

## Chapter 8

# Fidelity: Promise-Keeping, Loyalty to Patients, and Impaired Professionals

### Learning Objectives

1. Define the principle of fidelity.
2. Describe the explicit and implicit limits of promises.
3. Examine the moral limits of commitments once they are made.
4. Discern priorities of promises to patients and others.

### Other Cases Involving Fidelity

- Case 3-1: Physician Participation in Capital Punishment
- Case 3-2: When Should Clergy Intervene for the Patient?
- Case 4-2: The Benefits and Harms of High-Risk Chemotherapy
- Case 4-5: Intentional Exposure of Unknowing Sexual Partners to HIV
- Case 4-6: For the Welfare of the Profession: Should Nurses Strike?
- Case 4-7: A Physician Choosing between His Patient and His Own Family
- Case 5-1: Under the Gun: Staying on Schedule in the HMO
- Case 5-2: Unfunded Dialysis at the Expense of Other Patients
- Case 9-2: Karen Quinlan: The Case of Withdrawing a Ventilator

- Case 9-3: Separating Conjoined Twins: An Unintended but Foreseen Killing?
  - Case 9-5: Terri Schiavo: Choosing to Forgo Nutrition
  - Case 9-7: Pharmacist Participation in Lethal Injection Protocol Development
  - Case 11-4: Surrogate Motherhood: The Case of Baby M
  - Case 12-8: The Interrogation of Guantanamo Prisoner Mohammed al-Qahtani
  - Case 16-5: Surveying Illegal Immigrants
  - Case 16-6: Homicide in Research: A Duty to Breach Confidentiality?
  - Case 16-8: Paying Clinicians to Recruit Research Subjects
- Also see the cases in Chapter 13 dealing with confidentiality.

The cases in the previous chapter included a number of situations in which health professionals did not propose to overtly lie to patients but nevertheless contemplated withholding the truth. We noted that the principle of veracity treated the intentional telling of false information as a moral infringement but that it was less clear how to treat withholding of information. No one has a duty to tell all the truth to anyone who happens along. At the same time, certain people have a duty not only to avoid lying but also to tell certain things to others. In general, physicians who are in an ongoing relation with a patient or patients have a duty to disclose what the patient would reasonably want to know or find meaningful in making a decision related to care.

We might attribute such a duty to the principle of veracity (truthfulness, honesty, correctness, and accuracy), but it can also be associated with what we will call the *principle of fidelity*. When people exist in special relations with others, they take on special duties. Parents have duties to their children and spouses to each other that they do not have with other people. Likewise, when a health care professional enters a relation with a patient, certain special obligations are created. This relation is more than a legal contract: it is not just a matter of a business relation. A moral contract is established generating mutual obligations. This contract is sometimes referred to as a “covenant.”<sup>1</sup> As part of the contract or “covenant” that establishes the relation, commitments are made that generate new and special mutual obligations and rights.<sup>2</sup> The duty to disclose potentially meaningful information is one such duty, but there are many others.

In general, when one party promises something to another, such a special relation is established. That promise can take the form of a routine promise to return something that has been borrowed, or it can take the form of establishing a relation between provider and patient. Usually, promise-making is reciprocal. Each party offers something and agrees to be bound by mutual agreement. In health care, promises are made in scheduling appointments, agreeing to fee schedules, and in keeping records. More fundamentally, promises are made when a patient–provider relation is established that includes a provider’s pledge of loyalty to the patient—to abide by a code of ethics and to stay with the patient in time of need. Among the promises made is the promise to keep information confidential, a subject that will be the focus of Chapter 13.

All promises are made with implicit or explicit limits. The commitment to establish a provider–patient relation normally carries with it an implied limit that either party can break the relation under certain conditions: adequate notice, justifiable

reason, and—in the case of the health care professional—arrangement for a colleague to assume responsibility.

The contract, covenant, commitment, or promise that establishes the relation between provider and patient rests, in part, on the ethics of keeping promises. The principle underlying the idea that one has a duty—other things being equal—to keep a commitment once it is made is sometimes called the principle of fidelity. The cases in this chapter look at situations in which health care professionals are faced with problems of what the moral limits are on keeping commitments once they are made. In particular, we will face cases in which the physician or other health professional has made some sort of commitment and later discovers that, in the physician's estimate, the patient or someone else would be better off if the commitment were not kept. The general problem is, thus, one of conflict between the principle of beneficence (doing as much good as possible) and the principle of fidelity (keeping one's word).

The first cases involve general notions of fidelity to explicit and implicit promises. The second section of the chapter deals with the obligation of loyalty to patients in the face of financial and other conflicts of interest. Finally, we look at fidelity in terms of professional obligations and loyalty when dealing with incompetent, impaired, or dishonest colleagues.

### The Ethics of Promises: Explicit and Implicit

We all learn very young that it is immoral to break a promise. Unfortunately, soon thereafter we also learn that there are cases when one can give strong reasons why promises should not always be kept. There are promises that are in one's self-interest to break. Normally, however, we do not confuse self-interest with ethics. The interesting case is the one in which a promise has been made but one comes to believe that it will serve the welfare of others to break it. These other-regarding reasons for breaking promises may pose legitimate moral dilemmas.

Sometimes, as in the first case in this section, the promise is explicit and yet the one to whom the promise is made will be hurt only modestly if the promise is not kept, and someone else will benefit enormously if it is violated. The question raised here is whether that counts as an acceptable reason to break the promise. Sometimes patterns emerge in clinical practice that are so much a part of a practitioner's routine that he or she may even fail to grasp that a commitment has been made to a patient. One example is the making of an appointment with a patient.



#### Case 8-1 Keeping a Patient Waiting

Fifty-eight-year-old Judy Anderson had accepted the only appointment available with her internist, Anthony Fantaw, a member of one of the adult care teams at a major East Coast HMO. She had been diagnosed a month earlier with hypertension (175/95). Dr. Fantaw had prescribed the generic

for Microzide (hydrochlorothiazide) and Prinivil (lisinopril) and told her to schedule an appointment for follow-up.

Ms. Anderson had been bothered by jitteriness and loss of appetite since taking the medication, so she was eager to discuss these problems with Dr. Fantaw to see if they might be related to her medication. She had accepted a 1:30 p.m. appointment, which was the only one available even though she was responsible for picking up her grandson after school at 3 p.m. Since the HMO placed its physicians on a regimen of ten minutes per patient for such routine follow-up appointments, Ms. Anderson figured she would be done in plenty of time.

Ms. Anderson arrived at 1:15 p.m. She registered, paid her co-payment, and took a seat in the waiting room with about ten others. By 1:40 p.m. she had not been called by the nurse and was beginning to get nervous. By 1:50 p.m. she was more uncomfortable since her grandson's school was about a half hour away from the HMO offices. No one had said anything to her about the delay so she asked the receptionist what was happening.

The receptionist said that Dr. Fantaw had been running behind all day, a rather common pattern for him. He had spent twenty-five minutes with a patient that morning who had an unusually complicated set of problems. As a clinician deeply committed to high-quality medical care for his patients, he often found himself pressured to go a bit over the ten-minute time period. By this point in the afternoon he was running about forty-five minutes behind.

Ms. Anderson wondered why the receptionist had not told her all of this when she registered. She also wondered why, if this was a common pattern for Dr. Fantaw, some action was not taken to address the issue of his regular inability to stay on time.

### Commentary

This is a troublesome case of a physician creating problems for a patient by faithfully fulfilling his commitment to provide high-quality care to his patients, which, in turn, requires that he break his commitment to see patients at the scheduled time.

The pattern of physicians keeping patients waiting for appointments beyond their scheduled time is so common that some doctors may not even perceive this as breaking a promise. Nevertheless, there is a sense in which an appointment with a patient is a promise made to the patient. That promise is reciprocated when the patient commits to be there on time or call to cancel. Ms. Anderson kept her part of the "bargain." She went further. She showed up fifteen minutes early.

It is not that Dr. Fantaw is irresponsibly lacking in concern for his patients. In fact, it is his concern about them that gets him behind. In the interest of serving his patients and providing thorough patient care, he often falls into a pattern

of slipping behind his appointment schedule. In this case he took more than double the allotted time for a patient earlier in the day who had an unusually complicated set of problems. This is precisely what our stereotype of an ideal physician would be. Moreover, he has taken extra minutes with other patients to the point that, by the time he reaches Ms. Anderson's time slot, he is forty-five minutes behind.

In the language of moral philosophy, Dr. Fantaw has gotten behind by pursuing the principle of beneficence—maximizing each patient's best interest—and has manifested loyalty to his earlier patients—an implication of the principle of fidelity. In doing so, however, he has violated another implication of the principle of fidelity—the idea that once a commitment has been made to a patient, that commitment should be kept. Appointments are commitments—promises—and Dr. Fantaw has broken one of his promises.

Looked at strictly from the perspective of the principle of beneficence, Dr. Fantaw may have done exactly what was required. His beneficence-based duty would be to benefit the patient. In this case his duty is made more complicated by the fact that he has not one patient, but many. One of the problems with a strictly Hippocratic form of beneficence is that it assumes there is only one patient. Some Hippocratic physicians address this problem by serving the best interest of the patient with whom they are dealing at the moment. That may be precisely what Dr. Fantaw did—pursue the interest of each patient in front of him one at a time until he reached the end of his list of patients for the day.

Hippocratic beneficence presents some problems. First, it seems unlikely that the twenty-five minutes he spent with the earlier patient with the complicated problems was literally what was *best* for that patient. No doubt, he could have spent even more time with her and helped her at least somewhat more. Doing what is best for the current patient probably would put such high demands on the physician's schedule that he could see only a fraction of his scheduled patients each day.

Some critics of HMOs might argue that the fault lies with the health management for permitting only ten-minute appointment windows. Perhaps twenty- or thirty-minute windows would permit the physicians to come closer to the Hippocratic ideal with each patient. That strategy presents serious problems, however. If appointment slots are longer, physicians will see fewer patients. More physicians or other primary care providers such as nurse practitioners (NPs) or physician's assistants (PAs) will be required to cover the same number of patients. The cost of the health premium would go up proportionally (somewhat less so if NPs and PAs were used instead of MDs), an implication that may not be in the interest of patients. Would subscribers be willing to pay 100 percent more for twenty-minute slots with their physicians than they presently pay for the ten-minute windows?

Not all ethics that adopt the principle of beneficence do so Hippocratically. Utilitarian ethics also relies exclusively on beneficence but takes into account all the consequences for all parties affected by an action. In this case a utilitarian would set the time slots based on what was best for patients overall and would

allocate Dr. Fantaw's time on that basis. He would give some patients more time, others less than the typical slot.

Most critically from the point of view of ethics, the mere fact that a commitment had been made to Ms. Anderson would not count in determining what was ethical in Dr. Fantaw's time allocation. He would stay on schedule or slip behind solely on the basis of what was best overall. Of course, sophisticated utilitarians would have to take into account all of the indirect consequences of scheduling—the fact that Ms. Anderson might be late picking up her grandson and might lower her opinion of Dr. Fantaw as one who does not keep his word. It should become gradually clear that Dr. Fantaw is not in a good position to calculate whether the overall consequences of taking twenty-five minutes with his morning patient is utility maximizing or not. He simply cannot know whether later patients will need more or less time and cannot determine very easily what the indirect impacts will be on his or his institution's reputation if he fails to keep his scheduling commitments.

The fact that consequences are so difficult to determine makes it even more imperative that we also consider the principle of fidelity in this case. In particular, Dr. Fantaw has made a commitment to patients that he will see them at a certain time. They have organized their time accordingly, and the responsible ones have kept their part of the agreement by showing up on time (or early). Is the fact that a commitment was made relevant to the ethical analysis of this case? Defenders of the principle of fidelity hold that, independent of considerations of consequences, the fact that a commitment was made influences what is morally required of Dr. Fantaw. They hold that fidelity to commitments made is morally important even if the consequences are not better when one does so.

Ethical theorists attempt to make this point by asking us to imagine two possible actions one can take that will produce exactly the same amount of good consequences. They then add the fact that one has promised to do one of the actions, but not the other. The pure consequentialist, the one who works only with the principle of beneficence, should feel indifferent between the two actions. However, most people feel that if one has promised to do one of them, then that one is morally preferred. Really sophisticated analysts will eliminate the indirect consequences on one's reputation if one were to fail to do what one had promised by imagining a situation in which no one who can see which action is performed even knew that the promise was made (e.g., if the one to whom the promise was made had died or was in a position in which she could not learn which action were chosen). In these cases, if one feels morally obliged to pursue what one has promised rather than an equally beneficial action that one had not promised to do, then there must be something other than consequences shaping the judgment.

In Dr. Fantaw's case, Ms. Anderson and the other patients on the schedule for the day will know whether the doctor has kept his word about the appointment. That could tarnish his reputation and might be a reason some would conclude he should keep to his schedule. Consider the case, however, in which Dr. Fantaw takes all of this into account and discovers that he believes his early patient with a complicated case will benefit just enough more to offset the harm

to his reputation if he gets off schedule. If he is a utilitarian, he will be indifferent as to whether he keeps his schedule. If he gives weight to the principle of fidelity, he will have a reason to keep his commitments, at least to the point that the benefits to the patient with the complicated case get so overwhelming that they outweigh the force of the principle of fidelity. Defenders of that principle will at least claim that there is a moral issue when appointments are not kept. How much benefit is required to a patient with a complicated case to override the promises made to the other patients is a matter of dispute.

Here is another case in which a physician considers breaking a commitment made to a patient because he can do more good for another patient by breaking the promise.

#### Case 8-2

#### I Will Be There for You at the End: A Promise Broken?

Mabel Dacosta, an 80-year-old woman, was an end-stage cancer patient who had been admitted twelve days earlier to the inpatient hospice unit at City Hospital. She was now in the last stages of her illness under the care of the hospice team including Chris Humphries, MD, and Lois Kiger, RN, the primary nurse. She had also been visited regularly by the chaplain, a social worker, and a hospice volunteer. Her needs were met well even though she had no immediate family or friends who called upon her.

Ms. Dacosta had been quite depressed and nervous when under the care of her oncologist, but the transfer to the hospice unit had been reassuring. One of her key concerns was that she did not want to die alone. She repeatedly expressed her concern to Dr. Humphries, the hospice medical director, who said the team would be there to keep her comfortable twenty-four hours a day. She asked Dr. Humphries if he personally would be there when she died. He pointed out that he could not be present twenty-four hours a day, seven days a week, but he said, if he possibly could, he would be at her bedside when the time came.

As Ms. Dacosta declined, she spent most of her time sleeping. She appeared to recognize none of the staff when she was awake. When the day came when the team realized she would probably not last long, Dr. Humphries remembered his commitment. He completed his rounds and stopped at Ms. Dacosta's room. She did not appear to recognize him, but he sat in the chair near her. He was able to complete his notes for the charts of other patients. After some time, Ms. Kiger appeared at the door. Another patient was in serious pain and needed his attention. She offered to stay with Ms. Dacosta, but Dr. Humphries remembered his commitment to her.

He realized that she would not know whether he was actually present at her death and that no one else had heard him make the commitment to stay with her. He knew that Ms. Kiger was an excellent nurse who could do everything that could assist Ms. Dacosta at least as well or better than he could but that he was the best person to work up the patient who needed a new pain regimen. He realized that he could do more good for his two patients if he broke his promise to Ms. Dacosta and that he had explicitly mentioned to her that he could not be present twenty-four hours a day. At the same time he knew he had promised her his presence. A resident on the hospice unit could work up the patient in pain and give him a report on what she recommended. Did he make a promise, and should he break it?

#### Commentary

There seems little doubt that Dr. Humphries could do more good overall if he went back on his word and left Ms. Dacosta's room to care for the other patient. She would, in all likelihood, not even know whether he was present. Moreover, in this case (in contrast with Case 8-1), literally no one would know that he was breaking a commitment he had made since Ms. Dacosta had been the only one who heard him make it, and she was not conscious enough now to know who was present. From the point of view of the principle of beneficence, leaving to care for the patient in pain is the only defensible option.

The moral problem is that Dr. Humphries, in some sense, made a promise to be present at her dying if he possibly could. One way out of his dilemma would be to claim that he had not made an absolutely firm commitment. He said he would be present if he could be. He could try to convince himself that he could not possibly be present because another patient was in need.

This is a case in which almost certainly more good would be done for patients overall if he breaks his commitment. Only the principle of fidelity should lead him to consider staying with Ms. Dacosta. Since the other patient will receive adequate, if not ideal care, should he keep his promise?

In Case 8-1 the patient was conscientious in keeping the commitment she made to her physician. In Case 8-2 the patient has done nothing that would provide a basis for the clinician to feel he is no longer obligated by his promise. In other cases, the moral limits on loyalty in the patient-physician relation are questioned because the patient fails to keep his or her part of an agreement. This could involve failing to follow the recommendations given by the clinician (as was the issue in Case 6-4). It can also arise, as in the next case, if the patient fails to keep a commitment to pay bills.

**Continuing Treatment of a Patient Who Will Not Pay Her Bills**

A thoracic surgeon, Beau Schenker, MD, was called to the Emergency Department to evaluate and treat Nelda Thomas, a 40-year-old female who had chest pain of sudden onset. Her history pointed to lung disease, not cardiac problems. The exam revealed decreased breath sounds in the left chest, and x-rays confirmed free air in the chest that had collapsed the left lung. Dr. Schenker determined that the patient had a spontaneous pneumothorax. He discussed with Ms. Thomas the well-established treatment: a chest tube. Dr. Schenker stated, "We will need to insert a small tube into your chest to withdraw the air and allow the lung to re-expand." Ms. Thomas and her husband were relieved to learn that the chest pain was not the result of a heart problem and agreed quickly to the procedure, which was successful.

During the brief hospital stay, Dr. Schenker and Mr. Thomas, the patient's husband, reminisced about their days in high school since they coincidentally attended the same school. Ms. Thomas was seen several times for appropriate follow-up in Dr. Schenker's office after her hospitalization. Several months later, Dr. Schenker's business manager reported that the balance of Ms. Thomas's bill had not been paid. Since Dr. Schenker's office had a policy of not using collection companies, Dr. Schenker said "write the bill off."

Two years later, Ms. Thomas was once again in the emergency room (ER) for recurrence of the same problem. She requested to be seen by Dr. Schenker. When the Emergency Department paged Dr. Schenker, he advised the staff to call another available thoracic surgeon to see Ms. Thomas. A few minutes later, Mr. Thomas called Dr. Schenker directly at his office. Mr. Thomas admitted he had not paid the earlier bill (although Dr. Schenker had not brought up the matter) and promised to pay the old balance and then prepay for the costs of his wife's current needs. Dr. Schenker replied, "It's not about the money but about mutual respect. I am sorry but I cannot take care of your wife at this time. Another thoracic surgeon will take the case so you have nothing to worry about." Ms. Thomas was treated successfully by another physician. Should Dr. Schenker have relented and taken the case the second time?

**Commentary**

In this case it is the patient who is threatening the trust of the patient-physician relationship. Much has been written about professional obligations in the relationship with patients, less about patient obligations. Once an ongoing clinical relation is established, physicians and other health professionals are obligated not to abandon

the patient. Even if the patient is difficult, fails to follow the physician's recommendations, or, as in this case, fails to pay bills, the physician continues to have responsibility for the medical welfare of the patient. Only after a competent colleague agrees to take over a case can an initial physician withdraw from the case.

This case is complicated by the fact that, in a real sense, the patient-physician relationship had ended when Ms. Thomas's follow-up care from the first episode was completed. There is no ethical responsibility for either party to resume a prior relationship if a new acute medical problem occurs and a competent alternative professional is available to serve the patient's needs. In this case, the initial thoracic surgeon, Dr. Schenker, might have agreed to resume care under the conditions the husband offered, but he apparently thought it was important that the relationship itself be one of mutual trust and respect and preferred not to be involved further. As long as it is legitimate to conceptualize this set of events as an attempt by Ms. Thomas to reestablish a relationship that had ended and a competent colleague is available, Dr. Schenker seems to be within his rights.

**Fidelity and Conflicts of Interest**

Another aspect of the principle of fidelity in the patient-physician relationship is the problem of conflict of interest. The principle of fidelity calls for loyalty of the health professional to the patient, and that loyalty can be challenged when other interests are on the agenda of the clinician. Physicians, like all human beings, have economic and other interests. Some of the conflicts of interest are overtly financial. A physician may, but should not be tempted to, prescribe a drug manufactured by a pharmaceutical company in which the physician owns stock. Health care specialists often feel a need to maintain good relations with internists who have the power to refer patients. These conflicts of interest are ubiquitous in life but pose special problems in health care because providers are in a fiduciary (trust) relation with patients who count on their professionals to make honest, unbiased treatment recommendations in areas in which the patient is not expected to have expertise. A recommendation for an expensive diagnostic procedure or for an extensive treatment regimen must be received by the patient on faith, but provider income will be impacted by such recommendations. The following two cases pose economic conflict-of-interest issues.

**A GP Assisting in Surgical Operations:  
Stealing Business and Harming Patients?**

After completing a lengthy and prestigious residency program, a young surgeon, Diane Daemer, began the difficult process of establishing a solo practice. She took frequent calls from ERs, did insurance physical exams, went to all hospital staff meetings, did not take vacation, and so on. The

practice grew slowly, and she was gratified when a busy general practitioner, David Parish, referred a patient with lung cancer for her evaluation. When an operation was recommended, the referring doctor asked to assist in the procedure, a custom not unusual in her community. She agreed and the procedure subsequently went well, after her usual meticulous preoperative care and communication with all parties.

Three weeks later, the same GP referred a patient who needed a partial resection of the stomach. Again, Dr. Parish assisted in the operation. Further operative cases followed. Then Dr. Parish spoke of his interest in doing "simple operations like hernia repairs and appendectomies" with Dr. Daemer assisting him. She politely refused, feeling manipulated because of the previous referrals, and was unwilling to "cover" the lack of surgical credentials of the other. The surgeon came to believe that the arrangement was a deception, clearly not in the interest of the patients.

#### Case 8-5

#### Profiting from Self-Referral for MRIs

For many years internist Jonathan Birch had performed x-rays on his patients in his private office. He billed them a reasonable charge for the time and materials involved, including enough to amortize the costs of the equipment. By the late 1980s Dr. Birch was making increased use of more sophisticated imaging techniques such as magnetic resonance imaging (MRI) and computed tomography (CT) scans. By comparison, this equipment was extremely expensive and would not be utilized sufficiently to justify having the equipment in his office. He began referring patients needing this type of diagnostic test to an imaging center at the local hospital. Patients were billed directly by the hospital. This had the effect of reducing Dr. Birch's income that he used to derive from the simpler in-office procedures.

In 1989 Dr. Birch was approached by Imaging Resources, Inc., about a new free-standing imaging facility it was launching. Dr. Birch was invited to visit the facility and inspect its state-of-the-art equipment. Dr. Birch was impressed. He considered it better than the hospital's facility and was considering shifting his referrals to the new center.

The director of the center then presented an offer to Dr. Birch. He was invited to invest in the center. He could buy a 1 percent interest in the facility with income on the investment projected as 12 percent. Furthermore, the facility would loan Dr. Birch the money he needed to make the investment at 6 percent interest with the interest and principal paid off with the earnings on the investment. As soon as the investment was paid off, Dr. Birch

would own his share in the company and would receive profits on his ownership.

Dr. Birch realized that the more patients he referred, the better the imaging business would do. In effect, he would be able to recoup some of the income he had lost when he shifted from x-rays in his office to the use of the outside imaging facility at the hospital. Dr. Birch was vaguely uncomfortable with the offer he received. It could be interpreted as giving him an ownership interest in order to influence his decisions about when to order imaging and what facility to recommend. He was made more uncomfortable when he learned that only physicians were being offered the favorable investment terms. He learned that only colleagues who did substantial amounts of referral for imaging were approached. Even so, Dr. Birch accepted the offer and the loan.

#### Follow-up

By 1991 the U.S. Department of Health and Human Services was taking action against some of these joint-venture investment schemes that gave the appearance of being designed to provide financial incentives to physicians to channel business to certain imaging centers.<sup>3</sup> There were accusations of kickbacks. In response, the government issued regulations that provided "safe harbors," provisions which, if met, would give physicians assurance that they would not be guilty of violating anti-kickback laws. The original provisions made clear that investment in large, public corporations (such as drug companies) was acceptable, that physicians could provide services to joint ventures for a reasonable fee, and that investment terms (such as the loan received by Dr. Birch) had to be available to all investors, not just doctors who referred patients.<sup>4</sup> Later amendments clarified these provisions, but they remain in place essentially as originally promulgated. More recently, regulations governing self-referral have appeared in 2001, 2004, and 2007, and in 2010 a Medicare self-referral disclosure protocol was published pursuant to the Patient Protection and Affordable Care Act (Obamacare).<sup>5</sup>

As a result of these regulations, Dr. Birch decided to repay the loan and made an effort to assure that the company made a good faith effort to conform to all the provisions of the safe-harbor regulations. He was convinced that the company, of which he was now a minority owner, was the best facility in town and that he would never refer a patient in order to increase the profits of the company. Still, he was concerned about whether this arrangement was ethical.

#### Commentary

These two cases raise questions about fidelity to patients and potential economic conflicts of interest. In many such cases, patient well-being as well as the economic interests of the provider are at stake.

In Case 8-4 involving a GP who wants to assist in surgery, both the surgeon, Dr. Daemer, and the GP, Dr. Parish, could claim that their concerns were for the welfare of patients. Dr. Daemer was concerned that a physician without proper training in surgery was posing a risk to patients, while Dr. Parish could cite continuity of care and long-term knowledge of the patient as a reason why his presence as an assistant in the surgery could help the patient. He might also point to eventual lower costs if he performs minor surgical procedures himself rather than referring to a more expensive surgeon.

In spite of the potential patient-centered agendas for each of these physicians, there were also concerns of economic self-interest. Dr. Parish seems to be pursuing a course that will permit him to retain his patients for surgical procedures and capture some additional income. On the other hand, the surgeon might be concerned about losing a potential source of patient referrals.

Case 8-5 escalates the conflict of interest to the institutional level. An entire arrangement between a physician with potential to generate lucrative referrals and the for-profit imaging center smacks of conflict of interest.<sup>6</sup> Dr. Birch seems honestly to believe that the center in which he has invested and to which he steers patients is the best available. On the other hand, the economic arrangement, at least as it was originally established, seems clearly to be designed to induce Dr. Birch to generate business for the imaging center. Kickback is not an inappropriate term for such an arrangement. The adjustments following the development of federal safe-harbor provisions make the moral problem more subtle. The investment terms and the profits generated are now more reasonable, but still Dr. Birch will gain income from his inclination to point patients toward this particular center. Does the fact that he profited without controversy from the in-office x-rays provide a basis for justifying his income from the imaging center? Would fidelity to patients require an absolute prohibition on any such financial interests? If so, why should physicians be able to charge for in-office procedures and tests?

### Incompetent and Dishonest Colleagues

The principle of fidelity has thus far been applied to the areas of the making and breaking of promises and conflicts of interest. Those who recognize an independent principle of fidelity believe that there is something intrinsically immoral about breaking a promise or commitment, including a commitment to the patient's well-being.

There are other implications of the principle of fidelity. One of the most significant regards loyalty to colleagues, especially when it conflicts with loyalty to the profession as a whole or loyalty to the patient. Many of the professional codes require reporting of incompetent or dishonest practices. This seems consistent with serving the welfare of patients as well as showing loyalty to the profession of which one is a member. However, we are also expected in life to be loyal to our friends and colleagues. If a colleague appears to be incompetent or dishonest, as in the following cases, the health care worker is often put in a situation of conflict.

#### Case 8-6

### Incompetent Colleagues and Basic Patient Assessment

Mary Jo Orlando, RN, believed that careful inspection of the skin was one of the most important parts of patient assessment. She was well aware that most of the patients on the post-critical care unit where she worked were at high risk for skin impairment because they were elderly and often dehydrated and malnourished in addition to other chronic health problems. As part of each admission, the nurses on all of the units in the hospital were required to inspect newly admitted patients from head to toe to determine the general condition of the skin. This inspection included assessment of the skin over bony prominences such as the sacrum, trochanters, and even the elbows and heels. Needless to say, this part of the overall patient assessment took time and often the involvement of more than one nurse since many of the patients were unable to stand or roll over in the bed without assistance. For the past month, Ms. Orlando suspected that a new nurse on the floor, Nancy Hess, RN, didn't share her view about the importance of good skin assessment. One reason for her suspicion was that Ms. Hess never asked for help during her assessments of new patients. Another reason that Ms. Orlando thinks Ms. Hess is just filling in the computer form and not really checking her patients' skin condition is that, when she works on the evening shift and takes care of Ms. Hess's patients, she found skin problems with patients that Ms. Hess hadn't documented on the admission assessment. Skin problems can develop relatively quickly, but it is highly unlikely that they developed within a single shift. Ms. Orlando tried to be subtle and helpful to Ms. Hess by pointing out high-risk patients and offering to help with the skin assessment, yet Ms. Hess never asked for Ms. Orlando's or anyone else's help. Ms. Orlando spoke to the head nurse on the unit to share her concerns, and that seemed to result in some improvement for a short time, but then Ms. Hess returned to her previous behavior. Ms. Orlando believes that Ms. Hess's treatment of patients in this regard is substandard and potentially dangerous for this vulnerable population of patients.

### Questions for Thought and Discussion

- Is it the nurse's responsibility to take action to address Ms. Hess's problem, or should that responsibility fall on someone else (the head nurse of the attending physician)?
- What actions might Ms. Orlando consider once her initial efforts have failed?
- Should Ms. Orlando provide the necessary assessment for Ms. Hess's patients herself or only take actions to attempt to get Ms. Hess to provide a competent assessment?
- What moral duty underlies Ms. Orlando's responsibility in this case?

## Commentary

Most codes of ethics for health professionals include a provision that the clinician has a duty to maintain professional competence. This includes obligations for continuing education and staying current on new developments in one's field as well as making a good-faith effort to meet the standard of care for the patient. For example, the American Medical Association's (AMA's) principles include the provision that:

The physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public and obtain consultation, and use the talents of other health professionals when indicated.<sup>7</sup>

Similarly, the American Nurses Association Code states:

When the needs of the patient are beyond qualifications and competencies of the nurse, consultation and collaboration must be sought from qualified nurses, other health professionals, or other appropriate sources.<sup>8</sup>

The more complex moral issue is what obligations, if any, the one observing the error of a colleague bears. The nurse's code imposes a clear obligation on the nurse who is the colleague of a member of the health care team who is lacking in competence or commitment:

As an advocate for the patient, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, illegal, or impaired practice by any member of the health care team or the health care system of any action on the part of others that places the rights or best interests of the patient in jeopardy.<sup>9</sup>

In this case, Ms. Orlando thought she recognized incompetence or lack of commitment on Ms. Hess's part. The case, then, can be seen as raising the ethical question of the duty of a health professional to question a colleague's judgment, competence, or commitment. Ms. Orlando has already taken an appropriate first step. She pointed out high-risk patients and tried to help with the skin assessment. Then she spoke to the head nurse, which resulted in only temporary improvement. Both of these are appropriate initial steps. The code for nurses, however, seems to expect more if these initial steps are unsuccessful. The question is what more Ms. Orlando might do at this point. One approach would be to talk to the head nurse again and set up continuing education for all of the nurses on the unit about various aspects of assessment to make sure that everyone knows the proper procedure and the importance of this part of the assessment. She could also pursue the case up the line of nursing authority. She might, for example, seek out the director of nursing and explore corrective action with that person. If there is still no improvement

she might have to consider consultation with the hospital's attorney or an entity outside of the hospital such as the nursing licensing board. The next case raises such issues regarding responsibilities of reporting actions of a colleague to external authorities.

### Case 8-7

#### Dishonest Colleagues: Intentionally Shorting Tablet Counts

After Lorine Lance, Pharm.D., counseled Ferris Janowski, an elderly patient, about his three cardiac maintenance medications, she was surprised by Mr. Janowski's final question, "Would you please open these prescriptions and count them for me so that I know I'm getting what I paid for? There was a letter in my favorite advice column last night that told about how you can get shorted on your prescriptions, so I just want to make sure all the pills are there. No offense meant, you understand. I just can't afford to pay for pills and not get them."

Mr. Janowski's prescriptions had been filled by the owner of the pharmacy, Glen Battin, R.Ph., who would not be in for several hours. Dr. Lance decided to humor Mr. Janowski and opened the first bottle. To her dismay, the prescription was four tablets short. She made up the difference. The remaining two prescriptions were also short by the same amount—four pills each. Dr. Lance remedied the shortage in these two and returned all three prescriptions to Mr. Janowski. "I guarantee you that these are filled accurately and fully," Dr. Lance told Mr. Janowski as she handed him his medications.

Mr. Janowski was not the only patient with concerns about shortages that day. Evidently, several patients were prompted by the newspaper article to count their pills and found less than there should have been. Dr. Lance took numerous calls from angry patients and tried to determine if the caller might have miscounted, lost a pill, or took more than they should have, all reasons that the prescriptions could appear short. She noted that all of the prescriptions that patients claimed were shorted were for maintenance drugs and that Mr. Battin had filled them.

When Mr. Battin arrived at the pharmacy, an exhausted Dr. Lance told him about what she had discovered and the number of dissatisfied patients that called to complain about shortages. She was certain Mr. Battin would have a reasonable explanation. He stated, "It's really a shame that advice column printed that letter. We'll have to stop shorting maintenance prescriptions for a while until people get over the excitement and the need to count every prescription."

Dr. Lance could not believe what she was hearing. "You mean that you have been shorting prescriptions?" Mr. Battin shrugged, "Just the maintenance prescriptions and only on the higher-end products. People don't miss



three or four pills a month and the pharmacy recoups a steady amount. Besides, they always come in for a refill before they run out, so the patients aren't harmed."

Dr. Lance had always admired Mr. Battin, but his nonchalant admission of guilt instantly changed her appraisal of her employer. She had never knowingly shorted a prescription. How could she work for someone who did it as a matter of course? Furthermore, what should she do about this dishonest behavior?

## Commentary

Glen Battin, the owner of the pharmacy who is routinely shorting patients on their medication, spares us the problem we had encountered in the previous case of determining whether the practitioner understands and is responsible for what he is doing. He nonchalantly acknowledges to Lorine Lance what he is doing. He seems to think that as long as he limits his practice to maintenance prescriptions and his patients get them refilled before they run out, he is not causing any harm and that his behavior is tolerable.

Of course, patients can be injured financially as well as medically. They are here being cheated out of four tablets for which they are paying. Even if it is an insurer that is bearing the extra costs, someone is paying for something the patient is not getting. Mr. Battin also needs to take into account the fact that his dispensing practice constitutes a deception to the patient if not an outright lie. If ethics is a matter of keeping faith with patients as well as making sure that their interests are served, there is at minimum a challenge to fidelity in the pharmacist-patient relation with this practice.

The more subtle ethical issue raised by this case is what the implications of the principle of fidelity are for his employee, Dr. Lance. If she is operating strictly on the Hippocratic principle of protecting the patient's interests (especially if it is an insurer who is paying the bills), she might conclude that her employer's practice is not hurting the patient. No harm, no foul. However, she may understand her responsibilities to be more complex. Even if Mr. Janowski is not paying directly for the medication, he may pay indirectly in the form of extra premiums required to support Mr. Battin's practice (and other similar practices to which the insurer is exposed). Moreover, even if Mr. Janowski is insured through a public Medicare or Medicaid program for which he bears essentially no financial burden, somebody is paying the costs of this practice. If Dr. Lance is a utilitarian concerned about burdens to others as well as to her patient, she will have cause for concern.

Most critically, Dr. Lance may feel that she has an obligation to maintain trust with her patient. There is a sense in which the trust of the community in the profession of pharmacy is jeopardized by Mr. Battin's practice. If there are duties of fidelity incumbent upon a pharmacist, Dr. Lance owes it to her profession and patients in general to challenge the dishonest practice of one of the profession's members.

Pharmacists also have some kind of duty of fidelity to colleagues. A collegial relationship commands loyalty that is grounded in the principle of fidelity. Is there any sense in which a colleague's duties of loyalty require remaining silent about dishonest practices, especially those that seem not to jeopardize a patient's welfare in any dramatic and direct way? Is there any case to be made for remaining silent in the face of impaired, incompetent, and dishonest practices such as those in these last two cases? If not, what action can Dr. Lance take?

## Notes

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- 8 American Nurses Association. *Code of Ethics for Nurses with Interpretative Statements*, Provision 4.3. Available on the Internet at <http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.pdf> (accessed Dec. 9, 2013).
- 9 *Ibid.*, Provision 3.5.