

# Inserting microethics into paediatric clinical care: A consideration of the models of the doctor-patient relationship

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Microethics is about the ethics of everyday clinical practice. The subtle nuances in communication between doctor and patient (the doctor's choice of words, tone, body language, gestures, etc.) can influence the exercise of the patient's autonomy. The four models of the doctor-patient/physician-patient relationship (paternalistic, informative, interpretive, deliberative) weigh respect for autonomy and beneficence in varying proportions. Each model may be appropriate in certain circumstances. This article considers these models from the perspective of microethics and the unique dimensions created by the doctor-child-parent relationship. In particular, the article considers the nuances to the autonomy principle created by the child's developing maturity and the parent's role as a co-fiduciary of the child's interests. Ultimately, the deliberative model seems most appropriate to the paediatric setting, since it accommodates the child's developing maturity in making healthcare-related decisions. This model infuses care into the doctor's communication with the child and parent.

*S Afr J Bioethics Law* 2023;16(2):e515. <https://doi.org/10.7196/SAJBL.2023.v16i2.515>

The goal of the doctor-patient (physician-patient) relationship is for the doctor to act in the best interests of the patient. As a fiduciary, the doctor acts for the patient's benefit and not his/her own.<sup>[1]</sup> Western medical tradition was largely paternalistic up until the 18th century – the patient was obedient to the doctor.<sup>[2]</sup> Respect for the patient's autonomy is now considered a pivotal pillar of medical ethics, and imposes a correlative legal duty on the doctor to ensure that no treatment or surgical decision is taken without the patient's informed consent.<sup>[3,4]</sup> The essence of the doctor's ethical duty to the patient is to act in his/her best interests. This is well entrenched in ethical codes and principles<sup>[5-7]</sup> and as a legal imperative.<sup>[8]</sup>

In the paediatric clinical setting, the doctor and parent are co-fiduciaries of the child's interests. The parent is the child's fiduciary in all matters. However, as a lay person, the parent does not have medical knowledge. As the co-fiduciary with expertise in health-related matters, the doctor acts to protect the life and health of the child.<sup>[9]</sup> The child's diminished capacity reinforces the doctor's ethical duty to promote his/her best interests. The parent should not compel or expect the doctor to act in a manner that negatively infringes professional integrity.<sup>[9]</sup>

Microethics, or the ethics of everyday clinical practice,<sup>[10]</sup> is still fairly new to ethical discourse and has not been considered in the South African (SA) paediatric clinical context. This article aims to remedy this by contributing to the scholarship on the models of doctor-patient relationship as considered from a microethics perspective. Importantly, the article focuses on this relationship within the paediatric clinical context, and asserts that the age and stage of development of the child create important nuances in the relationship. Ultimately, microethics plays a pivotal role in shaping this relationship and ensures that the child's best interests are given paramount consideration.

## What is microethics?

Komesaroff<sup>[11]</sup> famously surmised that ethics is what happens in every interaction between every doctor and every patient. Microethics is 'the view from the inside.' In contrast, traditional medical ethics is 'the view from the outside' since it is generalisable and can be considered in the same manner in every situation.<sup>[10]</sup> For instance, the four principles framework is well-known and frequently used by clinicians to analyse ethical dilemmas.<sup>[12]</sup> The principles (respect for autonomy, beneficence, non-maleficence and justice) are the foundation of a doctor's fiduciary duty to a patient. The advantage of considering ethical dilemmas from an 'outside' vantage point allows for consistency across similar cases, whereas the 'inside' approach shows how the relationship between doctor and patient can shade the ethical issue.

Truog *et al.*<sup>[10]</sup> suggest that the case-base method of teaching ethics at medical school relies on 'extreme or unusual situations,' creating the perception that ethics is only relevant in special instances, such as in 'headline-grabbing' end-of-life decisions.<sup>[13]</sup> Microethics, on the other hand, is a relatively new term and views ethical decision-making as a continuous science and not a separate or special event.<sup>[14]</sup> It is conscious of the subtle nuances in the communication between doctor and patient and how these impact medical decision-making. For instance, the choice of words used by the doctor (including what is withheld), making or avoiding eye contact, responding to patient concerns about treatment and general body language can all influence decision-making in subtle ways.<sup>[10]</sup> Truog *et al.*<sup>[10]</sup> suggest that too often it is assumed that patients have clearly defined preferences and values in exercising their autonomy. If a patient is unsure of his/her values, decision-making becomes difficult no matter how well informed (s)he is. Microethics can be considered in three

ways: 'the ethics of respecting – and constructing – patient values and preferences'; 'self-awareness and management of clinicians' values and biases'; and 'managing medical information'.<sup>(10,13)</sup> These three aspects have a direct bearing on the doctor-patient relationship.

When treating a child, a doctor forms a relationship with two entities – the child and his/her parent/guardian. The doctor should be aware of his/her ability to influence or manipulate the exercise of patient autonomy. If the patient and parent do not have a set of preferences and values to guide the medical decision-making, the doctor is able to influence the construction of such values and preferences directly or tacitly. The choice of words used by the doctor as well as the tone and non-verbal cues 'can affect the family's understanding'<sup>(15)</sup> of the child's medical condition and the interventions required. This does not mean that a doctor should be value-neutral, but rather transparent about his/her biases.<sup>(10)</sup> Such biases may be influenced by past experiences and patient encounters. Such experiences may also impact how the doctor chooses to manage medical information conveyed to the patient. The choice of words used matters, especially since it may have the persuasive pull to evoke a particular response from the patient. For instance, should a patient be fully informed of every risk associated with a treatment or intervention, however slight, or 'can less be more?'<sup>(10)</sup> In the paediatric context, the doctor must be mindful of the age and developing capacities of the child in how such information is conveyed. The child should have an opportunity to express his/her view, and such view should be taken into consideration by the doctor.<sup>(4)</sup> The child is an active participant in this process, especially if his/her age and stage of development statutorily require consent for medical treatment or surgical operations.<sup>(4)</sup> The child does not have the requisite capacity to act in all instances, and requires the assistance of a parent. The child is emotionally, psychologically, physically and financially dependent on the parent or guardian. This means that the doctor must include the child and parent in consultations and decision-making pertaining to the child's health. This creates a unique triangular relationship between the doctor, child and parent.

### The models of the doctor-patient relationship in the paediatric clinical context

This triangular relationship can be understood within the four broad models categorising the doctor-patient relationship developed by ethicists Emanuel and Emanuel.<sup>(16)</sup> Each model weighs autonomy and beneficence in varying proportions. This has a bearing on its suitability to the paediatric context. While all four models are not directly suitable to the child health context, since little provision is made for the child's developing capacity and the parent's fiduciary role, certain characteristics of each provide a useful starting point for understanding the microethical dimensions of the relationship. The Emanuels posit that each model has its own merit, and each may be appropriate to particular clinical circumstances.<sup>(16)</sup> The models have particular value to the paediatric clinical context if one considers the age and developing capacity of the child.

Paternalism or the paternalistic model is based on the idea that 'the doctor knows best'. The patient's wellbeing trumps autonomy and choice. The doctor is the patient's guardian and always acts in his/her best interests. Due to this dynamic, there is no deliberation or discussion between the doctor and patient about which intervention

should be followed.<sup>(2)</sup> The doctor is active in decision-making and the patient takes on a passive role.<sup>(2)</sup> Paternalistic conduct in its most extreme form would be when a doctor acts without obtaining patient consent.<sup>(17)</sup> In most cases, it may mean that the patient is excluded from the deliberation process and is only consulted when consent is required for the intervention to proceed. The doctor expects his/her decision to be complied with since (s)he is providing the patient with the best treatment available, and always places the patient's interests above his/her own.<sup>(2)</sup>

Of course, there are limitations to such a model. The limited patient participation is a problematic aspect. Furthermore, this model incorrectly assumes that the patient does not have an understanding of his/her health-related values, or if (s)he is aware of such values, shares the same values as the doctor.<sup>(16)</sup> This model is not tenable in a culture of human rights where patient autonomy is legislatively protected.<sup>(3,4,8)</sup> However, it may still have relevance in limited circumstances. For instance, in emergency situations when time is of the essence, delays in obtaining patient consent could result in irreversible harm to the patient. In such an instance, paternalistic conduct is justified since beneficence and the need to prevent further harm means acting even at the expense of the patient's autonomy.

Aoun *et al.*<sup>(2)</sup> suggest that paternalism is still prevalent in the treatment of children and other legally incapacitated individuals. This could mean that the child's developing agency is ignored by both the doctor and parent, or that the child's and parent's autonomy are disregarded by the doctor. The extent of the child's ability to participate, and the correlative parental involvement, depends on the child's age and stage of development.<sup>(18)</sup> Paternalism may be justified in instances when the child is unable to, is of insufficient maturity or is too young to express a view and the parent's consent cannot be obtained, or the parent withholds consent. In such an instance, beneficence trumps autonomy. The Children's Act No. 38 of 2005<sup>(4)</sup> provides for such situations, and requires the doctor to obtain consent from the hospital superintendent for the treatment or surgical procedure, and where appropriate to obtain consent from the Minister of Health. However, paternalism need not take such extreme forms. It becomes unclear whether the child or parent is truly acting with autonomy if the doctor's expressed or implicit bias tilts the decision-making in a particular direction. From a microethics perspective, the doctor's manner of speaking, tone, inflection, words used, body language and eye contact can all contribute to influencing the child and parent.

On the other end of the spectrum is the informative model. In terms of this model, the doctor informs the patient of all the medical options available, and the patient chooses the preferred option. A distinction is drawn between facts and values. The patient's fixed value system informs the decision taken. The patient, however, lacks the medical facts. The doctor, on the other hand, does not impose his or her value system on the patient, but merely relays and explains the medical facts. This model is the least practical to the paediatric clinical context since it assumes complete autonomy and maturity on the part of the patient. It does not accommodate the child's developing autonomy, in which self-reflection and changes to his or her value system are expected.<sup>(2)</sup> Even from the perspective of the parent, the model is too rigid to accommodate the nuances of a diverse society such as SA, where differences in language, culture, race, gender and ethnicity between the doctor and the child (and the child's family)

could create communication challenges.<sup>[13]</sup> This in turn impacts the level of understanding between doctor and parent.

The interpretive model appears to balance the paternalistic and informative models. In this model, the doctor provides the patient with all the required information to make an informed decision. Instead of dictating the required path to be taken, the doctor assists the patient to determine and interpret his or her values in order to make a decision about the options available. The doctor helps the patient to understand him- or herself and his/her identity by considering the patient's entire life experience.<sup>[2]</sup> This means that the doctor does not make a decision for the patient, but helps him/her to determine what is important to him/her.<sup>[16]</sup> In terms of this model, the patient's values are not fixed, and may not be known to the patient. The doctor acts as a counsellor and plays an advisory role. Communication is therefore key in managing patient expectations and creating a level of understanding between the doctor and patient. In addition, patient autonomy is about self-understanding. Given the level of understanding and maturity required, this model is not well suited for the treatment of the young child. It may be suited for the adolescent clinical context, since the child is likely to be at a level of maturity to understand and respond to the information conveyed by the doctor. However, the model does not accommodate the developing maturity of the child and his/her need for guidance. The interpretive model is best suited to the adult patient context. In any event, if the child lacks capacity and is not of statutory age to consent to treatment or surgical intervention, the parent acts on his/her behalf. The doctor should be particularly mindful of his/her influence in terms of demeanour, action and words. Aoun *et al.*<sup>[2]</sup> caution against the doctor, limited in time and skills, involuntarily imposing a preference on the patient instead of trying to understand the patient's values. In the paediatric context, this may translate into the doctor hastily suggesting treatment options and not properly consulting with the child and parents. This seems likely in a context such as SA, where healthcare professionals are faced with resource limitations and heavy patient loads.<sup>[19]</sup> As with the concerns expressed with the informative model, the communication challenges and possible power dynamics between doctor, child and parent may create an atmosphere ripe for the doctor's influence.

Based on the aforementioned, it would appear that the model best suited to the paediatric context is the deliberative model. The doctor acts as a teacher or friend, and suggests a course of action, aiming to convince the patient of such course, based on what is known about the patient and his or her medical condition. The patient ultimately decides on the course to be taken. Patient autonomy in this model is tantamount to moral self-development.<sup>[16]</sup> While the doctor takes an active role in the deliberation, it is the patient who makes the ultimate decision. The doctor is focused on persuading the patient of a course of action rather than imposing it against the patient's will.<sup>[16]</sup>

Given the doctor's expertise in matters relating to health and wellbeing, Aoun *et al.*<sup>[2]</sup> argue that the doctor is entitled to convince the patient of an intervention or course of action that is in the patient's best interests. This paternalistic-type conduct is cushioned by open communication and deliberation between doctor and patient on the patient's core values and the proposed intervention, with the ultimate decision left to the patient. Emanuel and Emanuel<sup>[16]</sup> postulate that the deliberative model is the ideal model. They argue that it is not a 'disguised form of paternalism' but rather

embodies their 'ideal of autonomy' in that the deliberation process (critically assessing one's values and preferences) is essential to realising patient autonomy.<sup>[16]</sup> Others have justified this position by contending that the deliberative model incorporates a beneficent or caring attitude.<sup>[2,17]</sup> Ahuja,<sup>[17]</sup> in particular, believes that this caring attitude can reduce clinician bias and ultimately improve patient care. While it can be argued that all four models incorporate beneficence, the deliberative model finds the delicate balance between respecting autonomy while doing the most good for the patient.

In a paediatric setting, the deliberative model would be ideal for the treatment of young children and adolescents since it accommodates the moral self-development of the patient, a concept easily understood from a developing child perspective. It also imbibes the necessary cushioning needed in a paediatric healthcare context to allow for the child to participate in decision-making while providing a 'soft landing' – the doctor acts with care and concern in trying to persuade the patient and/or parent of the reasonable course of action. Kling and Kruger<sup>[18]</sup> argue that a trusting relationship should be fostered between the doctor, child and parent, allowing for deliberation, communication and the flow of information. This is especially important in the adolescent healthcare setting.<sup>[18]</sup> Indeed, from a microethics perspective, it is this infusion of care that sets this model apart. This caring attitude should be evident in the doctor's mannerisms, words, intentions and general engagement with the child and parent. Open communication is essential to avoid misunderstandings and manage expectations. In this way, the doctor is mindful of preventing his or her own biases and preferences inadvertently influencing the child's (and parent's) autonomy while conveying information at a level at which the child can understand.

This model, which requires the doctor to have time to deliberate and discuss options with the patient, seems misplaced in a healthcare setting such as SA, which suffers from resource shortages and is generally overburdened. Harried healthcare professionals may not have the luxury of time. It is accepted that the analysis undertaken in this article does not respond directly to these constraints. However, the microethics of clinical practice, even in such a setting, would ensure that the doctor carefully balances the principles of autonomy and beneficence in the treatment of the child. Ballot *et al.*<sup>[19]</sup> have argued that the ethics of care and the principle of *ubuntu* are more appropriate to a resource-stricken healthcare environment. The analysis in this article resonates with that conclusion.

## Conclusion

While respect for autonomy, beneficence, non-maleficence and justice are entrenched principles of medical ethics, a consideration of microethics sheds light on the ethics of the everyday contact between doctor and patient. This relationship between doctor and patient has distinct nuances in the paediatric context given the role of the parent as a co-fiduciary of the child's interests and the child's relative agency in the health context. The deliberative model seems best suited to the paediatric clinical context since it can be applied to the care of young and adolescent children. Importantly, it introduces a caring attitude into the relationship between doctor, child and parent. In its most ideal state, the deliberative model includes a built-in understanding of the doctor as a co-fiduciary of the child's interests along with a healthy respect for the child's autonomy, ultimately working towards promoting the child's best interests. Further empirical research in the

SA context could consider the impact of this model in a resource-limited paediatric healthcare context.

**Declaration.** None.

**Acknowledgements.** None.

**Author contributions.** Sole author.

**Funding.** None.

**Conflicts of interest.** None.

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Accepted 20 June 2023.