Virtual Mentor

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From the Editor

Whose Values?

There is a moral component in the decision to enter the field of medicine, or at least an argument can be made that there ought to be. There are much easier ways to make a living—ways that do not involve years of education, mountains of debt, and a lifetime of helping people through their most difficult days. The medical school applicant's personal statement is a prospective physician's first attempt at showing his or her commitment to the values of medicine. Indeed, medical students around the country are quick to criticize colleagues who seem to have gone into medicine "for all the wrong reasons."

People enter medicine out of concern for the sick and, for the more ambitious of them, the betterment of society as a whole. These values are critical to maintaining high standards of professionalism in the medical community. They are the values that have earned medicine its reputation as a noble profession.

But medicine is not an insulated profession, and the question of how to help the sick is becoming an increasingly complex one. Growing political debates over stem cell research, abortion, end-of-life care, and a host of other moral concerns surround the practice of medicine. For better or worse, debates about these topics are not restricted to the political arena. The conflicts of values these subjects reflect often arise in the most private of relationships—the delicate encounters between a patient and physician.

As the push away from paternalism and toward patient autonomy continues, conflicts of values take on greater meaning. More attention is being paid to the power differential between physicians and patients and to the potential of a paternalistic relationship to subvert a patient's sense of his own best interest. As patients become more vocal partners in the clinical encounter, the physician's once-unquestioned values are being challenged by patients, and sometimes there is no apparent common ground.

What is a physician's role in this complicated medical landscape of shared decision making when interpersonal value conflict arises? What happens when a patient's values and the health care choices that stem from them are at odds with the values of a physician? Is it ethical for a physician to opt out of treating a patient with conflicting beliefs? More pragmatically, can a physician rightfully use his or her authority to influence not only the behaviors but also the values and beliefs of patients?

Physicians may wish the best for their patients, but there is a great deal of subjective judgment wrapped up in one's notion of "the best." This issue of *Virtual Mentor* considers those moments when physicians and patients disagree, on moral grounds, about the desired course of treatment. It draws from a diverse group of experts in the health care profession in an attempt to shed light on these difficult medical conflicts.

In the first case commentary, Drs Kelly Brownell and Rebecca Puhl look specifically at the effects that societal and, more specifically, physician bias can have on the treatment of obese patients. In case 2, Dr Jack Drescher reminds us that the conduct of a physician who refuses to accept patients for who they are may diminish their willingness to seek medical care in the future. Commenting on the same case, Dr Andrew Fergusson urges physicians not to lose sight of the whole patient in their rush to treat what they think is the problem. Commenting on the final case, Dr John Lorenz explores how 2 rational parties can arrive at different decisions, and he considers the ethical obligations of physicians who find themselves at odds with the wishes of surrogate decision makers.

In this month's journal discussion, Helen Harrison takes a hard look at a quality-of-life study of people with severe disabilities and asks difficult questions about the quality-of-life assessments that physicians and patients make. Dr Sayantani DasGupta's contribution to the medical education section explains the Columbia University Community Pediatrics Program's unique approach to teaching cultural responsiveness, suggesting that many of the conflicts that arise in clinical settings are rooted in cultural or religious misunderstandings rather than in true clashes of values. In the clinical pearl, Drs Nicholas Fitzsimons and Stephen Freedland share expert opinions on the screening, diagnosis, and treatment of prostate cancer in obese men.

The remainder of this issue looks at some broader consequences of value conflicts in the clinical setting. Dr Mahendr Kochar examines the commitments physicians make when choosing to enter medicine and expresses the belief that those commitments take priority over personal values. Dr June McKoy compares the public defender's professional obligation to serve indigent clients who need representation with the absence of a similar professional obligation for physicians. In the law and medicine section, Allison Grady examines the conscience clause movement, focusing on the efforts taking place in the state of Michigan.

Finally, in the op-ed section, Dr Paul Hoehner questions physicians' ability to practice value-neutral medicine, and Rebecca Cook and Bernard Dickens consider the use, and perhaps abuse, of "conscientious objection" as a way to avoid performing professional services that would violate one's personal beliefs.

Values, be they religious or secular, are integral to a physician's commitment to his or her patients. As long as there are diverse beliefs and cultures, there will be at least occasional clashes of values in the clinical encounter. It is my hope that considering these difficult conflicts will contribute to the discussion of values in medicine. I would like to thank all of the contributors to this issue for their expertise and wisdom. Their

contributions are an excellent starting point that will enhance our ability to provide care for an increasingly diverse patient population.

Manish Tushar Raiji
Second-year medical school student at Michigan State University in East Lansing.

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