

Diagnostic frequency and principal problems of clinical ethics in general medical practice

Dr. med. Giovanni Fantacci, FMH für Allgemeinmedizin
8155 Niederhasli

Abstract

There are 15,000 specialists practising in Switzerland, including 3,000 each of general practitioners and internists (the number of internists includes sub-specialisms: rheumatology 300, cardiology 300, gastroenterology 200 doctors). Combined with the 670 paediatricians, this comes to some 6,000 basic providers.

The GP plays an important key function in the health system. Most patients are satisfied with their doctor. In this function, there are opportunities for control, e.g. whether certain expensive investigations should be performed, or whether operations are useful and necessary. Their clinical strategies differ fundamentally from those of the specialists: The GP much more often has to rule out what is not present (i.e. be certain that there is no preventable potentially dangerous outcome), than he can make a precise medical diagnosis.

During the past 5 years in my practice, diagnoses and treatments from consultations have been recorded twice annually for one week in the frame of a study. Each year 7,500 consultations are held, with 2,200 different patients. The average age of the patient group is low, at 33 years, since I see many paediatric cases and conduct immunisations.

The current treatment guidelines recommend ever-more complex treatment schedules, e.g. for diabetes mellitus patients. They are now supposed to receive, in addition to antidiabetic drugs, Aspirin Cardio and a cholesterol reducer, since from the point of view of risk, they are treated the same as myocardial infarction patients. This measure alone triggers a huge rise in costs. What is the GP supposed to do? The division proposed by Jonsen/Siegler/Winslade into medical indication/ patient preferences/ quality of life and contextual aspects to examine each individual case works well for everyday practice, including for terminal patients, in whom ethical challenges are especially great. This involves following a path between the wishes of the patient to find therapeutic options and at the same time to tolerate their powerlessness in the face of a terminal illness. For example, an ophthalmologist recently recommended a terminally-ill patient for a cataract operation. I advised the patient against it, since he would not get any benefit from this operation. He died four weeks later from the underlying disease. In a case like this, the GP also bears a responsibility towards society, by avoiding unnecessary costs.

We are often confronted by patients with an unhealthy lifestyle (smoking, overweight, drugs) or who, for various reasons, fail to follow therapeutic advice (e.g. not keeping to the diabetes diet or insufficient compliance in taking medicines). It takes a lot of patience to deal with such patients and one is constantly confronted by ethical borderline situations (e.g. a patient with cirrhosis of the liver continues to consume alcohol, even though he has just been in hospital for an oesophageal variceal bleeding).

Resumen

Existen 15,000 especialistas que practican la medicina en Suiza, incluyendo 3,000 médicos generales y 3,000 internistas (dentro de los que se incluyen: 300 reumatólogos, 300 cardiólogos y 200 gastroenterólogos). Combinados con los 670 pediatras, esto nos lleva a alrededor de 6,000 proveedores básicos del cuidado de la salud.

Los médicos generales juegan un rol muy importante en el sistema de salud. La mayoría de los pacientes están satisfechos con su médico. Mediante esta función, existen muchas oportunidades para controlar (por Ej., si ciertas investigaciones costosas se deberían de llevar a cabo, o si una cirugía es o no útil y necesaria). Sus estrategias clínicas difieren fundamentalmente de aquellas llevadas a cabo por los especialistas. Los médicos generales, por lo general, más que llegar a diagnósticos precisos, buscan descartar problemas que no están presentes (por Ej. asegurarse de que no se llegue a presentar un resultado peligroso que pudo ser prevenido).

Durante los últimos 5 años de mi práctica, se han compilado los diagnósticos y tratamientos efectuados en la consulta por una semana dos veces al año, con la finalidad de ser estudiados. Cada año, se proporcionan 7,500 consultas a 2,200 pacientes distintos. La edad promedio del grupo de pacientes es baja, es de 33 años, ya que muchos de mis pacientes son casos pediátricos y acuden a recibir inmunizaciones.

Las guías de tratamientos actuales recomiendan esquemas de tratamiento más complejos (por Ej. los pacientes con diabetes mellitus). Se supone que ellos deben de recibir, además de los medicamentos antidiabéticos, aspirina y un reductor del colesterol, ya que, desde el punto de vista de riesgos, ellos son tratados como pacientes con infarto al miocardio. Esta medida, por sí misma, eleva mucho los costos en la atención médica.

¿Qué es lo que se supone que debe de hacer un médico general?

La división, propuesta por Jonson/ Siegler/ Winslade en cuanto a indicaciones médicas/ preferencias del paciente/ calidad de vida y aspectos contextuales para examinar a cada caso de manera individual en el trabajo de cada día, incluyendo a los pacientes terminales, en quienes los retos éticos son mayores.

Lo anterior implica seguir un camino que se ubica entre los deseos del paciente para encontrar las opciones terapéuticas y, al mismo tiempo, la tolerancia de su impotencia para enfrentar una enfermedad terminal. Por ejemplo, recientemente, un oftalmólogo recomendó una cirugía de extracción de catarata para un paciente con enfermedad terminal. Le aconsejé al paciente que no aceptara, ya que él no obtendría ningún beneficio de esta cirugía. Él murió cuatro semanas más tarde a causa de su enfermedad terminal. En un caso como éste, el médico general actúa como responsable ante la sociedad, evitando costos no necesarios.

Somos confrontados frecuentemente por pacientes que llevan un estilo de vida no saludable (fumadores, obesos, adictos a drogas) o, quienes por varias razones, no siguen las indicaciones terapéuticas (por Ej. diabéticos que no siguen la dieta indicada o no toman sus medicinas). Es necesaria una gran paciencia para tratar con este tipo de pacientes y uno es constantemente confrontado por situaciones éticas límite (por Ej. un paciente con cirrosis hepática que continúa ingiriendo alcohol a pesar de que ha estado internado en el hospital para ser atendido de sangrado por várices esofágicas).

Palabras clave: medicina general, calidad de vida, relación médico-paciente.

Keywords: general practice, quality of life, patient-doctor relationship.

Introduction

There are 15,000 specialists practising in Switzerland, of which there are 3,000 each of general practitioners and internists (the number of internists includes sub-specialisms: rheumatology 300, cardiology 300, gastroenterology 200 doctors). Combined with the 670 paediatricians, this comes to some 6,000 basic providers.

The GP plays an important key function in the health system. Most patients are satisfied with their doctor. In this function, there are opportunities for control, e.g. whether expensive investigations should be performed, or whether operations are useful and necessary. Their clinical strategies differ fundamentally from those of the specialists: The GP much more often has to rule out what is not present (i.e. be certain that there is no preventable potentially-dangerous outcome), than he can make a precise medical diagnosis.

General practice is a mirror image of the social reality in terms of the incidence of illness and health problems. The GP comes into contact with every possible problem and has a co-ordinating task in the overall care of polymorbid patients. He can also work cost-effectively, in that he is familiar with the previous history of the patient. A relationship of trust has built up over a number of years, in which, too, essential questions about life and death are discussed. The GP's position is now under threat. Many young colleagues are training as specialists and there is no new blood coming into general practice.

The essential characteristics of general medicine will be highlighted next, after which some special ethical challenges will be examined.

In 2002, the European Society of General Practice, WONCA, issued some fundamental ideas on the characteristics of general practice, which will be reproduced here.

The European definition of general practice / family medicine

The characteristics of general practice

- A) General practice is normally the point of first medical contact within the health care system and guarantees open and unlimited access for all users and for all health problems, regardless of the age, sex or any other characteristic of the person concerned.
- B) It makes efficient use of the resources of the health care system by co-ordinating care, co-operating with other professionals in the primary care setting, and by managing the interface with other specialities, where, if necessary, it takes on the role of advocate for the patient.
- C) It adopts a person-centred approach, which is oriented to the individual as well as his or her family and community.
- D) It uses a special consultation process, which allows a long-term treatment relationship to be built up through effective communication between doctor and patient.
- E) It is responsible for the provision of long-term continuity of care as determined by the needs of the patient.
- F) It has a specific decision-making process, which is determined by the prevalence and incidence of illness in the population.
- G) It simultaneously concerns itself with the acute and the chronic health problems of individual patients.

- H) It is concerned with illnesses which present in an undifferentiated way at an early stage of their development and may require urgent intervention.
- I) It promotes health and well-being by appropriate and effective intervention.
- J) It bears a specific responsibility for the health of the community in general.
- K) It deals with health problems in their physical, psychological, social, cultural and existential dimensions.

The person-centred approach in general practice and consideration of the needs of the patient are the central concern of the GP. There are hundreds of guidelines and directives, but ultimately it is the doctor who must determine the right treatment for the individual patient. No robot or virtual physician can take over this task. There is a relationship between the patient and the doctor within which worries and considerations about the planned treatment can be expressed. There are a wide variety of computer platforms now available to patients. However, laymen often cannot correctly assess the individual items of information. This requires someone with specialist knowledge, who can look at and correctly assess the existing information. Not every piece of information is of equal importance.

Ethics as the basis for medical conduct

The basis for proper conduct is an ethical foundation for the doctor: How does he himself evaluate illness, life and death? What does he see as life's challenges, how much experience of life does he himself have? This is not just a question of specialist knowledge. A frequent observation is that the patient group becomes older as the doctor ages. Evaluations can also alter during one's lifetime. The Hippocratic oath, which came into being in about 270 B.C., continues to be important to medical practice, far from any concept of benefit. So it reads:

“I will treat the sick according to my best ability and judgment, and I shall refrain from that which will be harmful and injurious.
I will give no-one a lethal poison, not even if they ask for it, and nor will I suggest such a plan.”

It is not the right of the doctor to assess life according to its value. He must intercede for each individual patient and treat him to the best of his knowledge and belief. In today's complex world, it is difficult to find one's way through the multitude of medical options. The division proposed by Jonsen/Siegler/Winslade into medical indication/ patient preferences/ quality of life and contextual aspects in order to examine each individual case works well for everyday practice, including for terminal patients, in whom ethical challenges are especially great. Problems can thus be examined afresh time and time again. The act of dealing with medical ethics enables the doctor to respond more skilfully. The cost pressure from insurers can lead the doctor into wrong decisions. At the same time, there is a need to allocate the available resources appropriately among his patients. Important terms in this connection are patient autonomy, quality of life and the dignity of the patient. The authors have formulated an overview of the basic questions which can arise in a clinical situation.

Medical indications	Patient preferences
<p>The Principles of Beneficence and Nonmaleficence</p> <ol style="list-style-type: none"> 1. What is the patient's medical problem? 2. History? Diagnosis? Prognosis? 3. Is the problem acute? Chronic? Critical? Emergent? Reversible? 4. What are the goals of treatment? 5. What are the probabilities of success? 6. What are the plans in case of therapeutic failure? 7. In sum, how can this patient be benefited by medical and nursing care, and how can harm be avoided? 	<p>The Principle of Respect for Autonomy</p> <ol style="list-style-type: none"> 1. Is the patient mentally capable and legally competent? Is there evidence of incapacity? 2. If competent, what is the patient stating about preferences for treatment? 3. Has the patient been informed of benefits and risks, understood this information, and given consent? 4. If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards for decision making? 5. Has the patient expressed prior preferences, e.g. Advance Directives? 6. Is the patient unwilling or unable to cooperate with medical treatment? If so, why? 7. In sum, is the patient's right to choose being respected to the extent possible in ethics and law?
<p>Quality of life</p>	<p>Contextual features</p>
<p>The Principles of Beneficence and Nonmaleficence and Respect for Autonomy</p> <ol style="list-style-type: none"> 1. What are the prospects, with or without treatment, for a return to normal life? 2. What physical, mental, and social deficits is the patient likely to experience if treatment succeeds? 3. Are there biases that might prejudice the provider's evaluation of the patient's quality of life? 4. Is the patient's present or future condition such that his or her continued life might be judged undesirable? 5. Is there any plan and rationale to forgo treatment? 6. Are there plans for comfort and palliative care? 	<p>The Principles of Loyalty and Fairness</p> <ol style="list-style-type: none"> 1. Are there family issues that might influence treatment decisions? 2. Are there provider (physicians and nurses) issues that might influence treatment decisions? 3. Are there financial and economic factors? 4. Are there religious or cultural factors? 5. Are there limits on confidentiality? 6. Are there problems of allocation of resources? 7. How does the law affect treatment decisions? 8. Is clinical research or teaching involved? 9. Is there any conflict of interest on the part of the providers or the institution?

My own practice

During the past 5 years in my practice, diagnoses and treatments from consultations have been recorded twice annually for one week in the frame of a study. Each year, 7,500 consultations are held, with 2200 different patients. The average age of the patient group is low, at 33 years, since I see many paediatric cases and conduct immunisations.

The following picture emerged on evaluation of the questionnaires; the comparison group consists of other GPs. The questionnaires were prepared by IMS Health (Swiss Diagnosis index).

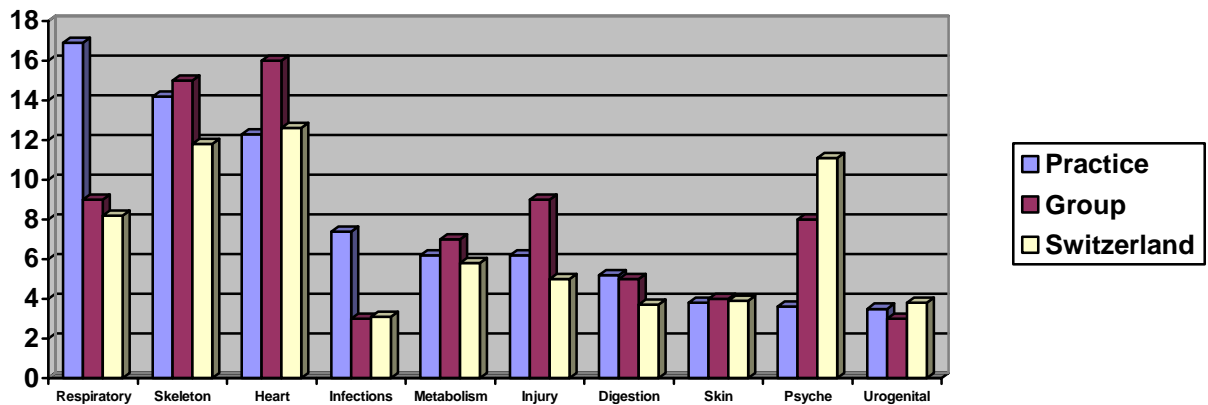
Own practice (1351 consultations, 1737 diagnoses = 100%)
Comparison group (7600 consultations, 10900 diagnoses = 100%)

Diagnoses	Own practice	Comparison group
Diseases of the respiratory system (294 cases)	16.9%	9%
Skeleton/locomotor apparatus (248)	14.2%	15%
Cardiovascular (215)	12.3%	16%
Infections (129)	7.4%	3%
Metabolism (109)	6.2%	7%
Injuries /accidents (108)	6.2%	9%
Digestive system (92)	5.2%	5%
Skin (67)	3.85%	4%
Psyche (63)	3.6%	8%
Urogenital system (61)	3.5%	3%

Diagnoses in the medical practice according to disease groups 2003
100% = 80.8 million diagnoses (IHA-IMS Health)

Cardiovascular 12.6%
Locomotor apparatus 11.8%
Mental illnesses 11.1%
Nervous system and sensory organs 9.7%
Respiratory system 8.2%
Metabolism 5.8%
Accidents and violence 5.0%
Skin diseases 3.9%
Urogenital organs 3.8%
Digestive system 3.7%
Infections 3.1%
Other 21.3%

In the following table the diagnoses from my own practice have been compared with those of the comparison group and then with the more broadly distributed Swiss diagnosis index of 2003.



If one compares the diagnosis distribution in my practice with that of the comparison group, then it corresponds fairly precisely to it. In a young patient group with children, infections are more common than in an older patient group. I thought it was interesting that general practice reflects the diagnosis distribution in the outpatient domain. Understandably, accidents are more common in general practice compared with specialists, and this also corresponds to the nature of a family doctor's practice as the first point of contact. This can vary from one country to another, as in some countries accident cases go straight to hospital and less often to the GP.

Effective deployment of resources

About 6% of diagnoses relate to the metabolism, and these are mainly diabetes mellitus patients. In the more recent guidelines, it is recommended that diabetes patients are classed as a high-risk group with respect to coronary heart disease and they should therefore as a matter of principle be treated with a cholesterol-reducing medicine. These cost roughly 1000 francs per year and per patient. As diabetes mellitus is the commonest metabolic disease, this measure alone causes an increase in health costs of several million francs. In order to deploy the available resources cost-effectively, it would make sense to look for other markers (e.g. C-reactive protein, CRP) or other risk factors, in order that only those patients who would clearly benefit from it have to be treated.

Every GP is familiar with the vexatious problem of continued nicotine consumption by people with coronary heart disease, arteriosclerosis or emphysema. Or the problem of continued alcohol consumption in those with cirrhosis of the liver or oesophageal varices. In many areas, we see self-destructive behaviour. This is where society as well as the GP must alert people to the personal responsibility of the patient. When self-destructive behaviour puts others at risk, e.g. drink-driving, it is the State which has a duty to intervene in the public interest and take the appropriate steps. There is certainly a case to be answered as to whether patients with self-destructive behaviour ought to pay higher premiums for medical cover. Which criteria play a role in this, e.g. smoking, alcohol, overweight, drugs, is a political decision. For all these types of behaviour, however, there are economic grounds for a greater contribution to costs.

Special ethical challenges in general practice

Dementia patients are a special ethical challenge, since they are often no longer able to make their own decisions. This is when the doctor takes on a responsible role as their

representative. He may also be compelled by relatives to make certain decisions. In such cases he must act in the best interests of the patient and his well-being. The same position exists in the case of children when parents act contrary to the best interests of the child's welfare. In this case, the doctor also has legal options, in the sense of child protection, to carry out a treatment against the wishes of the parents. This concerns mainly oncological cases or cases involving child abuse.

Problematic escalation of the conflicts between insurers and doctors

The relationship of trust between doctor and patient is being increasingly undermined by insurers and media, in that doctors are being indiscriminately reviled for driving up costs. This happens when isolated top earners are portrayed as representative of thousands of doctors. Undermining this relationship of trust generates even more costs, since increasing mistrust of doctors on the whole leads to unjustified changing of GPs. A meaningful collaboration between insurers and doctors can only take place on the basis of trust and not with mistrust and a general suspicion that doctors are acting maliciously.

Conclusions

General practice is a mirror image of the incidence of illness in society. The GP plays a central role in the health system, since he can treat illnesses cost-effectively. When it comes to ethical challenges, the model proposed by Jonsen/Siegler/Winslade offers a good basis for making difficult decisions.

Literature:

Albert R. Jonsen/Mark Siegler/William J. Winslade: Clinical ethics. Fifth edition. McGraw-Hill 2002.

Giovanni Fantacci: Euthanasie-Entwicklungen in der Schweiz [Euthanasia – Developments in Switzerland]. *Imago Hominis* 2004; 11:86-91.

Diagnostic statistics: In co-operation with IMS Health (Swiss Diagnosis Index) and santésuisse. Medical statistics from the Swiss Medical Association FMH.

Marc-André Raetzo and Alexander Restellini (ed.): Alltagsbeschwerden. Diagnostische und therapeutische Strategien in der allgemeinmedizinischen Praxis [Everyday complaints. Diagnostic and therapeutic strategies in general medical practice] Published by Huber Bern, 1998.

Ian R. McWhinney: Being a general practitioner: what it means. *Eur J Gen Pract* 2000; 6: 135-9.

Karl Deichgräber: Der hippokratische Eid. [The Hippocratic Oath] Hippokrates Verlag Stuttgart, 1983.

Die Europäische Definition der Allgemeinmedizin/Hausarztmedizin. [The European definition of general practice / family medicine]. Schweizerische Gesellschaft für Allgemeinmedizin 2002.