An ethical dilemma on call

Introduction

Being a junior doctor, especially early on, can be very daunting. A new hospital, new colleagues and new authority along with the incumbent added responsibility. The amalgamation of these issues, in tandem with a difficult ethical dilemma let alone a medical dilemma, can pose problems for any doctor.

This article highlights the importance of reflection at all levels in medicine, but particularly in the early years, in that it promotes good habits early on in one's career. Similarly, having been involved with such decision-making processes provides junior doctors with invaluable experience which should be cherished, reflected upon and in some cases extrapolated, in order to improve decision making and uphold the constitution of *Good Medical Practice* (General Medical Council, 2009).

Case presentation

One night, as the surgical doctor on-call, I was asked to see a young woman who had been admitted with abdominal pain. She was accompanied by two police officers. The patient was well known to the hospital as a result of recurrent prior admissions on the background of a complex history of drug and alcohol misuse plus other social issues. I prepared myself by reading previous correspondence in the medical notes and previous admissions. I also had a brief discussion with the sister on the surgical admissions unit. Accompanied by a female nurse I introduced myself and began receiving the history from the patient. I asked the police officers to wait outside while I was assessing the patient.

Her vital signs were normal, with the only abnormality being the respiratory rate which was 30 breaths per minute. Her history was very vague and inconsistent. On examination she had some vague generalized abdominal tenderness. Her pupils were equal and reactive to light. There was some clinical evidence of previous intravenous drug abuse. Serum beta human chorionic gonadotrophin was negative and ruled out ectopic pregnancy, a potential cause of her abdominal pain. Given the history, a working diagnosis of non-specific abdominal pain with features of irritable bowel syndrome was made. The patient was managed conservatively with analgesia and fluids.

Having answered her questions, my rapport with the patient was such that she felt comfortable with me. I had a very frank discussion with her with respect to drug misuse and related future complications. She was keen to start a family at some stage and told me that she had previously concealed drugs per vaginum, but had not done so on this occasion. At this point I deemed her to be competent.

After some enquiries with local services, it transpired that the patient was well known to police and had been arrested for offences relating to the buying and selling of heroin and other street drugs. They had 'reason to believe' that the patient was hiding some drugs per vaginum, and thus they wanted me to perform a vaginal examination on this premise. Clinically, the patient was haemodynamically stable and I did not envisage or suspect any toxic symptoms. I had no reason to perform such an examination, and therefore refused to do so pending discussion with my seniors.

I contacted my senior house officer who agreed with me and discussed the matter with the police officers. On the post-take ward round we presented the case to the consultant and it was discussed in detail. The consultant supported the decisions made and decided that the patient should stay in for a period of observation, slow wean off analgesia and convalescence after the ordeal. The patient was subsequently discharged.

Discussion

Dilemmas such as this are not uncommon in busy city or regional hospitals. Patients present with their own idiosyncrasies and nuances which need a doctor's due care and attention. Being familiar with the law and medical ethics is imperative in situations such as this, as medicine in the UK is seemingly becoming more litigious with costs of clinical negligence rising as a result of more claims payouts and increasing legal costs (Upadhyay et al, 2008).

Through the course of undergraduate medical study, medical students are taught about medical law and are assessed on their knowledge in their medical curricula. Further, as postgraduates, preparation for membership examinations as well as on the job learning helps doctors to cultivate the relevant knowledge, skills and attitudes required to uphold the law while still protecting patients. Like most medical ethical dilemmas, cases are never straightforward, and demand a cultured and measured approach to their management, i.e. senior help should always be sought as the experience of colleagues who have been in similar situations previously is invaluable (Lo, 2000; Howsepian, 2006). Arguably, the doctor in question could or should have sought advice from a medical defence organization as they offer 24-hour advice. In reality, this may not have been practical, as often it takes 24–48 hours to have each case analysed and assessed.

Being able to act rationally and calmly is also important especially in a situation such as this. Such ethical dilemmas raise a myriad of hypothetical questions. A patient would only be examined per vaginum by a police surgeon or if the patient was medically incompetent, i.e. under common law. In the latter case, it would in practice be the consultant or registrar who would perform the examination.

This case is not easy to 'solve' and, as in most similar situations, there is never one correct approach to managing a case. Many doctors would manage a case such as this differently depending on their experience, applied theoretical knowledge, clinical scenarios and workshops, and how they have been taught by their seniors (Howsepian, 2006).

What are the options?

Some may argue that the doctor should do nothing and discharge the patient with some analgesia. He could take the advice of his seniors and/or that of a clinical ethics committee if available. Although all doctors should try to help patients and act

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in their best interests (beneficence), they need to bear in mind another valuable tenet, namely 'primum non nocere' which means 'first do no harm'. So thorough history, examination, diagnosis and a management plan is imperative. Consultant advice should be sought early. In some centres there is a clinical ethicist available for consultation.

The non-clinical circumstances have to be factored in too. After assessing this, one should devise a framework by which to address the problem (Howsepian, 2006). So for example, if the doctor had ignored the patient and gone along with the police officers' request, the dynamics of the situation along with the power and trust balance would break down immediately and ultimately prove unsuccessful. It would jeopardize the issue of trust and ultimately care, and probably lead to both a legal and professional complaint and their numerous sequelae.

Conclusions

This case has dealt with ethical issues such as autonomy, beneficence, non-maleficence, consent, capacity and futility (Howsepian, 2006). The author has highlighted some core ethical issues which present to doctors in the UK on a daily basis. As mentioned these dilemmas take many shapes and forms and in the vast majority of cases, there is no set way of dealing with them. However, through stimulating thought-provoking and educational debate and learning from experience, doctors would be better positioned to effectively manage such situations which in turn deliver the necessary care to patients who need it, without the potential threat of litigation clouding rational, well-informed and essential decision-making processes (Upadhyay et al, 2008). **BJHM**

KEY POINTS

- Being a junior doctor can be daunting, but don't worry.
- Ask for help early.
- Read about medical law, as well as the law of the land – something which is often poorly taught in undergraduate courses.

Conflict of interest: none.

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