You should get that mole checked out: Ethical and legal considerations of the unsolicited clinical opinion

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Background

Legal and ethical obligations do not always align when doctors become aware of a clinical situation involving a person with whom they have no pre-existing therapeutic relationship. Noting a potentially malignant skin lesion, such as a melanoma on a person outside the clinical setting, provides a pertinent example.

Objectives

The aim of this article is to describe the legal, ethical and professional considerations surrounding proffering a dermatological opinion in the case of suspected melanoma outside the clinical setting.

Discussion

The application of professional and ethical standards may require the doctor to act in some way to alert the person of their findings in a context whereby there is no defined positive duty to do so in Australian law. The degree to which the doctor is ethically obligated to provide an unsolicited dermatological opinion is affected by numerous and, oftentimes, competing factors.

Hypothetical case

A general practitioner (GP) is dining out with family. The GP notices an asymmetric, variegated, nodular lesion of 2 cm diameter on the posterior neck of a neighbouring patron. The GP is clinically suspicious that this lesion might represent a melanoma and is unsure about whether they should communicate this to the restaurant patron sitting nearby.

Legal considerations

Medical practitioners have no defined positive duty in Australian law to provide care in non-urgent situations where there is no pre-existing therapeutic relationship between the two parties.[1] This is critical because in the absence of a recognisable positive duty of care between two parties, there can be no breach of said duty (whether this be a breach by an action or an omission).

Where a pre-existing duty of care does exist, it is certainly feasible that failure to notify a patient within a therapeutic relationship of a potentially dangerous diagnosis, even if noted only incidentally, might give rise to a claim of professional negligence or professional misconduct. In such a situation, however, there is an expectation that the medical practitioner, who has been tasked with examining a patient for the purposes of discerning or excluding disease, will fulfil their duties to an ordinary standard.

Outside a professional environment, where there is not only no pre-existing therapeutic relationship between a doctor and another party, but no relationship whatsoever between the two except for proximity, there exists no expectation of, or reliance on, care and thus no duty to provide it. In Australia, over many decades, there has been great reluctance to create a legal standard, either through statutory or common law, whereby medical practitioners can be compelled to act in circumstances where other professions would not be.[2,3]

The issue of proximity is one that has a history within Australian common law in the case of *Lowns v Woods*.[4] In this case, which has been heavily criticised and analysed, a doctor refused to come to the aid during an emergency situation involving a young boy who was not a patient of the doctor.[4] The case provides one of few in Australian legal history where the courts did determine that a doctor had a positive duty to help a previously unknown third party. As part of the court's reasoning, an argument was proposed that the geographic proximity of the medical practitioner was a key factor in determining whether the doctor had a positive duty to assist the plaintiff.[4] Of note, *Lowns v Woods* referred to legislative provisions that have since been repealed and replaced. In the case of *Lowns v Woods*, the doctor was practising

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in an operating clinic at the time that the family member presented requesting help, which is quite different from the hypothetical case presented above where the doctor was not at the workplace. As such, although the judgement in *Lowns v Woods* provides an interesting perspective on how proximity can factor into a court's decision, it cannot be applied to our scenario with authority.

Refusal to render aid and assist third parties in need of medical attention has, over time, become less the purview of professional negligence and more a matter of potential professional misconduct under the auspices of governing regulatory bodies such as the Australian Health Practitioner Regulation Agency (AHPRA).

Ethical considerations

Ethics is dynamic, purposefully non-formulaic, involves communicative exchanges and responds to individual interactions.[5] An understanding of the legal underpinnings of the case discussed is paramount. Nonetheless, the law will not necessarily solve ethical dilemmas.[5] To this end, the succeeding commentary focuses on the ethical considerations related to proffering a medical opinion outside the clinical setting.

While these complex issues are not novel, they are worthwhile revisiting, particularly in the context of our shift from an almost exclusive emphasis on the traditional pillars of medical ethics (ie Principlism) in favour of more nuanced ethical frameworks. This issue also presents as an increasingly common dilemma, as the incidence of melanoma has increased over previous decades.[6]

The Principlist approach is centred around the four pillars, 'autonomy', 'beneficence', 'non-maleficence' and 'justice.' These principles are all relevant to this case; however, beneficence and non-maleficence are the most salient. A delay in melanoma diagnosis may worsen the patient's prognosis;[7] this is particularly the case if the melanoma displayed rapid vertical growth. Therefore, proffering an unsolicited opinion may be considered an act of beneficence, which denotes that healthcare professionals should promote the health and welfare of others.[8]

The notion of non-maleficence also requires consideration. The potential psychological distress of the recipient may serve as a significant barrier to the GP.[8,9] The unsuspecting individual may view this action as an unwanted intrusion of their privacy. Indeed, an observant dermatologist recently contacted the Australian swim team doctor to alert him to a suspicious mole on an Olympic gold medallist.[10] This lesion proved benign; nonetheless, the Olympian was grateful for the advice.[10] While this individual was thankful for the advice, others might find this to be an unwelcome disturbance.

The recipient may later request an excision of the suspect lesion on the basis, at least in part, of the GP's informal opinion. If the excisional biopsy does not demonstrate melanoma, this may represent an unnecessarily invasive and expensive procedure. It is certainly more difficult to make an accurate diagnosis outside the clinical setting as lighting is not necessarily ideal and there is an absence of dermoscopy.[11] Thus, the risk of causing unnecessary harm to the recipient might appear to contravene the ethical principle of non-maleficence. However, these risks need to be weighed seriously against the benefits of a possible earlier diagnosis of melanoma.

The Principlist approach may serve as a foundation for medical ethics; however, there are alternative ethical frameworks that take into consideration the context-specific psychosocial milieu in which ethical decisions are made. The ethics-of-care approach, which provides a normative ethical framework, is contextual, need-centred and focuses on the interconnectedness with others.[12] According to an ethics-of-care framework, the needs of others play a central part in informing ethical decision-making as care is viewed as a central virtue to moral action.[12] Care ethics may argue that the GP is ethically obliged to inform the patron of their concern as an act of care towards that individual. According to consequentialism, a morally right act is an act that leads to a good outcome or consequence. Therefore, from a consequentialist perspective, the consequences of not intervening in this situation need to be weighed carefully against the consequences of intervening. In this scenario, the possibility of a delayed diagnosis for the patient and a potential ensuing sense of guilt or regret by the doctor are consequences that require serious consideration if the doctor decides not to intervene.

Both Moseley[13] and Ratzan[9] have suggested certain criteria that ought to be fulfilled prior to proffering an unsolicited medical opinion (Table 1). These criteria need to be considered and interpreted within ethical and professional frameworks to guide clinicians' decision-making. Mosley's first criterion is that the individual must have a serious risk to their health. Undoubtedly, a malignant melanoma, particularly if the lesion is nodular in appearance, would fulfil this criterion. Mosley's second criterion contends that the doctor should feel relatively certain of the diagnosis. The level of certainty will depend on numerous factors, which would include, but would not be limited to, the training and experience of the GP. The anatomical location on the posterior neck might suggest that the individual is likely to be unaware of this lesion; thus, it is possible that the condition will remain unattended, thereby fulfilling Mosely's third criterion.[13] Moseley's fourth and fifth criteria would similarly be fulfilled as a reasonable person would want to be made aware of a melanoma diagnosis and there are available treatment options for patients with melanoma.[13] Furthermore, a study by Zwitter and colleagues found that lay people are more likely than doctors to consider an unsolicited medical opinion as appropriate,[14] reflecting the public's high expectation of doctors in the community. The Medical Board of Australia does not provide guidelines or codes on offering medical advice outside the clinical setting in non-emergency cases.

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Table 1. Moseley's[13] and Ratzan's[9] suggested criteria that ought to be fulfilled prior to proffering an unsolicited medical opinion

Adapted Moseley's criteria[13]	Adapted Ratzan's criteria[9]
1. The recipient must have a serious impending risk to their health.	1. The doctor assesses a high probability of a potentially serious disease in a stranger.
2. The doctor should feel relatively certain of the diagnosis.*	2. The doctor considers this information to be latent (ie not readily interpretable as potentially dangerous by the stranger) and likely to remain latent prior to symptom onset.
3. The condition would potentially remain untreated or unattended.	3. The doctor possess the medical knowledge appropriate to the professional interpretation of this information.
4. A reasonable person would want to be made aware of this condition.	
5. Treatment options (including comfort measures) are available for the condition.	

**Moseley qualifies this criterion by stating that if the condition is significantly serious, the doctor could be less certain of the diagnosis and notification would still be warranted.*

Assuming the GP decides to express their concerns to the neighbouring patron, it is important that this discussion occur in the most ideal manner. Providing informal medical advice outside the professional milieu is often fraught with difficulty. Appropriate and sensitive communication is key. The GP should approach the patient discreetly and, ideally, in a private setting.[9,13] The GP should begin by identifying themselves as a registered and practising GP.[13] The precise training experience of the GP does not require specific mention; however, this might be considered in some circumstances. Following this, the GP should express their concerns regarding the suspect lesion. They should not inform the person that the lesion definitely represents a melanoma. On the contrary, the GP should explain that they are concerned that there might be a possibility that it represents an abnormal lesion and requires formal medical review. The GP should suggest that the patron make an appointment with their local GP as soon as practicable.

It could be argued that the act of approaching the patron and providing advice establishes a therapeutic relationship. However, the extent of the duty of care in these circumstances is limited. It would be unreasonable to expect, and arguably overly invasive, for the GP to follow up the patient's progress, especially if the patron's identifying information is not volunteered. Even in the absence of knowledge of identifying information, assuming that a therapeutic relationship exists in this scenario, respecting and maintaining patient confidentiality is recommended.

Conclusion

While doctors may not have a legal obligation to proffer an unsolicited opinion in the case of suspected melanoma outside the clinical setting, they may have an ethical responsibility to do so. The degree to which the GP is ethically obligated to provide an unsolicited dermatological opinion is affected by numerous and, oftentimes, competing factors. As with all decision making, there are potential risks and benefits that require careful consideration.

Many individuals would be grateful for a fortuitous diagnosis of a possible melanoma (as opposed to a late diagnosis), but others might perceive the interaction as overly intrusive, unwelcome, a source of distress and, in some situations, a challenge to a well-developed denial preferred by the individual. GPs should prepare themselves for such a negative reaction if they decide to offer their opinion. Nonetheless, the potential benefits may mitigate these risks in certain circumstances. With respect to melanoma, timely diagnosis may improve patient outcomes.

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