

Ethics and Family Medicine

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The *Oxford English Dictionary* defines ethics as “moral principles that govern a person’s behavior.” It is a branch of philosophy that has been studied since at least the time of ancient Greece. So it is no small task to define a unique approach to medical ethics for family medicine, but this is exactly what Tunzi and Ventres have tried to do in this issue of *Family Medicine*.¹ Traditionally, moral philosophers have conceptualized ethics using three broad approaches: virtue ethics, consequentialism, and deontology.² Virtue ethics, first described by Aristotle, defines the morally correct course of action as that which would be chosen by a virtuous person in similar circumstances. To a virtue ethicist, we should live our lives in such a way as to incorporate virtue into our characters. Aristotle went on to define four cardinal virtues: temperance, prudence, courage, and justice. The second approach, consequentialism, argues that moral choices should be evaluated on the basis of their outcomes, which might include benefit to others, benefit to self, or benefit to society. The third approach, deontology, is based on fulfilling moral duties, with the best example being the work of Immanuel Kant. Modern medical ethicists have largely adapted Aristotle’s approach and have defined beneficence, nonmalevolence, autonomy, and justice as the four cardinal virtues of medical decision-making. This forms the foundation of how medical ethics is usually taught to health care professionals. Karches and Sulmasy took this one step further in a 2016 paper in this journal arguing that virtue-based education should form the foundation of training in medical professionalism.³

Tunzi and Ventres take a substantially different approach. They argue that the comprehensive and relationship-based nature of family medicine requires a different theoretical framework, and assert that moral choices are inherently present in the day-to-day work of family physicians as we seek to explain the complexities of modern medicine to our patients and their families. They envision an ethical approach that flows from our duties as patient and community advocates, an approach that is fundamentally deontological. Within the context of trusting relationships, family physicians assume a moral duty to balance the interests of our patients with societal interests such as the just allocation of resources to achieve population health goals. All too often, we find these interests to be in conflict. At our best, we help patients and communities to understand these tensions. At our worst, we move chaotically from one situation to the next without seriously considering the moral dimensions of our choices.

Most family physicians seek to do the right thing in our daily work, but modern medicine renders this task harder and harder as competing interests vie for our attention. So Tunzi and Ventres argue that an ethical model based on balancing these competing duties is a better model for ethics education in primary care. Of course these models do not need to be mutually exclusive; understanding the moral foundation of our duties as physicians does not mean that virtue-based decision making is not important. They simply argue that virtue ethics is insufficient to address the full scope of ethical problems in the primary care setting.

A central point of this paper is that being someone's family physician necessarily includes certain moral duties. For example, a family physician has a duty to be honest in explaining things to patients. We have a moral duty to advocate for the best interests of our patients and to protect them from harm and misinformation. As health care has become increasingly more complicated, these duties become more challenging. Historically, family physicians do not define the boundaries of our practices in such a way as to limit which patients we will care for on the basis of age, gender, or medical problem. We have a duty to be available to patients and to ensure they can get care even when we are not personally available. Our care flows from trusting relationships, so we have a duty to not violate the trust of our patients. We also have a duty to help patients to get the care they need even when we are not trained to provide that care ourselves. So it matters which specialists we refer our patients to and which hospitals they use when seriously ill. We also have a societal duty to use resources wisely and to promote their just distribution. This lies at the heart of our duty to the community itself. The list of duties inherent in being a family physician is considerable. Furthermore, we no longer agree with one another about these duties as clearly as we once did.

Tunzi and Ventres propose four steps (listed in figure 1 of their paper) for us to take in our efforts to make morally justifiable decisions in our daily work. These steps are admittedly simplistic and they may or not be helpful. That these authors have at least made the attempt is a remarkable contribution with direct implications for how we might incorporate professionalism into our curricula. Professionalism has been adopted as one of the six core competencies of medical education, but we usually evaluate this competency by noting its absence.^{4,5} We recognize when students violate confidentiality or when they are disrespectful to colleagues, but we have no generally accepted standard by which to judge professional excellence. This is a tragedy because it can easily give students the idea that a professional is simply someone who refrains from unprofessional behavior. A careful read of the paper by Tunzi and Ventres suggests a different approach. The first step would be to agree on a set of moral duties inherent to the role of a family physician, duties that might flow directly from core concepts such as accessibility, continuity, comprehensiveness, coordination

of care, and care in the family and community context. Professionalism in family medicine is then practicing with fidelity to these duties. In essence, we make promises to people when we agree to be their family physicians and we should hold ourselves and our colleagues accountable for fulfilling these promises. Can we agree on a common list of moral duties? What would it look like if all of us lived up to them every day?

In many ways, this has been at the heart of the Family Medicine for America's Health (FMAHealth) strategic planning process. We started with a core definition of family medicine⁶ and then proceeded to explore how our fundamental duties might be evolving in the rapidly changing environments in which we work.⁷ As FMAHealth nears the end of its 5-year mission, the trends of narrowing scope of practice and physician employment continue unabated. Do we still agree on this core definition? Do we still have a shared moral purpose?

Tunzi and Ventres have suggested a good place for us to start if we want to answer these questions in our own communities. Their paper might be added to the papers published in this journal at the start of the FMAHealth project as a foundation for discussion with faculty, residents, and students in all of our departments and residencies.⁷ We can all agree that it should mean something when we take responsibility for being someone's family physician, and that core principles should guide the process by which we try to help patients to make the "right" choices for their health care. We just have some work to do in the process of defining exactly what "right" means in today's world.

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