ETHICS MAN **Daniel K Sokol**

Hippocrates, Michael Jackson, and medical ethics

Doctors must take special care that their judgment doesn't become impaired when attending to powerful patients

The Hippocratic oath has a part where the action shifts from the public sphere to the private: "Into as many houses as I may enter I will go for the benefit of the ill." After the death of Michael Jackson in June 2009, suspicious eyes have turned towards the singer's personal physician, Conrad Murray. Although Dr Murray has denied any wrongdoing, this turn of events has forced the doctor-patient relationship into the spotlight. How does the dynamic of this relationship alter when the patient is more powerful than the doctor?

In medical school we teach students to be aware of the power differential between doctor and patient. In a hospital setting, patients may be sick, frightened, and medically unsophisticated. Doctors, on the other hand, are generally healthy, medically knowledgeable, and in a familiar environment. Such is the typical clinical encounter. Doctors are strong; patients are vulnerable. In some cases, however, the power relationship is altered and a different set of challenges arises.

At times the locus of power is external. Military doctors, for example, can be both physicians and soldiers. They have superiors whose orders they must obey and for whom the welfare of a patient may be less important than the military mission. Edmund Howe, a psychiatrist who served in the US army, gives the example of treating patients with combat fatigue in the battlefield. If a military psychiatrist allows a soldier with combat fatigue to return home, many more soldiers may feign symptoms to escape combat. This floodgate effect may undermine the mission's success. The doctor's dual loyalty to the military and to patients is an example of mixed agency.

Mixed agency also exists in the field of sports medicine. Sports doctors may be torn between their duties to the patient and their duties, as an employee of the club, to the manager. Should a star athlete with an injury be allowed to compete if the manager instructs the club doctor that he or she should? An injection of pain killers will satisfy the manager and may improve the team's performance, but the patient will be put at risk. As these are coveted medical jobs, the manager would have no trouble finding a replacement. Should self interest trump the lofty principles of medical ethics? Should the scope of best interests be enlarged to encompass the team? As in the military situation, the manager has the best interests of the team in mind, and this will not always coincide with the medical best interests of the patient.

One notable area where the power differential is reversed is in the medical care of heads of state. When in office the former French president François Mitterrand told his personal physician, Claude Gubler, that his diagnosis of prostate cancer was a "state secret" that should be kept even from the president's wife. For the next 11 years Dr Gubler prepared and signed medical bulletins giving the president a clean bill of health and never mentioning his cancer. When laboratory tests were needed Dr Gubler sent specimens under a pseudonym. Meanwhile Mitterrand justified his pains by disguising them as tennis injuries. France is a nuclear power, and it seems reasonable that someone should know if the president, who can pull the nuclear trigger, has experienced a decline in mental competence, succumbed to a drug or alcohol addiction, or is simply spending all of his time in bed, as was the case with Mitterrand towards the end of 1994. Keeping a medical secret is not an absolute obligation, but breaching confidentiality must be particularly challenging when your patient is a president or prime minister.

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As personal physicians tend to spend prolonged periods with their patients—in times of sickness and, significantly, of health—a danger exists that professional boundaries become blurred and judgment impaired. The prestige of the job and a generous salary can also distort ethical and clinical judgment. For the unscrupulous and unreflective doctor, life can be sweet. For the more thoughtful ones, knowingly practising ethically dubious medicine can be emotionally distressing.

The Hippocratic oath was written at a time when doctors were not the trusted professionals they are today. Medicine was unregulated, and charlatans abounded. Such was the potential for abuse that the author of the oath stressed the need for moral and professional integrity: "In a pure and holy way, I will guard my life and my art and my science." For private doctors of the 21st century, the public's trust in the profession, external pressure from third parties, the social power of some patients, relative isolation from colleagues, and the temptations of money, fame, and luxury combine to create barriers to good practice. These barriers are not, I think, insurmountable, but they must firstly be recognised. Education at undergraduate and postgraduate level about the challenges of caring for powerful patients, of mixed agency, and of self interest may go some way towards revealing the barriers. Yet no amount of education and no code of practice will resolve all the ethical problems. When the moment of truth comes, only individual doctors can decide whether to choose their art, their ego, or their pocket.

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