

Pragmatic message to junior doctors

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ABSTRACT

Although several studies described the experience of doctors in their first postgraduate years, few shed the light on the ethical issues encountered by them. These doctors face a broad range of 'everyday' ethical challenges, from breach of confidentiality to truth-telling or improper informed consent. The daily ethical issues faced by junior doctors are not as dramatic as the major issues learned at medical school. Junior doctors have to make the best ethical decisions within the time limits available. Undergraduate medical ethics curricula should give priority to the real-life issues that doctors will face in their first years of practice.

INTRODUCTION

Junior doctors working in hospitals are characterised by playing multiple roles. They are medical practitioners, learners and employees at the same time. The multiple roles they play predisposes them to a unique set of ethical issues which is clearly specific to this group and partially overlapping with the one faced by medical students and the other faced by senior doctors. Junior doctors have several clinical responsibilities: admitting patients, prescribing medications and updating medical records. Despite the fact that they are responsible clinicians, they remain students, continuously acquiring skills and knowledge.¹ Their junior position in the medical ranking and limited experience may create striking conflicts between their various roles.

Unfortunately, the available medical ethics resources usually address the profession as a whole, without making any distinctions between junior doctors and their senior colleagues. Contrary to medical students or the senior doctors, the junior doctor in his or her early postgraduate years is concurrent, a responsible clinician, a learner and a human resource.¹

Doctors' responsibility often changes with achieving clinical experience, and senior doctors meet the patients assigned according to their specialty. Junior doctors, on the other hand, exert their job on the wards and emergency rooms, where they encounter a wide range of cases and problems. Consequently, doctors' professional approaches will be influenced by the state of clinical experience as well as the position and allocated responsibilities.²

Ethics and law, which may seem to be dry and irrelevant subject to medical students, may suddenly transform into a practical regimen that has a direct clinical influence on their professional lives.³

DOCTOR–PATIENT RELATIONSHIP

A common ethical challenge to junior doctors is the state of transience created by the constant rotations. Junior doctors' frequent movement through

different divisions may lead to a rather weak doctor–patient relationship, and may contribute to the erosion of junior doctors' empathy. Dr Francis W Peabody who left incredible number for medical students, residents and physicians to follow, said in his last speech to the medical students of Harvard University on 21 October 1926:

“The most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine. While the treatment of a disease may be entirely impersonal; the care of a patient should be completely personal. The importance of the intimate personal relationship between physician and patient cannot be overemphasized, since in a large number of cases both the diagnosis and treatment are intimately dependent on it. The failure of the young physician to establish this relationship accounts for much of his ineffectiveness in the care of patients”.⁴

The history-taking period should be used for obtaining clinical information and is an opportunity to know the patient as a human being. That is also the time when patients begin to know their doctor as a person. During such time, the patient decides if his doctor is like a robot with no feeling or a caring human being. Patients should realise that the doctor cares about them as persons.⁵ J Willis Hurst, who was an icon in cardiovascular medicine and a role model for countless physicians worldwide, wrote at the age of 90: ‘Hospitalized patients need special care. Go to see the patient you admit as soon as possible; day or night. Go and see the patient who is critically ill or deteriorating; night and day. No drug or any substitute doctor will be as effective as your presence’.⁵

Performing a quick ward round in the morning, and making quick decisions about the patient with little information given to him, poses a dilemma for a junior doctor who is used to a more thoughtful style of doctor–patient relationship.⁶

ETHICAL ISSUES FACING JUNIOR DOCTORS

Junior doctors' ethical issues are usually seen in their communication with patients and about limited healthcare resources attempting to use in the most cost-effective way.³

Ethical issues arise far more frequently than most junior doctors would have anticipated when they were medical students. During an average day of a junior doctor, there may be no ethical dilemmas at all about genetic testing, cloning or end-of-life care. However, the junior doctors are exposed to breach of confidentiality, seeing patients misinformed about the purpose of the procedure or taking a photograph of their physical signs without a properly informed consent.⁶

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TELLING THE TRUTH

Like all doctors, junior doctors experience truth-telling dilemmas. Should they tell patients about their lack of experience for example? And should not they tell their consultants the truth when they forget to do what the consultant requested? Green *et al* found that 14% participants of a study (doctors in their first three postgraduate years) indicated that they were likely to fabricate a laboratory result to a consultant to avoid being humiliated.⁷ Never fabricate a result to your consultant since once he finds out he will never trust a word you say. Junior doctors may, occasionally, slightly exaggerate the patients' symptoms to the radiologist, for example, so that he cannot refuse to carry out the investigation.⁶

CONFIDENTIALITY

Junior doctors may breach patient confidentiality, often unintentionally, by disclosing clinical information without the patient's permission or by looking at the medical records of hospitalised friends.⁸ Many hospital wards cater for several beds in each room, and hence the only privacy available is a curtain pulled around the bed! This kind of set-up poses a great problem with maintaining confidentiality. During ward round, every patient in the room may hear the symptoms, the history of alcohol intake, or sexual history and the rest of conversation between the doctor and the interviewed patient. Many patients are within earshot of doctor's conversation in front of nursing station too. This is a common place where confidentiality is often breached.⁶

In places where many patients do not speak English, the morning rounds are usually done in English with medical jargon, so that most patients may not be able to discern what is going on. However, doctors should take every possible precaution to maintain confidentiality of their patients.

Sharing information within a professional team may not be considered a breach confidentiality if it is meant to ensure that all members are informed of the current decisions. Whenever you talk in the ward, remember that there are ears next to you, and you may be liable to breach patient confidentiality.

INFORMED CONSENT

Junior doctors may intentionally influence patients to accept or reject procedures. Verbal consent is usually sufficient to take blood for multiple tests without explaining each in detail to a patient.⁹ A nurse in operating room may phone the ward rushing the junior doctor to obtain informed consent without giving him adequate time to explain to the patient the benefits and possible complications of the surgery. Unless you are in an emergency state, do not rush with obtaining the informed consent and ensure that the patient is fully aware of the risks and possible complications associated with the procedure.

PHOTOGRAPHY

Digital photography has made the process of obtaining and using medical images very simplified, and the evolution of smartphone has become an essential component in the teaching of healthcare professionals. The inappropriate use of digital images within the healthcare environment has the potential to endanger patient confidentiality and increase the likelihood of litigation. Although guidelines are made available by the General Medical Council¹⁰ in the UK and the Health Insurance Portability and Accountability Act in the USA,¹¹ many healthcare professionals were either unaware of them or hate to follow them. The consent should be informed, written and

obtained from the patient or his/her legal representative before the procedure. It should include full detail of how images are to be taken, stored and deidentified and how they will be used and which audiences are likely to view them.¹²

FUTILE TREATMENT

Junior doctors usually spend more time with their patients than their senior colleagues. Hence, they may have further insights and information that make them able to contribute to decision-making about patients' care. Because of their limited clinical experience, junior doctors may have an unjustifiable level of conviction about a patient's imminent death. They have not seen yet the patients recovering from a situation where death seemed to be inevitable.¹³

Junior doctors must participate in the discussion with their seniors if they have a different opinion and feel that the treatment of a patient is futile. If a junior doctor still considers a proposed treatment futile, then further morally appropriate action should be taken such as refusal to participate in the futile treatment. However, a junior doctor refusing to be involved in a procedure is likely to burden other staff.¹³

THE CONSULTANT IS A ROLE MODEL

Doctors are keen on being a model for their junior colleagues and students in clinical practice. Consequently, the doctor's professional approach and behaviour is expected to have educational consequences.³

Having a frequent dialogue and exchange with a supervising consultant is extremely important.

In one survey, 59% of cases described the exchange as positive, with the young doctor describing being praised or thanked, taught, or given career advice or support. These house officers admired and respected their consultants.¹⁴

On the other hand, a consultant may act as poor role model. After an unexpected death, a surgical consultant tried to take advantage of a resident's inexperience by asking him to write retrospectively in the notes. In another incident, a resident phoned up the consultant at home who told him to administer a fatal dose of diamorphine to the terminal patient. The doctor felt this was inappropriate as the patient needed to speak to his relatives.¹⁴ The junior doctor may have religious objections to euthanasia, which is not allowed by most countries. He should not comply with his consultant's orders, and should raise the issue to hospital authorities. If a junior doctor asked to do an unethical task by his consultant, he should stand for his principles and can firmly say: no.

Many junior and even senior doctors, who witness ethical violations keep quiet about them, even if they realise that the 'right' answer would be to address the problem face to face. Should they do or say anything about these violations? The medical societies have given helpful advice to junior doctors about whistleblowing that in itself offers a degree of protection from reprisal.³ Additional knowledge and skills for dealing with the pressures of hospital work that may act against their ethical convictions are necessary.¹⁵

CONCLUSION

Unlike the medical student or the more senior physician, the doctor in his or her early postgraduate years is concurrently a responsible clinician, a subjugate learner and a human resource. The current undergraduate teaching of moral principles and thinking skills may be insufficient for junior doctors.

Although the teaching of ethics and law varies widely within medical education, in some instances, little curriculum time is

given to a certain ethical subject. The inadequate undergraduate teaching may partly explain the apparent disjunction between theory and practice.³ Specific ethical training of daily life clinical scenarios at the undergraduate level and during the first years of clinical practice is mandatory.

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