Ethical consultation

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A harmonious relationship between family physicians and specialist consultants is essential for high quality medical care."[1] This was the conclusion of a 1991 task force established to advise the Royal College of Physicians and Surgeons of Canada and the College of Family Physicians of Canada (CFPC) on matters affecting the relationship between family physicians and consultants. After 2 years of extensive national inquiry, the task force reminded both parties of their commitment to basic ethical principles of patient care and professionalism, as well as to providing a positive model of the process for medical students and residents.

Similarly, in 2002, members of the Medical Professionalism Project representing 1 European and 2 American national internal medicine boards published an article outlining 10 commitments—one of which is the commitment to professional responsibilities.[2] Specifically, they state that "physicians are expected to work collaboratively to maximize patient care, be respectful of one another, and participate in the processes of self-regulation, including remediation and discipline of members who have failed to meet professional standards."[2]

While the need for ethical and collaborative relationships has been acknowledged, achieving such relationships remains challenging. The following case, which occurred in a Canadian university teaching hospital, illustrates the potential effects of poor relationships between family physicians and consultants on patient care and on modeling of ethical professional behaviour for residents. While this particular case occurred in a hospital, similar communication difficulties exist when community FPs seek consultations with specialists.

Case description

An elderly woman was admitted to the family medicine ward with heart failure. She had a pacemaker that had been implanted 6 months previously for sick sinus syndrome. Clearly the pacemaker was malfunctioning and responsible for her heart failure. The family medicine staff physician asked the resident working with him to request a cardiology consultation.

The family practice resident paged the resident on call for ward consultations in cardiology and explained the case. The cardiology resident said he would speak to his staff physician about the priority of the consultation because they were swamped with requests. He phoned back an hour later and reported that the staff physician had said that this was an inappropriate request. The physician advised increasing the patient's furosemide, discharging her, and getting her an appointment at the pacemaker clinic.

The family practice staff physician phoned the cardiologist to protest and to defend the relevance and urgency of the consultation. The cardiologist disputed the urgency of the case. While he did not deny that the patient was sick, he said that, in the face of scarce resources, "we have to prioritize."

The family medicine staff physician called the hospital director of professional services to protest the cardiologist's response. Before the director returned the call, the patient suffered pulmonary edema and was admitted to the intensive care unit.

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Discussion

Both the FP and the consultant faced difficult challenges in this case. Consultants cannot respond to an overwhelming number of urgent requests simultaneously. They also must deal with some inappropriate requests. The difficulty is exacerbated by insufficient resources, including inadequate numbers of specialists.

The FP contested the cardiologist's clinical judgment in advising that the patient be discharged to await an outpatient appointment at the pacemaker clinic. The FP then sent a letter to the hospital director of professional services, in which he asked that the cardiologist's professional conduct be addressed. The 2004 update of the *CMA Code of Ethics* stresses a physician's responsibility to report a colleague whose ethical or clinical performance is substandard: "Recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege."[3] The FP conceded that the health care system is overburdened and that the cardiologist could not respond to all cases simultaneously; nevertheless the FP felt he could have expected some estimate of when this patient would be seen, even if it was not until the next day.

Individual solutions. In this case, the FP's letter led to creation of a task force on the consultation process in the hospital, and a questionnaire was distributed to the approximately 500 specialists and 100 FPs associated

with the hospital. Three quarters of these FPs had their offices outside the hospital, and either did not participate in hospital care or did so sporadically. The return rate was approximately 30% for both groups. The consensus was that professionalism—the manner in which colleagues treat one another in the face of pressure—and the consulting process were deteriorating because of work overload.

Approximately 70% of both groups thought that protocols outlining what primary care physicians should do before asking for consultations would be useful. Similarly, approximately 80% of both groups favoured creating a system of designated appointment slots with certain specialties for primary care physicians—a system that would recognize referring physicians' clinical judgments about the validity and severity of cases. The task force, therefore, resulted in some attempts to improve the system. While this solution was specific to the hospital in question, it does illustrate that a cooperative approach can address the problem of poor relationships between family physicians and consultants.

Larger-scale solutions. Questions arise about other larger-scale issues: physicians' ethical duty to improve a failing health care system and their obligation to be professional and to behave appropriately toward one another as they work at capacity in overloaded systems. The *CMA Code of Ethics* addresses these issues: article 43 states that we must "Recognize the responsibility of physicians to promote equitable access to health care resources."[3] Article 52 advises that we must "Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services."[3]

In the summary of the charter on professionalism created by the Medical Professionalism Project, the authors state that "to maintain the fidelity of medicine's social contract during this turbulent time, we believe that physicians must reaffirm their active dedication to the principles of professionalism, which entails not only their personal commitment to the welfare of their patients but also collective efforts to improve the health care system for the welfare of society."[2]

To this end, the CFPC Ethics Committee has developed *Family Practice Concepts and Values: Benchmarks for Health Care Reform*. This document provides guidelines to help FPs "sustain and indeed improve our health care system."[4] The guidelines focus on explicit concepts and values as a basis for health system reform, and on evaluating reform.

Education and standards. The authors of the charter on professionalism also believe that the medical profession should "define and organize the educational and standard-setting process for current and future members."[2] The "future members" in the case presented above are the family practice resident and the cardiology resident. Their staff physicians are role models for professional behaviour in the consultation process. For these future physicians, as well as for patients, we have an ethical duty to collaborate in designing and demanding a health care system that brings out the best in us.

The *CMA Code of Ethics* maintains that, to preserve a sound moral ground in the practice of medicine, "training in ethical analysis and decision-making during undergraduate, postgraduate and continuing medical education is recommended for physicians to develop their knowledge, skills and attitudes needed to deal with ethical conflicts."[3] The *Family Medicine Bioethics Curriculum* from the CFPC Ethics Committee provides guidance in ethics education in family medicine training programs, analytical methodology for ethical problem-solving, and clinical case presentations that explore ethical challenges—including FP-consultant relations.[5]

Conclusion

The state of the consultation process in the case presented reflects conflicting ethical issues of patient welfare, social justice, and commitment to improving the quality of care. These issues will continue to challenge FPs and affect their patients and their relationships with their specialist colleagues. Applying principles of ethics and working collaboratively to find solutions can help us make our way through rocky ethical terrain.

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