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What are the ethical conflicts faced by Mexican internists?

Octavio Márquez Mendoza[1], José de Jesús Garduño García[2], Marcela Veytia López[1], Jorge Rodríguez García[3], Rosalía García Peña[2] and Benjamin Herreros[4]

Abstract

Background: No studies have been conducted in Mexico to ascertain what ethical problems doctors working at hospitals deal with. This article aims to describe the ethical conflicts most commonly identified by Mexican internists and the importance they attribute to each of these conflicts.

Methods: Voluntary survey to the members of the Internal Medicine Association of Mexico.

Results: Responses were submitted by 347 internists. Half of those face ethical conflicts almost always or frequently. The most commonplace and relevant conflicts are those resulting from the clinical relationship (communication, confidentiality, informed consent, assessment of mental capacity, decisions involving incapacitated patients, and conflicts with family members), and secondly those problems related with the end of life (palliative care, withholding or withdrawing treatment, and "No CPR orders"). To resolve conflicts they seek support through protocols, Institutional Ethics Committees (IECs), and consultations with colleagues and, occasionally, with bioethics experts. Protocols and IECs are the tools most in demand among them.

Conclusions: 1) the most frequent and relevant conflicts are those caused by the clinical relationship, above all those due to doctor–patient communication, and secondly those due to problems which arise at the end of life; 2) though nearly all of them have doubts about how to resolve conflicts, the vast majority are satisfied with the way in which they do so; 3) to deal with conflicts, they seek support mainly in protocols, IECs, and consultation with colleagues; and 4) in order to resolve them better, what they most demand are protocols and IECs, but also bioethics consultants.

Keywords

Bioethics, Clinical ethics, Ethical conflicts, End-of-life issues, Cultural pluralism, Behavioral research

Introduction

Ethical problems are very frequent in clinical practice.[1,2] These difficulties inherent to clinical practice have an especially negative effect on internists, because they are responsible for reaching decisions about critically ill patients at the end of life, and in complex decision-making environments.[3,4] According to studies completed in different environments, the most frequent ethical conflicts encountered by internists arise when dealing with the end of life,[2,4] especially with regard to withholding or withdrawing treatment and invasive interventions, specifically in terms of determining no cardiopulmonary resuscitation ("No CPR") orders and handling patients' palliative care. Another significant set is those ethical problems resulting from the clinical relationship,[5,6] above all with regard to communication and handling information (i.e. the truth, how much information to provide, conflicts with family and friends, confidentiality, etc.), though they also arise when having to reach decisions involving patients with impaired mental capacity. Along with these two sets of problems

[1]Instituto de Estudios Superiores, Universidad Autónoma del Estado de México, Toluca, México, Mexico
[2]Facultad de Medicina, Universidad Autónoma del Estado de Méxicvao, Toluca, México, Mexico
[3]Hospital Regional de Alta Especialidad de Ciudad Victoria, Ciudad Victoria, Tamaulipas, Mexico
[4]Instituto de Ética Clínica Francisco Vallés, Universidad Europea de Madrid Campus de Villaviciosa de Odón, Madrid, Spain

Corresponding author:
Benjamin Herreros, Instituto de Ética Clínica Francisco Vallés, Universidad Europea de Madrid Campus de Villaviciosa de Odón, Madrid, Spain.
Email: benjaminherreros@gmail.com

(the end of life and the clinical relationship), ethical problems in internal medicine have also frequently been described in relation with the patients' rejection of diagnostic or therapeutic interventions,[7] with broad-ranging examples of causes leading to ethical problems:[8–10] conscientious objection, the distribution of scarce resources, abuse, trouble among co-workers or with hierarchical superiors, conflicts with third parties, cultural problems, and so on.

It is essential to ascertain what ethical problems are dealt with by doctors, because by doing so strategies can be determined to prevent them, to improve the ways in which they are handled, and to reach better decisions, all of which can improve the quality of health care and ethics at institutions.[11,12] However, up to the current time no studies have been conducted in Mexico to discover what ethical problems are faced by the doctors who work at hospitals, and more specifically, by internists. Because of this, we propose a study with the main objective of describing the ethical conflicts most often identified by Mexican internists and the importance which they attribute to each conflict type. The secondary objectives are to discover whether internists are satisfied with the way in which conflicts are resolved, learn how they resolve them, and find out what tools are most in demand among them in order to resolve conflicts better.

Methods

Study design

A cross-sectional observational study by way of a voluntary, anonymous survey intended for Mexican internist physicians. In order to conduct the study, the survey designed by Blanco *et al*. was used.[13] This survey was designed to identify the ethical problems faced by internists in Spain (Appendix 1). To conduct the survey, the authors reviewed surveys given in the past to detect the ethical problems faced by clinical physicians and, more specifically, by internists. The decision was reached to use the questionnaire by Blanco *et al*., because of the high quality of the survey (it is based on a broad bibliographic search; a pre-test was performed in advance), the extensive list of problems it brings up (19 in all), and because it is the most recent questionnaire found. To use the survey, permission was requested from the survey's authors.

Questionnaire and variables

A multidisciplinary team of internists, bioethics specialists, and experts on research methods created the Blanco *et al*. questionnaire. Two literature searches were conducted in order to develop it. The first was intended to determine the main ethical conflicts described by internists. The second was on questionnaires used to explore the presence of these conflicts. The form was made in accordance with the results of these searches. The questions were adapted to our setting as described in the section titled "Variables." A trial test was administered to ten internists and ten internal medicine residents. This allowed us to evaluate their understanding of the questionnaire and improve the way the questions were worded.

The questionnaire asks about 19 ethical conflicts which may arise in the clinical practice of internists, to be scored on a scale of 0 to 5: 1) the frequency with which doctors identify the ethical conflicts and 2) the importance (relevance) which they attribute to each conflict in their everyday clinical practice. In addition to this, the questionnaire uses a Likert scale (1–4, based on the level of agreement) to explore whether the ethical problems are frequent in clinical practice and the degree of difficulty which they produce. The survey-takers are also asked about their degree of satisfaction in terms of resolving conflicts (0 meaning no satisfaction and 5 meaning full satisfaction), in what way they resolve conflicts and what tools are in demand among them in order to resolve conflicts better. Demographic variables (age and gender) are also included, as well as the number of years worked, the position they hold within their institution, the field of professional activity, and training on bioethics and hospital type.

The survey was completed through the Internal Medicine Association of Mexico. An email message was sent to the Association's members on September 1, 2018 with an explanation of the project. The email specified that the survey was anonymous and voluntary. A second email was sent 15 days later as a reminder to submit the survey. The questionnaire could be submitted using a link which provided access to a Google form. When the survey-takers completed the survey, the data were stored directly on a spreadsheet, which was then recoded in SPSS to make it possible to perform the later analysis.

Ethical aspects

The study is compliant with the ethical rules and research standards stated in the Helsinki Declaration of the World Medical Association and the Oviedo Convention, on human rights and biomedicine. Before completion, the study was approved by the Mexican Society of Internal Medicine, the institution that assessed the ethical aspects of the study.

Results

The statistical analysis was performed with the program SPSS v14 for Windows. The descriptive analysis was carried out using averages, medians and standard deviations for continuous variables. Prevalences were stated in the form of percentages. The Kolmogorov-Smirnov test (KS) was performed to define normality. The difference between two sets of continuous variables was calculated

with or Mann Whitney's u-test. The difference between qualitative variables was calculated using the chi-squared test

The questionnaire was sent to 548 internist physicians, with 347 responses (63.3%) from 31 of the country's states. The characteristics of the survey-takers can be found in Table 1. Of the survey-takers, 90% have had some sort of training on bioethics, above all through personal study (47%). Regarding the occurrence of ethical conflicts in their health care activity, half of the respondents (49.3%) frequently or almost always encounter ethical conflicts in their health care work, whereas 50.7% encounter them infrequently or almost never do. As for satisfaction with the ethical conflict resolution, the vast majority (92.2%) resolve them satisfactorily either frequently (40.2%) or almost always (52%). The average degree of satisfaction with conflict resolution is 4.04 (SD $\pm$ 0.85) out of 5 (0: no satisfaction and 5: full satisfaction).

Table 1. Survey-taker characteristics.

Variable	n (%) or average (SD)
Age (mean)	48 (37-59)
Years of medical practice (mean)	19 (8-30)
Gender	
Male (%)	233 (67)
Female (%)	113 (33)
Nationality	
Mexican (%)	342 (99)
Other (%)	4 (1)
Employment status	
Service/section chief (%)	66 (19.1)
Staff doctor (%)	250 (72.3)
Resident (%)	8 (2.3)
Other (management, research, and university) (%)	22 (6.4)
Hospital type	
Public (%)	192 (55.5)
Other (%)	154 (45.5)
Hospital size	
<200 beds (%)	57 (16.5)
201–500 beds (%)	60 (17.3)
501–1000 beds (%)	78 (22.5)
>1000 beds (%)	151 (43.6)
Health care activity	
Hospitalization (%)	285 (82.4)
Outpatient visits (%)	254 (73.4)
Emergency care (%)	77 (22.3)
Other (%)	24 (6.9)
Bioethics training	
None (%)	33 (10)
Personal study (%)	164 (47)
University (%)	131 (38)
Graduate courses (%)	104 (30)
Master's degree (%)	22 (6)

By relating the frequency of ethical conflicts in health care work with the difficulty caused by ethical conflicts, all (100%) of those who almost never encounter ethical conflicts respond that these conflicts almost never create difficulty for them in their health care work, whereas half (50.3%) of those who almost always encounter conflicts say that such difficulty is frequently or almost always created in their health care work (Table 2).

Table 3 shows the results related with the main study objective: the most frequent ethical conflicts and those most important to Mexican internists. The most frequent are those resulting from the clinical relationship (communication, confidentiality, informed consent, assessing mental capacity, reaching decisions about incapacitated patients, and conflicts with family members), and the second most frequent is the set of problems related with the end of life (palliative care, withholding or withdrawing treatment and invasive interventions, and No CPR orders). The only conflict which does not belong to these two groups among the top ten is the rejection of diagnostic or therapeutic procedures. As for their importance (relevance), there is a certain symmetry, but it must be highlighted that withholding or withdrawing treatment and invasive interventions is the second most important, and that No CPR orders, a subtype of that set, is the fourth in importance.

61.6% have access to Institutional Ethics Committees (IECs), 29.5% do not have access, and 8.9% do not know whether they do. Table 4 shows how the survey-takers resolve ethical conflicts, and Figure 1 shows what supporting tools are in demand among them.

Table 2. Frequency and difficulty of ethical conflicts.

Occurrence of ethical conflicts in health care activity; n (%)	Ethical conflicts cause difficulties in health care activity	(%)
Almost never: 32 (9.2) →	**Almost never**	32 (100)
	Infrequently	0
	Frequently	0
	Almost always	0
Infrequently 144 (41.6) →	Almost never	51 (35.4)
	Infrequently	83 (57.6)
	Frequently	9 (6.3)
	Almost always	1 (0.7)
Frequently: 148 (42.8) →	Almost never	18 (12.1)
	Infrequently	92 (62.2)
	Frequently	38 (25.7)
	Almost always	0
Almost always: 22 (6.4) →	Almost never	3 (13.6)
	Infrequently	6 (27.3)
	Frequently	9 (41)
	Almost always	4 (18.2)

Table 3. Average rating of frequency and importance of ethical conflicts (between parentheses is the ranking compared with all others).

Ethical conflict	Frequency	Importance (relevance)
Doctor–patient communication	4.47 (1)	3.61 (1)
Privacy and confidentiality of patient data.	4.38 (2)	3.26 (3)
Palliative treatment (including terminal sedation)	4.17 (3)	3.06 (8)
Informed consent	4.17 (4)	3.20 (5)
Evaluation of the patients' capacity to reach decisions	4.15 (5)	3.07 (7)
Limitation of therapeutic efforts with patients in poor clinical condition	4,10 (6)	3.30 (2)
No cardiopulmonary Resuscitation orders	4.08 (7)	3.20 (4)
Reaching decisions for patients mentally unable to decide	4,02 (8)	2.90 (10)
Rejection of diagnostic or therapeutic procedures	3.99 (9)	3.02 (9)
Conflicts with patients' family members	3.92 (10)	3.13 (6)
Abuse (domestic violence or other abuse) of the patient	3.91 (11)	2.22 (16)
Advance directives or living will of patient	3.82 (12)	2.31 (13)
Conflict with patients' religious or cultural values	3.81 (13)	2.77 (11)
Vital risk to the doctor	3.75 (14)	2.23 (15)
Distribution of scare and/or very expensive health care resources	3.44 (15)	2.37 (14)
Conflicts with hierarchical superiors or subordinates	3.24 (16)	2.60 (12)
Conflicts with work colleagues	3.24 (17)	2.21 (17)
Conflicts of interest with third parties	2.65 (18)	1.74 (19)
Giving preferential treatment to certain patients	2.17 (19)	1.95 (18)

Table 4. Internists' manner of resolving ethical conflicts.

Manner of resolving doubts	N (%)
Using protocols	99 (28.6)
Consulting an IEC (†)	80 (23.1)
Consulting with colleagues	77 (22.3)
On their own/alone	54 (15.6)
Consulting a bioethics expert	24 (7)
Does not know how to resolve them	7 (2)
Has no questions/doubts	5 (1.4)

(†) IEC: Institutional Ethical Committees.

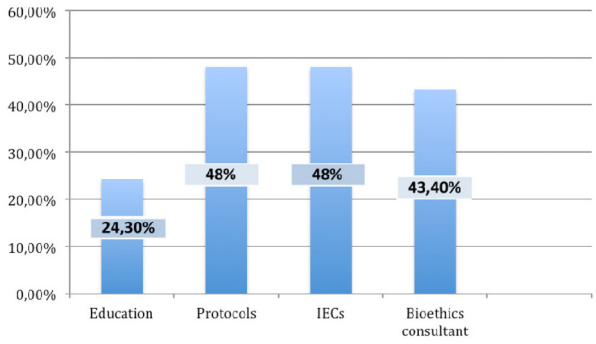

Figure 1. Preferred tools for seeking help with ethical conflicts.
* The sum of these percentages is greater than 100%, because survey-takers could provide more than one response.
** IECs: Institutional Ethical Committees.

Discussion

The study is an unprecedented snapshot of the ethical conflicts encountered by internists in Mexico. Half of the broad study sample (347 internists from 31 states, in general with clinical experience in both public and private medicine) point out that they face ethical conflicts almost always or frequently in their clinical practice. The most frequent ethical conflicts are those resulting from the clinical relationship (communication, confidentiality, informed consent, assessing physical/mental capacity, reaching decisions about incapacitated patients, and conflicts with family members), and the second most frequently the ethical problems related with the end of life (palliative care, withholding or withdrawing treatment and invasive interventions, and No CPR orders). In terms of their importance (relevance), there are certain parallels, and the problems which arise in the clinical relationship are also the most relevant. More specifically, the conflicts related with doctor–patient communication are the most frequent and most relevant. The second in terms of relevance are problems at the end of life, highlighting that the withdrawal of treatment and invasive interventions rank second, and that No CPR orders, a subset of the aforementioned group, is ranked fourth.

Given the tasks of internists, who usually deal with very complex patients often enduring end-of-life situations,[14] it is understandable that the main ethical problems for them are caused by the clinical relationship and the end of life. These data partially coincide with the data observed in other studies, though in Europe and the United States, ethical problems at the end of life, above all those related with withholding and withdrawing treatment and invasive interventions, tend to be most frequent.[2,4,6,13] How can this difference be explained? On the one hand, because life expectancy is higher in the United States and even more so in Europe,[15] ethical problems involving patients of higher ages near the end of life may arise more often. One must not fail to note the fact that, in Mexico, the technological equipment for dealing with the end of life is less commonplace than in Europe and the United States,[16] and many ethical conflicts arise from the use of technology at the end of life. Another hypothesis is that Mexico's special relationship with death may bear some

relationship.[17,18] In Mexico, death is lived in a more natural manner[19] than in other countries. In Europe and the United States, there are many taboos surrounding death,[20] greater difficulty in accepting it, and perhaps in coming to terms with it.[21] All of this may mean that dealing with death creates less conflicts in Mexico, though this is nothing more than a hypothesis. In order to explain this divergence, it would be advisable to perform a qualitative study with focus groups of patients and doctors originating in Mexico, Europe and the United States.

In Mexico, there are no descriptive studies about the ethical problems faced by clinics. In a qualitative study completed in Mexico, 421 ethical dilemmas were encountered with geriatric patients. The values encountered most frequently were classified into three sets (impact of the health care system, role of the doctor, and rejection of therapy), and the values found most frequently were the role of the health care educator, caring for the life of patients, and the imminent risk of death.[12] These are values related to the clinical relationship and the end of life, with treatment rejection appearing, as well. In our study, the only conflict that is listed among the top ten but which does not belong to the two aforementioned sets (clinical relationship and the end of life) is the rejection of diagnostic or therapeutic procedures. The rejection of procedures is a widely studied ethical conflict, and though it may arise in all fields of medicine (rejection of vaccines and rejection of a therapeutic surgery),[7] it also arises at the end of life[22] and is related with problems in the clinical relationship.[23] Rejection is frequently caused by poor communication or occurs among patients who do not have the proper mental capacity to reach decisions. One must not forget that treatment rejection leads to difficulties with informed consent and may alter the clinical relationship; one example may arise when a doctor does not accept reasoned arguments stated for rejecting a treatment.

Most of the internists surveyed have training in bioethics, mostly through personal study, and the vast majority are satisfied with the way in which they resolve ethical conflicts. Nevertheless, nearly all internists have doubts about the way to resolve conflicts. In terms of the ways in which they do so, over half have an IEC at their institution, but of these only 31.7% use it. This low use of IECs has also been found in other countries[24] and has led to the advent of other supporting tools to resolve ethical conflicts. This is reflected in our study, in which we found commonplace methods for dealing with ethical conflicts to include established protocols (the main form of support used), consultation with colleagues, and a small percentage who consult with bioethics experts. Protocols and IECs are the methods in greatest demand to deal with ethical conflicts better, though the figure of the bioethics consultant is also mentioned. In Mexico, this figure has undergone little development, whereas in the United States and Europe it is increasingly common.[25] In order to improve the way in which ethical conflicts are handled in Mexico, it may be helpful to train professionals on ethical consultation, a concept which is compatible with the existence of IECs.

In terms of the implications for clinical practice, given the importance of ethical problems among Mexican internists (half of them face ethical conflicts almost always or frequently), the way in which they are dealt with and solved requires improvement. This survey also reveals which problems should be prioritized when designing training programs and decision-supporting tools: those resulting from the clinical relationship and related with the end of life. To improve the way these problems are handled in clinical practice, internists must include a record of patients' ethical values in the clinical record (CR). In other words, what values are at stake in each case and what are the priorities of the patients (and their family, when necessary)? To improve the handling of ethical problems in clinical practice, they must be dealt with on a daily basis, and the best way to do this is to include a record of the patients' ethical values within the CR, bearing in mind that internists must place the greatest emphasis on those problems related with the clinical relationship and the end of life.

Limitations

To be mentioned as limitations on the study are the fact that it is a voluntary study which was not random, which may lead to a selection bias (the internists who respond may be more sensitive to the survey topic). At the same time, because it is a survey given to Mexican internists, the data may not be extrapolated to other locations. However, it must be pointed out that the sample is very broad when compared with other studies, and that it was given to internists with clinical experience throughout the entire country, thus lending credibility to the data obtained and making it possible to draw useful conclusions for Mexico.

Conclusions

Conclusions which may be stated from the study are that the most frequent conflicts among Mexican internists and most relevant to them are those resulting from the clinical relationship, above all due to doctor–patient communication. Ranked second are the problems which arise at the end of life. Though nearly all internists have their doubts about how to resolve ethical conflicts, the vast majority are satisfied with the way in which they are resolved. In order to resolve these conflicts, they seek support (in this order) in protocols, IECs (less than one-third), and consultations with colleagues and, occasionally, with bioethics experts. In order to find better solutions to conflicts, they demand protocols and IECs, as well as the figure of a bioethics consultant. An additional conclusion would be to point out that the study data may be useful for planning training on bioethics among Mexican internists, and for the optimization

of tools for support in the event of ethical conflicts, as well as stressing the importance of including a record of the patients' ethical values within the CR. If there is greater awareness about problems, they can be dealt with better, especially if doctors are given the tools they need.

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ORCID iD

Benjamin Herreros https://orcid.org/0000-0001-6708-7102

Supplemental material

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