MEDICAL ETHICS LECTURE SERIES

# Lecture 4

## *Physician's Duties to Patients*

Department of Psychiatry • Jordan University Hospital
Psychiatry Residency Training Program

*Duration: 40 minutes*

LECTURE OVERVIEW

# Learning Objectives

- Describe the physician-patient relationship as a fiduciary relationship
- List the core duties physicians owe individual patients, beyond consent and confidentiality
- Explain the ethical duty to disclose medical errors, and how to do so appropriately
- Recognise conflicts of interest and professional boundary risks in everyday practice
- Describe how a physician may appropriately end a physician-patient relationship

LET'S BEGIN WITH A SCENARIO

# Case Study

CASE VIGNETTE

A resident treating a patient for hypertension prescribed a dose with a misplaced decimal point. The patient took the higher dose for two weeks, experienced dizziness, and had one fall at home without serious injury. At the next visit, reviewing the chart, the resident discovers the error. The patient has not connected the fall to the medication and seems to be recovering well.

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*Discussion: Does the resident have to say anything? What does he actually owe this patient right now? Hold this question; we will return to it.*

*No harm was intended, and the patient is recovering — does that change what is owed here?*

A FIDUCIARY RELATIONSHIP

# The Physician-Patient Relationship

> *"A relationship of trust in which one party (the physician) is entrusted to act in the best interest of another (the patient), who is inherently in a position of dependence and vulnerability."*
>
> — Adapted from WMA Medical Ethics Manual, 3rd ed.[1]

Unlike an ordinary commercial exchange, this relationship obliges the physician to place the patient's interest ahead of the physician's own convenience or gain.

**Eight duties flow from this trust — today's roadmap:**

### Competence & continuity

Maintaining skill; not abandoning patients mid-care.

### Honesty & disclosure

Truthful communication, including when things go wrong.

### Loyalty & boundaries

Avoiding conflicts of interest and improper dual relationships.

# Duty 1: Professional Competence

*"A physician shall maintain the highest standards of professional conduct and provide competent medical service ... with full technical and moral independence."*[2]

**In practice, this means:**

- Keep clinical knowledge and skills current through ongoing education
- Recognise the limits of one's own competence and refer when appropriate
- Exercise sound clinical judgement, not just technical correctness
- Report and address one's own errors as part of maintaining competence, not hiding from it

[2] *WMA International Code of Medical Ethics, 2022 revision.*

# Duty 2: Continuity of Care

*"Once a physician has agreed to care for a patient, they must not discontinue treatment without giving the patient reasonable notice and the opportunity to secure other care."*[3]

**In practice, this means:**

- A physician may decline to take on a new patient, but may not abruptly abandon an existing one
- Coverage must be arranged during vacations, illness, or unavailability
- Continuity matters most for patients mid-treatment — e.g., during an acute psychiatric admission
- Transfers of care require adequate handover of clinical information

[3] *AMA Code of Medical Ethics, Opinion 1.1.5, Terminating a Patient-Physician Relationship.*

WHEN CARE MUST TRANSITION

# Ending a Relationship Properly

| | |
|---|---|
| **Give reasonable notice** | Inform the patient clearly, in writing where possible, with enough time to find alternative care. |
| **Ensure continuity** | Provide records, a summary, and where needed, direct referral to a new physician or service. |
| **Never abandon mid-crisis** | A relationship should not be ended during an acute episode, hospitalisation, or unstable period. |
| **Distinguish from discrimination** | Ending a relationship for legitimate reasons (e.g., persistent non-payment, safety) differs from refusing care based on a patient's identity or diagnosis. |

# Duty 3: Informed Consent

*"Valid consent requires that the patient has adequate information, is competent to decide, and decides voluntarily."[4] (Recap from Lecture 1 — autonomy in practice)*

**In practice, this means:**

- Disclose diagnosis, prognosis, treatment options, risks, and alternatives — including the option of no treatment
- Confirm understanding, not just delivery of information
- Reassess consent when circumstances or the treatment plan materially change
- Document consent discussions, particularly for higher-risk interventions

[4] *WMA Medical Ethics Manual, 3rd ed., Chapter Two.*

# Duty 4: Truthfulness

*"Physicians have an obligation to deal honestly with patients ... at all times."*[5]

**In practice, this means:**

- Deliver difficult news honestly, with compassion — avoiding both cruelty and false reassurance
- Do not withhold information out of concern that legal liability might follow disclosure
- Correct misunderstandings a patient may have about their condition, even if uncomfortable
- Truthfulness extends to disclosing the physician's own errors — explored on the next slide

[5] *AMA Code of Medical Ethics, Opinion 8.6, Promoting Patient Safety.*

# Disclosure of Medical Errors

> *"Patients have a right to know their past and present medical status, including conditions that may have resulted from medical error."*[5]

**A good-practice disclosure conversation includes:**

- Disclosing that an error occurred, and explaining the actual or potential harm caused
- Acknowledging the error and expressing genuine, professional concern — not deflecting or minimising
- Explaining what is being done to address any harm, and to prevent recurrence
- Providing continuity of care, including facilitating transfer if the patient has lost trust

*Legal liability concerns should not override the duty of honest disclosure — and many jurisdictions have 'apology laws' that protect disclosure conversations from being used as an admission of liability.*

# Duty 5: Confidentiality

*“Whatever I see or hear in the course of treatment ... which ought not to be spoken abroad, I will keep secret.” (Recap from Lecture 2 — privacy as a right)*

**In practice, this means:**

- Confidentiality is the default; disclosure requires either the patient's consent or a clear, narrow exception
- Extends to colleagues, family members, and administrative staff — share only on a need-to-know basis
- Continues after the physician-patient relationship ends, and after the patient's death
- Applies to psychiatric records with particular sensitivity, given potential for stigma and discrimination

*See Lecture 2, Slide 14 for the recognised exceptions to confidentiality.*

WHEN OTHER INTERESTS COMPETE

# Duty 6: Avoiding Conflicts of Interest

### Industry gifts & hospitality

Gifts from pharmaceutical or device companies can subtly bias prescribing — minimise and disclose.

### Self-referral

Referring patients to a facility or service in which the physician has a financial stake requires disclosure, at minimum.

### Research incentives

Recruitment bonuses for enrolling patients in trials must never influence clinical recommendations.

### Managing unavoidable conflicts

When a conflict cannot be eliminated, disclose it to the patient and, where possible, remove yourself from the decision.

# Duty 7: Professional Boundaries

### Sexual boundaries — absolute

Sexual contact with a current patient is never ethically acceptable, regardless of who initiates it. The power asymmetry in the relationship makes genuine consent impossible to guarantee. This is especially salient in psychiatry, given the intimacy of the therapeutic relationship.[6]

### Other dual relationships — use caution

Treating close friends, family, or employees blurs objectivity and can compromise both care and confidentiality. Financial relationships (e.g., business dealings with a patient) and social media connections deserve similar caution.

# Duty 8: Emergency Care

*"A physician shall give emergency care as a humanitarian duty, unless assured that others are willing and able to give such care."*[7]

**In practice, this means:**

- This duty can arise even outside a formal physician-patient relationship — e.g., a bystander emergency
- Care should be limited to what is reasonably possible given the physician's training, setting, and resources
- Most jurisdictions offer 'Good Samaritan' legal protection for care given in good faith in emergencies
- In an institutional emergency, coordinate with the emergency response system rather than acting alone where possible

[7] *WMA International Code of Medical Ethics, 2022 revision.*

SUPPORTING, NOT RESISTING, PATIENT CHOICE

# Respecting the Right to a Second Opinion

*Patients retain the right to seek another physician's opinion at any time, and to choose or change their treating physician — a core protection under the Declaration of Lisbon.[8]*

**What this means in practice:**

| | |
|---|---|
| **Facilitate, don't obstruct** | Provide records and a summary promptly when a patient requests a second opinion. |
| **No defensiveness** | A request for a second opinion is not a personal criticism — respond professionally, not defensively. |
| **Continue care in the meantime** | Ongoing treatment should continue unless the patient specifically requests otherwise. |

A PRACTICAL FRAMEWORK

# When Duties Conflict

*Duties rarely conflict in the abstract — they conflict in specific, time-pressured moments. A framework helps you reason under pressure.*

1

**Name the competing duties**

E.g., truthfulness vs. avoiding unnecessary distress; confidentiality vs. safety.

2

**Identify the primary duty-holder**

In almost every case, the individual patient's interest is the anchor for resolving the conflict.

3

**Consult guidance or colleagues**

Institutional policy, ethics consultation, or senior colleagues can help weigh competing duties.

4

**Choose the most transparent path**

When in doubt, the more transparent, more accountable option is usually the more ethical one.

5

**Document your reasoning**

A documented, reasoned decision withstands scrutiny far better than an undocumented instinct.

RESOLUTION

# Back to the Case Study

Yes — the resident must disclose the error. The patient was harmed (dizziness and a fall), and has a right to know the cause, regardless of how the patient currently feels or whether it changes future treatment.

**How the duties apply:**

- Truthfulness requires disclosing the error and explaining the likely cause of the fall
- Confidentiality is not at issue here — this is a disclosure to the patient about their own care
- Competence includes correcting the dosing and reviewing how the error occurred
- Continuity of care means proactively monitoring for any ongoing effects of the overdose

KEY TAKEAWAYS

# Physician's Duties to Patients

- The physician-patient relationship is fiduciary — the patient's interest comes before the physician's own
- Competence and continuity of care are ongoing duties, not one-time boxes to check
- Truthfulness includes disclosing medical errors — legal liability concerns should not override this duty
- Conflicts of interest and professional boundaries must be actively managed, not merely avoided when convenient
- When duties conflict, favour the more transparent path and document your reasoning

# References

1. World Medical Association. Medical Ethics Manual. 3rd ed. Ferney-Voltaire: WMA; 2015.

2. World Medical Association. WMA International Code of Medical Ethics. Adopted 1949; revised 2022.

3. American Medical Association. AMA Code of Medical Ethics, Opinion 1.1.5 — Terminating a Patient-Physician Relationship.

4. World Medical Association. Medical Ethics Manual, 3rd ed., Chapter Two — Physicians and Patients.

5. American Medical Association. AMA Code of Medical Ethics, Opinion 8.6 — Promoting Patient Safety.

6. World Psychiatric Association. Madrid Declaration on Ethical Standards for Psychiatric Practice. Adopted 1996; amended 2011.

7. World Medical Association. WMA International Code of Medical Ethics, Physician's duty of emergency care.

8. World Medical Association. WMA Declaration of Lisbon on the Rights of the Patient. Adopted 1981; revised 2015.