

Leaders

Ethical issues and clinical pathology

D N Baron

Introduction

I propose that it is possible to classify most doctors, and equivalent health care and biomedical professionals who are not medically qualified, into one of three categories of practice—and that this division has ethical relevance.

(1) *Personal medicine*—Here the key encounter is directly between one doctor, whether general practitioner or specialist clinician, and a single index patient whom she is seeing at that time.

(2) *Public health*—Here the doctor does not usually have direct or indirect contact with individual patients, but has responsibilities towards a whole group of patients or potential patients in the community.

(3) *Pathology*

The major problems in medical ethics concern life and death. They relate to such matters as the beginning and end of “personhood”, and arise mainly as conflicts within the moral obligations inherent in the relationship of one doctor to one index patient. Such problems do not affect pathologists in their practice of pathology, because they do not usually have direct contact with living patients. Some pathologists, especially haematologists, act as clinicians for part of the time.

Pathologists have paid little attention to whether they, because of the different nature of their work, might have ethical problems that differ from those of clinicians, and how these might be resolved. A widely accepted statement, “the health of my patient will be my first consideration,” does not apply because a pathologist does not have “my patient”.¹ The ethical problems of pathologists lie mainly in the conflicts between moral obligations to the responsible clinician, to the index patient being investigated, and to others.

Ethical principles

To whom, therefore, may the pathologist have ethical responsibilities?

- (a) the index patient;
- (b) the clinician requesting the investigation;
- (c) other patients;

- (d) a patient with whom he is in direct contact;
- (e) his employer;
- (f) his staff;
- (g) other pathologists;
- (h) the profession of pathology;
- (i) undergraduate and postgraduate students;
- (j) research subjects;
- (k) experimental animals;
- (l) the general public.

The possible ethical issues facing any pathologist will be considered here primarily in the context of clinical pathology, applied to patient care, and in respect of an index patient for whose investigation (initiated and authenticated by the clinician) a *properly described and identifiable* request, specimen, or report is before him or his staff.

These issues may be discussed in various ethical frameworks. For a general assessment one can begin by seeking applications to the work of pathologists of four widely discussed proposals² for general principles in medical ethics—namely, the duties of: respect for autonomy; non-maleficence; beneficence; justice.

In situations where an ethical decision has to be made, a problem arises when two or more ethical principles seem to conflict, and the difficulty lies in the relative weight to be attached to the different principles, balancing possible harms against benefits. The conflict may arise within one of the above principles, such as autonomy of Dr A versus autonomy of patient B. It may also arise between principles, such as autonomy of patient B versus beneficence towards patient B, or towards patients C and D. These various factors and principles may well be considered differently by different pathologists and different clinicians.

Respect for autonomy

PATIENT'S AUTONOMY

A competent patient—though the notion of competence is not always straightforward—has the primary right to decide what is to be done to him, his tissues, and to information about himself.

If we override these rights we are breaking

For the sake of clarity, a pathologist (and a patient) are referred to as **he**, a clinician as **she**, throughout this article.

47 Holne Chase,
London N2 0QG
D N Baron

Correspondence to:
D N Baron

Accepted for publication
9 December 1992

the Kantian imperative, and not treating the patient as a rational agent with his own ends but merely as a means towards our ends. Respect for autonomy is just as important in promoting general welfare in utilitarian theory, provided that others are not harmed.

There are circumstances when the pathologist is asked to take the specimen (involving breaching of bodily integrity) on behalf of the clinician. He should be able to assume that the responsible clinician has obtained specific or implied *consent* to the particular procedures that she has requested. This cannot be automatically taken for granted, however, and especially before doing any investigative interference that may be risky or uncomfortable, such as a bone marrow biopsy, the pathologist must confirm the patient's valid consent. Otherwise it is the pathologist who is acting unethically as well as the clinician, and is breaching the patient's autonomy.

Though diagnostic investigations may be assumed to have valid consent, unfortunately this is not always the case for tests arising out of clinical trials. The pathologist must satisfy himself that the patient is fully informed, with the trial having ethics committee approval, otherwise by participating he, as well as the clinician, is acting unethically.

The information about a patient in laboratory reports and record is *confidential* and for that patient's benefit, releasable with attribution only to those responsible for his care unless the patient consents. Conflict of ethics arises between the need to maintain the patient's autonomy and the need to protect others—for example, in the case of certain infectious diseases where the risk to the public may be great and there is a legal duty to inform the public health authorities. In cases of AIDS there is no such legal duty to inform.

CLINICIAN'S AND PATHOLOGIST'S AUTONOMY
How does the right of the clinician to ask for such investigations as she thinks appropriate (from her specialist knowledge of the patient for whom she is responsible, and has obtained consent) interact with the pathologist's right to organise the work of the laboratory as he thinks fit from his specialist knowledge. This is an example of a crucial difference of approach. The clinician's prime responsibility is to the index patient whom she is treating at that moment: the pathologist's responsibility is also to the patients, perhaps several hundred that day, all of whose investigations could have equal merit. A pathologist, unless persuaded by consultation, can only try to divide his resources equitably.

The pathologist must always remember that the final ethical and legal responsibility for the care of the index patient rests with the clinician, who in Britain *requests* tests and an opinion from the pathologist, and receives the report.

Non-maleficence

The duty not to harm another must be tempered by the consideration that their view of

what is harmful may not be the same as yours. *Primum non nocere* is influenced both by this, and the need to balance non-maleficence against the demands of other duties.

NON-MALEFICENCE TO PATIENTS AND TO CLINICIANS

The general duty of pathologists is to avoid mistakes and therefore to produce the best possible authorised result for the clinician to use. It is the clinician who may have ethical problems with what she tells the patient about the result, and the pathologist must not provide a fake report to be shown to the patient. Trust, good communication, and collaboration between pathologist and clinician are essential; anything that harms this link is ethically wrong because it harms patients. Non-maleficence to patients is particularly relevant when the pathologist believes that the clinician does not understand the limitations of certain investigations, and is therefore requesting and applying them in a way that might harm. He has to advise her accordingly.

Beneficence

This is acting in the best interests of others: but their view of what does good and what may be the preferable "best interest", may not be the same as yours. Beneficence towards one has to be balanced against respect for their autonomy, possible harm to others (non-maleficence), or against denying the possibility of benefiting others (justice).

BENEFICENCE TO PATIENTS AND TO CLINICIANS

The pathologist has an ethical duty to do his best, via the clinician, for the care of the index patient. The duty is not discharged just by sending back the best possible report from the laboratory, but by discussion with the clinician, and perhaps by seeing the patient, if he believes he can help further. Can laboratory investigations at a distance be valid clinical pathology? Pathologists are consultants to other doctors, not merely providers (or sellers?) of an investigative service.

If the interpretation is complex, the pathologist also has an obligation to seek expert advice, if necessary by sending the material elsewhere. If a requested test gives an unusual or unexpected result his duty, after checking, is to send the result (with comment) to the clinician as soon as possible, not forgetting that results that are telephoned or put up on a computer screen may be unreliably recorded. A corollary is that he has an obligation, for the patient's benefit, to admit to the clinician any error that he might detect after subsequent checking—hence the need, whenever feasible, to store specimens for possible repeat investigation.

The pathologist's beneficence, however, should be not restricted to the index patient. Knowledge and skills should be available in two ways for other members of the community as possible patients: (a) to ensure that

resources are free for their future needs; (b) to advance knowledge of pathology.

Justice

Theories of justice try to settle conflicting moral claims fairly, and vary in the weight that they give to different criteria by which to judge these moral claims.

Most discussions of justice begin with arguments around Aristotle: equals should be treated equally, and unequals may be treated unequally in proportion to their inequality. The problem in fairness is the assessment of equality and inequality. Among criteria that may be relevant are such possibly incompatible imponderables as right, need, or desert (as an individual or as a member of society).

In this context we are considering problems in comparative justice, where the claims and interests of one person or group have to be balanced against those of others that may well conflict when the relevant resources are limited—as they usually are for pathology.

RESOURCE ALLOCATION

The hospital pathologist has fixed limited resources, including time, space, and money, which are an argued-for share of the hospital budget (*macroallocation*), though this may change with clinical budgeting. The problem is what arguments should be used to allocate these resources when the claims from clinicians for different patients or groups of patients are greater than the resources can cover, and are there moral grounds for these arguments? In terms of *microallocation*, he does not usually have the information to judge relative needs or relative deserts, on whatever criteria, for individual patients but only for groups. Allocation of greater resources to one group becomes unjust when other groups suffer avoidable harm that exceeds the extra benefit for the first group. He also has to balance the direct claims of clinicians for patients against using resources to advance knowledge, thereby meeting his duties of beneficence to the profession of pathology and to future patients. Here we have managerial decisions that have to be justified to those whom they affect, and can only be so, and accepted by them, if based on ethical considerations.

But general practitioners argue that using relatively more pathology resources for their

patients keeps them out of hospital, thus saving health care money. The community physician may want laboratory resources concentrated on screening the population, arguing that this is more cost effective in improving health than many of the perhaps superfluous tests done on hospital or general practice patients.

A pathologist is not justified in introducing extra tests on specimens for his own interest, unless as part of a thought-out research or training scheme to advance knowledge of pathology. A pathologist has an ethical responsibility to save resources by advising clinicians generally on reducing investigations when he can offer evidence that these cannot help.

One patient overinvestigated at too great a cost may mean that another patient is underinvestigated.

Virtue ethics

One alternative approach for medical ethics, which is not discussed in detail here, is that of Aristotelian virtue ethics³ which is a movement away from rules and principles to ideals. This considers what sort of person the pathologist should be (his *virtues*), and is based on the “goods” that pathology tries to accomplish (such as laboratory competence), its *telos* or ultimate aim.

Conclusion

Ethical problems concerning a patient's investigation can usually be resolved by the pathologist deciding on what action would most help the responsible clinician. This does not always mean acceding to the clinician's demands, nor should resource implications affecting other patients be ignored.

This article is abridged from Ethical problems in clinical pathology. *Journal of Applied Philosophy* 1992;9:207–20, reproduced by kind permission of the Editors. Full references and acknowledgements are found therein.

- 1 World Medical Association. Declaration of Geneva (amended Sydney, 1968). In: *Philosophy and practise of medical ethics*. London: BMA, 1988:96.
- 2 Beauchamp TL, Childress JF. *Principles of biomedical ethics* 3rd edn. New York: Oxford University Press, 1989.
- 3 Stempsey WE. The virtuous pathologist: an ethical basis for laboratory medicine. *Am J Clin Pathol* 1989;91: 730–8.