray that revealed possible bony metastases.

Scott asked Dr. Carlson whether they should call the radiologist who had read the film. "Hell, no. This guy probably knows all about his cancer. He came in to find out whether he had pneumonia and we told him he didn't. The discharge note says he'll be seeing his pulmonologist soon. I'm sure he's getting proper care."

Scott wasn't satisfied. Knowing that the examining radiologist notes all pertinent positive findings, Scott thought it possible that no one yet knew that Mr. Walters possibly had metastatic processes in his rib. Mr. Walters had gone home, and Dr. Carlson had said he couldn't be calling around the country to the docs of everyone who came into the ER to see what they knew and didn't know about that patient's overall health. That made sense. And certainly Scott couldn't take it upon himself to find out who Mr. Walter's physician was and call him. The guy would think he was nuts.

Scott mentioned the case to his wife that night, mostly to let her know about his diagnostic "catch." But Becky's response was all about Mr. Walters, and she didn't see things the way Dr. Carlson did.

"It's okay for you to practice on those patients," Becky said, "to peer and poke at them and talk about them. All for the good of medical education and the benefit of society. Now here comes a case where somebody might benefit right here and now from the fact that a student and a second radiologist took a look at his X-ray. That could only happen in a teaching hospital. You have to do something, Scott."

Scott didn't care for any of his options. Dr. Carlson had been clear that no follow up was necessary. He and Scott had no patient-physician relationship with Mr. Walters, this was not an emergency, and so on. If Scott went back to Dr. Carlson and received the same reply, that would have to be the end of it. Dr. Carlson was there to assess all of Scott's performance including his ability to follow instructions. Yet Scott was uncomfortable taking no action in Mr. Walter's behalf.

Commentary 2

Ethics asks, "What is the good or not so good? And how do we know"?1 Not everything that ethics authorizes or requires can always be called "good," like calling a patient who has already left the Emergency Department to tell him that his radiographs may contain bad news. Therefore, I substitute other words and phrases, so that the whole list looks like this:

1. What is the good or not so good in this situation?
2. What is right or wrong in this situation?
3. What is our responsibility in this situation?
4. What is the proper use of power in this situation?
5. In this situation what is the appropriate relationship of means to ends?

This month's case asks, "When is there a duty to inform?" That makes it similar to the third what-is-the-good question: "What is our responsibility?" The story offers a number of candidate statements about when there might be a duty to inform.

- When there is a patient-physician relationship.
- When uncertainty about the patient's care exceeds some unstated threshold.
- When a provider (or provider-in-preparation) believes she or he sees something that should be brought to the patient's attention.
- When there is no significant risk to the provider or student-provider who has the concern.
- When one feels a responsibility inside oneself. Perhaps when one feels that to live with oneself, to sleep at night, one needs to do something.

Then the question becomes, "Responsibility to whom, to do what?" My answer is, responsibility to assure myself that I have done what was needed to assure that the patient had the information I had, if the patient wanted to have that information.

I distinguish between ethics as what-to-do and why-to-do-it. Because ethics is about action, and health care ethics is about practical service to people, health care ethics easily steers toward what-to-do. As I am not a physician, my what-to-do solution becomes a following thought-experiment:

- I would call the pulmonologist and say that we believe that we have seen bony mets in the patient's ribs.
- I'd ask what the patient knows and understands about his condition.
- I'd ask whether the patient is involved in decision making or whether he has indicated that he wants others to deal with his health care information and decisions.
- I'd say I think the patient or his surrogate needs to know about our finding.
- If the pulmonologist didn't have enough information to satisfy me, I'd ask her or him who the patient's primary care physician was and what she or he knew about the bony mets.
- I'd try to speak to the PCP and I'd repeat the above steps.
- If I couldn't get to the PCP, I'd see whether Mr. Walters was still visiting his daughter and whether he could come in to the hospital for a conference.
- I'm almost done, but perhaps I would take other steps, until I had reached reflective and emotional equilibrium2 about my responsibilities. Reflective and emotional equilibrium means that I continue to entertain all the new thoughts and feelings that I can about the situation, but that none of them prompts any change in my solution.

What-to-do is where health care ethics often stops. When it stops there, it does not think about the ethics rationale (why-to-do-it). The rationale according to my why-to-do reasoning is that when patients come for health care they have a right to know their conditions. Physicians have a responsibility to learn what the patient wishes to know about her or his condition and to satisfy that desire to know. They also have a responsibility to learn how to deliver bad news as well as possible whether they know the patient or not.

Having said all this, I think this story is really about something else: The hidden curriculum in medical school. Dr. Carlson's real curriculum is teaching Scott how to rationalize not informing Mr. Walters.

1. "We can't be calling everyone's doctor all over the country."
2. We don't need to act, because the patient "probably knows already."
3. No follow-up with the patient is necessary.

If this curriculum were spelled out to Dr. Carlson, I doubt he would understand what was being said. The curriculum is most likely hidden more from Dr. Carlson than from Scott and his wife.

In addition, this story is about the fact that ethics is not an add-on. Ethics is built in to everything the health care team does. In that light, Dr. Carlson needs an "ethics kit-bag" that he can carry with him at all times, so that he can help students and house officers address the kind of question that concerns Scott. I can't imagine that Dr. Carlson (or any teaching physician) would address Scott's question by calling an ethics consultant or the ethics committee. That is a feasible approach. But if he isn't going to do that, Dr. Carlson needs an approach to ethics that is

1. practical,
2. portable,
3. flexible, and
4. reliable.

So what should this story be about? To answer that question, let's take a small step back: Medical ethics differs enough from the ethics of everyday life to make the transition to medical ethics long and complex. Scott is in the process of becoming a responsible, self-monitoring professional. Therefore, this story should be about a senior practitioner helping a practitioner-in-preparation learn important differences and overlaps between the ethics of everyday life and medical ethics. He has a responsibility to commend Scott's question and the sensitivity that prompted it. He should ask how Scott is thinking about his responsibility to this patient, how he might carry it out, and where he could responsibly stop. He may even need to talk with Scott about some of the preparation necessary to convey this information to Mr. Walters' doctor(s) and perhaps to Mr. Walters himself.

Dr. Carlson probably has not received the kind of mentoring that Scott needs from him. That's fine. We come by our deficits honestly. And we learn to defend them honestly. So moralizing about Dr. Carlson's teaching lapses with Scott is understandable, but not helpful. Rather, this story is about the obligation of practitioners to teach the ethics of their daily work responsibly or to call in clinically sensitive non-medical ethics professionals to walk students like Scott through their questions. The medical profession does not seem to be there yet. Perhaps non-medical ethics professionals are not even aware of this agenda. So that makes this story about a new direction in medical ethics for the future. This case would be a good place for radiologists to begin learning how to teach some ethics as part of their daily work.

References

1. Burck R, Lapidos S. Ethics and cultures of care. In: Mezey MD, Cassel CK, Bottrell MM, et al, eds. *Ethical Patient Care*. Baltimore: Johns Hopkins University Press; 2002:46.
2. Rawls J. *A Theory of Justice*. Cambridge, Mass.: Belknap Press of Harvard University Press; 1971:20-21.

Russell Burck, PhD is director, Program in Ethics and Ethics Consultation Service at Rush-Presbyterian-St. Luke's Medical Center.

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