

12 - 12 Ethical Issues in Clinical Medicine

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Treatment and with more recent articles that have confirmed their persistence and explored their root causes. Furthermore, another influential IOM report, *Crossing the Quality Chasm*, has highlighted the importance of equity—i.e., no variations in quality of care due to personal characteristics, including race and ethnicity—as a central principle of quality. Current efforts in health care reform and transformation, including a greater focus on value (high-quality care and cost control), will sharpen the nation's focus on the care of populations who experience low-quality, costly care. Addressing disparities will become a major focus, and there will be many obvious opportunities for interventions to eliminate them. Greater attention to addressing the root causes of disparities will improve the care provided to all patients, not just those who belong to racial and ethnic minorities.

PART 1 The Profession of Medicine ■ ■ FURTHER READING Buchmueller TC et al: The ACA's impact on racial and ethnic disparities in health insurance coverage and access to care. *Health Aff (Millwood)* 39:395, 2020. Dwyer-Lindgren L et al: Inequalities in life expectancy among US counties, 1980 to 2014: Temporal trends and key drivers. *JAMA Intern Med* 177:1003, 2017. Kreuter MW et al: Addressing social needs in health care settings: Evidence, challenges and opportunities for public health. *Annu Rev Public Health* 42:11, 2021. Krieger N: Measures of racism, sexism, heterosexism, and gender binarism for health equity research: From structural injustice to embodied harm: An ecosocial analysis. *Annu Rev Public Health* 41:37, 2020. LaVeist TA et al: The economic burden of racial, ethnic, and educational health inequities in the US. *JAMA* 329:1682, 2023. Medscape: Medscape Lifestyle Report 2016: Bias and burnout. <http://www.medscape.com/features/slideshow/lifestyle/2016/public/overview>. Vyas DA et al: Hidden in plain sight: Reconsidering the use of race correction in clinical algorithms. *N Engl J Med* 383:874, 2020. Williams DR et al: Racism and health: Evidence and needed research. *Annu Rev Public Health* 40:105, 2019. Christine Grady, Bernard Lo

Ethical Issues in Clinical Medicine Physicians face both enduring and novel ethical dilemmas that can be perplexing and emotionally draining and can sometimes lead to moral distress. For example, physicians may worry about the intensity of care that is appropriate at the end of life,

how to distribute time between critically ill patients, or their responsibilities for patients with limited access to needed care. Newer technologies such as artificial intelligence promise more coordinated and efficient care, but also raise concerns about confidentiality, the doctor-patient relationship, and accountability. New social and economic developments, such as greater attention to health disparities and the growth of for-profit enterprises, present additional issues. This chapter suggests how physicians can address important vexing ethical issues they encounter in their work. Physicians make ethical judgments about clinical situations every day and should prepare for lifelong learning about ethical issues so they can respond appropriately. Traditional professional codes and ethical principles provide instructive guidance but need to be interpreted and applied to each situation. When facing a challenging ethical issue, physicians may need to reevaluate their basic convictions, tolerate uncertainty, and act in a manner that maintains their integrity.

Physicians

should articulate their concerns and reasoning, listen to and respect the views of others involved in the patient's care, and utilize available resources, including members of the interdisciplinary health care team as well as ethics consultants in some cases. Ethics consultation services or a hospital ethics committee can help to clarify issues and identify strategies for resolution, including improving communication and dealing with strong or conflicting emotions. Through these efforts, physicians can gain deeper insight into the ethical issues they face and reach mutually acceptable resolutions to complex problems.

APPROACHES TO ETHICAL PROBLEMS

Several approaches are useful for addressing ethical issues, including approaches based on ethical principles, virtue ethics, professional oaths, and personal values. Sometimes these various sources of guidance may seem to conflict. In a diverse society, different individuals may turn to different sources of moral guidance. In addition, general moral precepts often need to be interpreted and applied to particular clinical situations.

■ ■ ETHICAL PRINCIPLES

Ethical principles serve as general guidelines to help physicians determine the right thing to do.

Respecting Patients

Physicians should always treat patients with respect, which entails understanding patients' goals, providing information, communicating effectively, obtaining informed and voluntary consent, respecting informed refusals, and protecting confidentiality. Different clinical goals and approaches are often feasible, and interventions can result in both benefit and harm. Individuals differ in how they value health and medical care and weigh the benefits and risks of medical interventions. Generally, physicians should respect patients' values and informed choices. Respect is especially important when patients are responding to experiences of, or concerns about, disrespect and discrimination. Physicians should consider patient confidentiality, professional boundaries, and therapeutic relationships in all spoken and written communications.

GOALS AND TREATMENT DECISIONS

Physicians should provide relevant and accurate information for patients about current clinical circumstances, diagnoses, expected future course, prognosis, treatment options, and uncertainties, and discuss how different options might realize patients' goals of care. Physicians may be tempted to withhold a serious diagnosis, misrepresent it by using ambiguous terms, or limit discussions of prognosis or risks for fear that patients will become anxious or depressed. However, providing honest information about clinical situations promotes patients' autonomy and trust. When sharing bad news with patients, physicians should adjust the pace of disclosure, offer empathy and hope, provide emotional support, and call on other resources such as spiritual care or social work. Some patients may choose not to receive such information or may ask surrogates to make decisions on their behalf, as is common with serious diagnoses in some cultures.

SHARED DECISION-MAKING AND OBTAINING INFORMED CONSENT

Physicians should engage in shared decision-making with patients, whenever appropriate. Physicians promote shared decision-making by informing and educating patients, eliciting and answering their questions, checking that they understand key issues, making recommendations, and helping them to deliberate. Medical jargon, needlessly complicated explanations, or the provision of too much information at once may overwhelm patients. Increasingly, decision aids can help patients play a more active role in decision-making, improve the accuracy of their perception of risk and benefit, and help them clarify their values and goals. Informed consent is more than obtaining signatures on consent forms and involves disclosure of honest and understandable information to promote understanding and choice. Competent, informed patients may refuse recommended interventions and choose among reasonable alternatives. In an emergency, treatment can be given without informed consent if patients cannot give their own consent and delaying treatment while surrogates are contacted would

jeopardize patients' lives or health. People are presumed to want such emergency care unless they have previously indicated otherwise, such as through a portable order for life-sustaining treatment (POLST). Respect for patients does not entitle patients to insist on any care or treatment that they want. Physicians are not obligated to provide interventions that have no physiologic rationale, have already failed, or are contrary to evidence-based practice recommendations or good clinical judgment. Public policies and laws also dictate certain decisions—e.g., allocation of scarce medical resources during public health crises such as the COVID-19 pandemic, use of cadaveric organs for transplantation, and responding to requests for physician aid in dying. CARING FOR PATIENTS WHO LACK DECISION-MAKING CAPACITY

Patients with decision-making capacity can express choices and appreciate their medical situation; the nature, risks, and benefits of proposed care; and the consequences of each alternative. Patient choices should be consistent with their values and not the result of delusions, hallucinations, or misinformation. Physicians should use available and validated assessment tools, resources such as psychiatry or ethics consultation, and clinical judgment to ascertain whether individuals have the capacity to make decisions for themselves. Some patients are unable to make informed decisions because of unconsciousness, advanced dementia, delirium, or other medical conditions that impair cognition. Courts have the legal authority to determine that a patient is legally incompetent, but physicians usually determine when patients lack the capacity to make particular health care decisions and arrange for authorized surrogates to make decisions, without involving the courts. Patients who disagree with recommendations or refuse treatment should not be assumed to lack capacity. Such decisions should be probed, however, to ensure the patient is not deciding based on misunderstandings and has the capacity to make an informed decision. When impairments are fluctuating or reversible, decisions should be postponed if possible and revisited when the patient recovers decisionmaking capacity. Physicians seek an appropriate surrogate for patients who lack decision-making capacity. Patients may designate a health care proxy through a POLST or an advance directive; such choices should be respected (see Chap. 13). For patients who lack decision-making capacity and have not previously designated a health care proxy, family members usually serve as surrogate decision-makers. Statutes in most U.S. states delineate a priority order of relatives to make medical decisions. For unrepresented patients who do not have relatives or friends who can be found and no previously appointed proxy, making decisions presents difficult dilemmas and should follow a fair and careful institutional or legal process. Patients' values, goals, and previously expressed preferences, when known, should guide surrogate decisions. However,

the patient's current best interests may sometimes justify overriding earlier preferences if an intervention is likely to provide significant benefit, previous statements do not fit the situation well, or the patient gave the surrogate leeway in decisions. **MAINTAINING CONFIDENTIALITY** Maintaining confidentiality is essential to respecting patients' autonomy and privacy; it encourages patients to seek treatment and discuss problems candidly. However, confidentiality may be overridden to prevent serious harm to third parties or to the patient. Exceptions to confidentiality are justified when the risk is serious and probable, no less restrictive measures can avert risk, and the adverse effects of overriding confidentiality are minimized and deemed acceptable by society. For example, laws require physicians to report cases of tuberculosis, sexually transmitted infections, elder or child abuse, and domestic violence. **Beneficence or Acting in Patients' Best Interests** The principle of beneficence requires physicians to act for the patient's benefit. Patients typically lack medical expertise, and illness often makes them vulnerable. Patients rely on and trust physicians to treat them with compassion and provide sound recommendations and treatments aimed to promote their well-being. Physicians encourage such trust and have a fiduciary duty to act in the best interests of patients, which should prevail over physicians' self-interest or the interests of third

parties such as hospitals or insurers. A related principle, "first do no harm," obliges physicians to prevent unnecessary harm by recommending interventions that maximize benefit and minimize harm and forbids physicians from providing known ineffective interventions or acting without due care. Although often cited, this precept alone provides limited guidance because many beneficial interventions also pose serious risks.

CHAPTER 12 Physicians often provide care within interdisciplinary teams and rely on consultation with or referral to specialists. Team members and consultants contribute different expertise to the provision of comprehensive, high-quality care for patients. Physicians should collaborate with and respect the contributions of interdisciplinary team members and should initiate and participate in regular communication and planning to avoid diffusion of responsibility and ensure accountability for quality patient care. **Ethical Issues in Clinical Medicine** **INFLUENCES ON PATIENTS' BEST INTERESTS** Conflicts arise when patients' refusals or requests for interventions thwart their own goals for care, cause serious harm, or jeopardize their best medical interests. For example, simply accepting a young asthmatic adult's refusal of mechanical ventilation for readily reversible respiratory failure, in the name of respecting autonomy, is morally constricted. Physicians should elicit patients' expectations and concerns, correct their misunderstandings, and try to persuade them to accept beneficial therapies. If disagreements persist after such efforts, physicians should call on institutional resources for assistance, but patients' informed choices and views of their own best interests should prevail. Drug prices and out-of-pocket expenses for patients have escalated in many parts of the world and may compromise care in the patients' best interests. Physicians should recognize that patients, especially those with high copayments or inadequate insurance, may not be able to afford prescribed tests and interventions. Physicians should strive to prescribe indicated medications that are affordable and acceptable to the patient. Knowing what kind of insurance, if any, the patient has and whether certain medications are likely to be covered may help in determining appropriate prescriptions. Physicians or their team should follow up with patients who don't fill prescriptions, don't take their medications, or skip doses to explore whether cost and affordability are obstacles. Clinical pharmacists, technicians, or social workers can help the prescribing physician appeal for coverage or find funding for needed medications. It may be reasonable for physicians to advocate for coverage of nonformulary products for sound reasons,

such as when the formulary drugs are ineffective or not tolerated. Organizational policies and workplace conditions may sometimes conflict with patients' best interests. Physicians' focus and dedication to the well-being and interests of patients may be negatively influenced by perceived or actual staffing inadequacies, unfair wages, deficiencies in equipment or infrastructure, work-hour limitations, corporate culture, violence, and other risks in the workplace. Physicians should work with institutional leaders to ensure that policies and practices support their ability to provide quality care focused on patients' best interests. Patients' interests are served by the increasing use of evidence-based practice guidelines and performance benchmarking. However, practice guideline recommendations may not serve the interests of each individual patient when another plan of care would provide substantially greater benefits. In prioritizing their duty to act in the patient's best interests, physicians should be familiar with relevant practice guidelines, be able to recognize situations that might justify exceptions, and advocate for reasonable exceptions. Acting Justly The principle of justice provides guidance to physicians about how to ethically treat patients and make decisions about allocating important resources, including their own time. Justice in a general sense means fairness: people should receive what they deserve or are owed. Justice also entails similar treatment of people who are similar in ethically relevant ways, in order to avoid arbitrary, biased, and unfair decisions. Justice forbids discrimination in health care based on race, religion, gender, sexual orientation, disability, age, or other personal characteristics (Chap. 11). Distributive justice requires fair

and equitable allocation of limited health care resources, which should be distributed equally or according to relevant moral considerations such as need, probability of benefit, or other factors.

ALLOCATION OF RESOURCES Universal access to medically needed health care remains an unrealized moral aspiration in the United States and around the world. Patients with no or inadequate health insurance, especially those with chronic diseases, often cannot afford needed care and lack access to safety-net services. Even among insured patients, insurers sometimes deny coverage for interventions recommended by their physician. Physicians should advocate for patients' affordable access to indicated care, try to help patients obtain needed care, and work with institutions and policies to promote wider access. **PART 1 The Profession of Medicine** Allocation of health care resources is unavoidable when resources are limited, such as during medication shortages due to manufacturing and quality problems or during public health crises. Allocation policies should be fair, transparent, accountable, responsive to the concerns of those affected, and proportionate to the situation, including the supply relative to the need. Difficult decisions about allocation of available scarce resources are inevitable. A fair process should aim to prioritize patients who are likely to have a large and irreversible decrement in health outcomes without the interventions; avoid discrimination; mitigate health disparities; save the most lives; and promote the good of the community. First-come, first-served allocation is often not fair, because it disadvantages patients who experience barriers to accessing care. To avoid discrimination, allocation decisions should not consider personal social characteristics such as race, gender, or disability, nor consider insurance status or wealth. Allocation policies should aspire to reduce health care disparities often due to social determinants of health including poverty, unhealthy living conditions, and poor access to health care. Fair and well-considered guidelines help mitigate emotional and moral distress for clinicians and patients when difficult allocation decisions are made. Physicians should act as patient advocates within constraints set by society, reasonable insurance policies, and evidence-based practice. Ad hoc resource allocation by individual physicians may be

inconsistent, unfair, and ineffective. Many allocation decisions are made at the institutional or public policy level with physician and public input, for example, decisions and criteria for allocating cadaveric organs for transplantation. ■ ■VIRTUE ETHICS Virtue ethics focuses on physicians' character and qualities, with the expectation that doctors will cultivate virtues such as compassion, trustworthiness, intellectual honesty, humility, and integrity. Proponents argue that, if such characteristics become ingrained, they help guide physicians in unforeseen situations. Moreover, simply following ethical precepts or principles without any of these virtues could lead to uncaring doctor-patient relationships. ■ ■PROFESSIONAL OATHS AND CODES Professional oaths and codes are useful guides for physicians. Most physicians take oaths during their medical training, and many are members of professional societies with codes of ethics. Physicians pledge to the public and to their patients that they will be guided by the principles and values in these oaths or codes and commit to the spirit of the ethical ideals and precepts represented in oaths and professional codes of ethics. ■ ■PERSONAL VALUES Personal values, cultural traditions, and religious beliefs are important sources of personal morality that help physicians address ethical issues and cope with any moral distress they may experience in practice. While essential, personal morality alone is a limited ethical guide in clinical practice. Physicians have role-specific ethical obligations that go beyond their obligations as good people, including the duties to obtain informed consent and maintain confidentiality discussed earlier. Furthermore, in a culturally and religiously diverse world, physicians should expect that many patients and colleagues will have personal moral beliefs that differ from their own.

ETHICALLY COMPLEX PROFESSIONAL ISSUES FOR PHYSICIANS ■ ■CLAIMS OF CONSCIENCE Some physicians, based on personal values, have legally protected conscientious objections to providing, or referring patients for, certain treatments such as contraception, abortion, or physician aid in dying. Although physicians should not be asked to violate deeply held moral beliefs or religious convictions, patients need medically appropriate and timely care, rely on physicians for medical advice, and should always be treated with respect. Institutions such as clinics and hospitals have a collective ethical duty to provide medical care that will avert serious risks and suffering to patients while accommodating health care workers' conscientious objections—for example, when possible, by arranging for another professional to provide the service in question or by referral to another institution. Ethically, patients seeking a relationship with a doctor or health care institution should be notified in advance of any conscientious objections to the provision of specific interventions. Since insurance often constrains patients' selection of physicians or health care facilities, switching providers can be problematic after an illness is recognized. There are also important limits on claims of conscience. Health care workers may not insist that patients receive unwanted medical interventions or refuse to treat or illegally discriminate against patients because of their race, ethnicity, disability, genetic information, or diagnosis. Refusal to treat patients because of personal characteristics, such as sexual orientation, gender identity, or immigration status is ethically inappropriate because it falls short of helping patients in need and respecting them as persons. Importantly, some physicians may object to laws, institutional policies, or insurance policies that restrict them from providing or even describing medically appropriate care to their patients. In some of these cases, work arounds are justified on the ethical basis of sound clinical practice. ■ ■PHYSICIAN AS GATEKEEPER In some cases, patients may ask their physicians to facilitate access to services that the physician has ethical and clinical qualms about providing. For example, a patient might request a prescription for a cognitive enhancing medication to temporarily augment cognitive abilities in order to take an exam or apply for employment, or request that the physician

sign a disability form when the patient does not meet disability criteria. Patients may request more pain medication than the physician believes is warranted for the given situation, or the physician may feel uncomfortable prescribing attention-deficit/hyperactivity disorder medications to a young child because of concerns that the possible benefit does not justify the risks despite the parent's request. In these and similar circumstances, the physician should work with the patient or parent to understand reasons for their requests, some of which might be legitimate. In addition to considering possible risks and benefits to the patient, the physician should consider how meeting the request might affect other patients, societal values, and public trust in the medical profession. If the physician determines that fulfilling the request requires deception, is unfair, jeopardizes professional responsibilities, could undermine the physician's credibility or trustworthiness, or is inconsistent with the patient's best medical interests, the physician should decline and explain the reasons to the patient. ■ ■

OCCUPATIONAL RISKS AND BURDENS Physicians accept some risks in fulfilling their professional responsibilities, including exposure to infectious agents or toxic substances, abuse from patients or families, distress, and violence or threats in the workplace. Nonetheless, most physicians, nurses, and other hospital staff willingly care for patients, despite personal risk, grueling hours, and sometimes inadequate resources or information. Health care institutions are responsible for preventing and addressing occupational risks and burdens and for providing proper information, training and supervision, resources, infrastructure and workflow modifications, and emotional and psychological support. Clinical leaders should acknowledge fears about personal safety and take steps to mitigate the impact of work on family responsibilities, moral distress, and burnout.

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MORAL DISTRESS AND WELL-BEING Clinicians, including residents, medical students, and experienced physicians, experience moral distress when they feel that ethically appropriate action is hindered by institutional policies or culture, decision-making hierarchies, limited resources, or other reasons. Moral distress can lead to anger, anxiety, depression, frustration, fatigue, work dissatisfaction, and burnout. A physician's health and well-being can affect how they care for patients and interact with colleagues. Discussing complex or unfamiliar clinical situations with colleagues and seeking assistance with difficult decisions can help mitigate moral distress, as can a healthy work environment characterized by open communication, mutual respect, adequate support and resources, and an emphasis on the common goal of good patient care. In addition, physicians should take good care of their own health and well-being and be aware of the personal and system factors associated with stress, burnout, and depression. Health care organizations should provide a supportive work environment, counseling, and other support services as needed.

CONFLICTS OF INTEREST Acting in patients' best interests may sometimes conflict with a physician's self-interest or the interests of third parties such as insurers or hospitals. From an ethical viewpoint, patients' interests are paramount. Transparency, appropriate disclosure, and management of conflicts of interest are essential to maintain the trust of patients, colleagues, and the public. Disclosure requirements vary for different purposes, and available software can assist physicians in complying with specific requirements. Importantly, not all conflicts are financial. Physicians sometimes face conflicts of commitment between their patient's interests and their own personal interests, professional goals, responsibilities, and aspirations or the interests of the health care institutions or corporations that employ them. Physicians should prioritize patients' interests while recognizing possible conflicts and use disclosure, discussion with institutional officials, and management of the conflict or recusal when appropriate. Medical institutions themselves may have conflicts of interest arising from patent rights, industry-funded research

programs, donations from individuals and companies, and priorities of the health care system, pharmacy benefits managers, insurers, and private equity or corporate owners. Institutions should be transparent about the presence and amount of such relationships and about the steps taken to prevent such relationships from influencing clinical or financial decisions. Institutions should take steps not to benefit from donations or honor donors when there is good evidence that a donor breached ethical or legal standards. ■ ■ **FINANCIAL INCENTIVES** Physicians have financial incentives to improve the quality or efficiency of care that might lead some to avoid patients who are older, chronically ill, or have more complicated problems, or to focus on benchmarked outcomes even when not in individual patients' best interests. In contrast, fee-for-service payments might encourage physicians to order more interventions than necessary or to refer patients to laboratory, imaging, or surgical facilities in which they have a financial stake. Regardless of financial incentives, physicians should recommend available care that is in the patient's best interests—no more and no less. ■ ■ **RELATIONSHIPS WITH PHARMACEUTICAL COMPANIES** Financial relationships between physicians and industry are increasingly scrutinized. Many medical centers have banned drug-company gifts, including branded pens or notepads or meals to physicians, to reduce risk of undue influence or subconscious feelings of reciprocity and to decrease possible influences on public trust or the costs of health care. The federal Open Payments website provides public information on the payments and amounts that drug and device companies give to individual physicians. The challenge is to distinguish payments for scientific consulting and research contracts—which should be encouraged as promoting professional and academic missions—from those for promotional speaking and other activities that aim to increase sales of company products.

■ ■ **LEARNING CLINICAL SKILLS** Medical students', residents', and physicians' interests in learning, which fosters the long-term goal of benefiting future patients, may sometimes conflict with the short-term goal of providing optimal care to current patients. When trainees are learning procedures on patients, they lack the proficiency of experienced physicians, and patients may experience inconvenience, discomfort, longer procedures, or increased risk. Increasingly, institutions are developing simulation-based clinical skills laboratories and requiring students to demonstrate proficiency before carrying out procedures such as venipuncture and intravenous lines in patients. Furthermore, teaching hospitals are establishing proceduralist services in which procedure-specialist faculty members directly supervise interns for procedures such as lumbar puncture and thoracentesis and certify their proficiency. Medical students may need to defer learning such invasive procedures until internship. It is always important to seek patients' consent for trainee participation in their care, particularly for intimate examinations, such as pelvic, rectal, breast, and testicular examinations, and for invasive procedures. Patients should be told who is providing care and how trainees are supervised. Failing to introduce students or trainees who will be performing procedures undermines trust, may lead to more elaborate deception, and hinders patients' informed choices about their care. Most patients, when informed, allow trainees to play an active role in their care.

CHAPTER 12 Ethical Issues in Clinical Medicine ■ ■ **RESPONSE TO MEDICAL ERRORS** Errors are inevitable in clinical medicine, and some errors cause harm to patients. Most errors are caused by lapses of attention or flaws in the system of delivering health care; only a small number result from blameworthy individual behavior. Many health care institutions have adopted a communication and resolution system that encourages open and honest reporting of errors as essential to quality of care and shifts the focus from individual blame to system redesign for improvement in quality and

safety (Chap. 7). This approach is more likely than a punitive approach to improve patient safety. However, professional discipline is appropriate for cases of gross incompetence, reckless behavior, physician impairment, and boundary violations. Physicians and students may fear that disclosing errors will damage their careers. Physicians and health care institutions show respect for patients by disclosing and explaining errors, offering apologies, offering appropriate compensation for harm done, and using errors as opportunities to improve the quality of care. ■ ■

PHYSICIAN IMPAIRMENT

Physicians may hesitate to intervene when colleagues impaired by alcohol, drugs, or psychiatric or medical illness place patients at risk. However, society relies on physicians to regulate themselves. Colleagues of an impaired physician should take steps to protect patients and help their impaired colleague, starting with reporting their concerns to their clinical supervisor or director, and institutions should have programs in place for assessing physician competence.

ETHICAL ISSUES IN CLINICAL RESEARCH

Clinical research is essential to translate scientific discoveries into beneficial interventions for patients. However, clinical research raises ethical concerns because participants face inconvenience and risks in research designed to advance scientific knowledge and not specifically to benefit them. Ethical guidelines require researchers to rigorously design and conduct research, minimize risk to participants, and obtain informed and voluntary participant consent and approval from an institutional review board (IRB). IRBs determine whether risks to participants are acceptable and adequately minimized, and recommend appropriate additional safeguards when research includes vulnerable participants. Physicians may be clinical research investigators themselves or in a position to refer or recommend research participation to their patients. Physician-investigators are likely to feel some inherent tension between conducting research and providing health care. Awareness of this tension, familiarity with research ethics, collaboration with research and clinical team members, and utilizing research ethics consultation can

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