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Beneficence and Behavior Control: Ethical Dilemmas in Gastroenterology

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Abstract

The physician-patient relationship is obviously based on communication. Both the physician and the patient permanently exchange messages verbally or non-verbally. Our paper aims at emphasizing some ethical dilemmas in medicine regarding the way in which communication betrays patterns of manipulation and behavior control. A number of ethical dilemmas are presented and analyzed. They are mainly derived from the gastroenterological and hepatological medical practice. In this respect there is a constant necessity of maintaining equilibrium between the patient's constant beneficence and his or her autonomy. But the therapeutic intervention also brings about changes in the patient's behavior making him or her more vulnerable to the physician's decisions. Therefore, there is a constant need for professional restraint in the medical decisions and interventional processes, bearing always in mind that the modern patient needs to be saved, not to be governed.

Keywords: behavior control, persuasive communication, paternalism, personal autonomy, gastroenterology.

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Introduction

Communication underlies the complex relationships, established from the first encounter, between physician and patient; it implies a complex language, by means of which the emitter transmits codified messages, interpreted by the receiver function of his/her own paradigms (Gavrilovici & Oprea, 2013). Communication becomes in this way the most important process among the social interaction means, the entire activity of the individual being thus based on the communication principles (Cojocaru, Islam & Timofte, 2015). Within the context of the gastroenterological and hepatological medical practice, doctor-patient communication acquires further valences, mainly because of the visibly multidisciplinary nature of the medical act in this field. Owing to the anatomic – structural, physiological and psychopathological – characteristics of the digestive system, the management of the patient with gastroenterological and hepatological troubles implies the involvement in the medical act of a multidisciplinary team, including practitioners in gastroenterology, dentists, surgeons, nutritionists or psychotherapists. The wide range of medical-surgical, dental or paramedical specialties involved increases the complexity of medical communication. It also implies the involvement of the patient in several clinical and paraclinical professional relationships.

Taking into account the challenges of the medical communication act in gastroenterology and hepatology, this paper aims at presenting and assessing several ethical dilemmas of the communication act between physician (emitter) – patient (receiver), mainly regarding the equilibrium between the principle of beneficence and various professional methods of behavior control. This kind of professional communication can have extremely different goals, even within the conditions of observing the shape and substance conditions, mainly within the ethical and professional deontological areas. We make this statement on the bases of the fact that the involvement of a physician with high communication skills can have a significant impact on the sometimes manipulatory control of the patients' decisions with regard to the diagnostic and therapeutic aspects. A patient, for instance, who is undecided in accepting a diagnostic or a therapeutic procedure proposed by a certain physician, can often become very determined to accept the procedure after having been in a professional relationship with another physician (van Langenberg & Andrews, 2012). For sure, the persuasion degree of a physician shall have, to a certain extent, a critical impact on the patient, mainly if the verbal language is congruent with the nonverbal one. Nevertheless, even if the verbal language is dissonant with the nonverbal one, the patient has the tendency to take over information mainly from the nonverbal language, so that the communication is finally influenced by the intrinsic non-verbalized physicians' persuasion (Oprea, 2009a). From an ethical point of view, has the physician the right to influence, even subtly, the decision alternatives of a patient? Which are the methods by means of which a physician could not involve himself in the decisional process? Is such an impartiality possible, useful and to the benefit of the patient? Before proceeding to the study of the ethical and deontological implications of certain versatile practices of manipulation and behavior control, within the context of the classical principles regarding the beneficence or the existence of an informed consent, we deem necessary to define several fundamental ethical and biomedical communicational concepts.

It has been recognized that autonomy and beneficence are two of the fundamental principles of biomedical ethics (Childress, 2007). By autonomy, we mean the independence or freedom of individual actions (Gramercy Books, 1996), regarded both in an intelligential and volitive manner. From an ethical point of view, autonomy highlights the individual's right to his or her own opinion, materialized in decisions and acts based on his own value system. Adjacent to the autonomy principle, paternalism refers to the system, principle or practice of managing or governing individuals in the manner of a father dealing benevolently and often intrusively with his children (Gramercy Books, 1996). The theoreticians of biomedical ethics identified a pattern of constructing one of the varieties of medical professional relationship, namely the situation in which beneficence justifies all actions of protecting the patient by the practitioner who "impersonates" the patient in the decision taking process (Craciun *et al.*, 2013). Therefore, based on the beneficence principle, the physician takes the unilateral responsibility of guiding an asymmetric medical act, by the absence of the decision reciprocity. Consecutively, beneficence presupposes the existence of the medical ethical obligation of acting for the purpose of helping the patient or for the purpose of avoiding a certain imminent damage. In fact, the principle of beneficence is closely related to the non-injury context; it means that the practitioner has first of all the obligation of not provoking injuries and of constantly acting for the purpose of the prophylaxis of the probable medical risks (Churchill, 1995).

With regard to the classical paradigms of medical communication, by receiver (recipient) we understand a person who takes, acquires, accepts, gives credit, reacts or consents to something (Webster, 1998). Alternatively, the notion of emitter (sender) refers to the person who orders, causes, grants or dismisses a message to be conveyed (Webster, 1998). The emitter and the receiver change multivalent information on a constant basis, materialized in the message specific to the physician – patient communication. Within this professional relationship, we deem necessary to highlight the fact that both the doctor and the beneficiary change successively the roles of emitter and of receiver, according to a semiotic model, in which paternalism and autonomy are valorized to variable extents.

This variability of involvement and valorization of the intrinsic beliefs of the professional partner determine the conflict, at times hard to identify, between beneficence and injury. It follows that from purely paternalist values to the promotion of an absolute autonomy, one can identify different degrees of behavior control. This control, even if it is often unavoidable in such a complex professional relationship, can be materialized in genuine manipulation techniques which visibly contradict the fundamental beneficence and non-injury obligations.

The interrelation between Beneficence and the Behavior Control

Beneficence, one of the main characteristics that lead to teleological bases of biomedical ethics, represents, from an etymological point of view, the acquirement and practice of well-doing, *bene* – good, *facere* – to do. As an ethical principle, beneficence appears as an obligation of acting by virtue of the welfare for the others and of constantly searching for this welfare from a deeply humanist and philanthropist perspective. Therefore, we consider beneficence one of the fundamental purposes of medicine since ancient times. These historical roots, solidly accepted as a general truth at social and professional level, can however be justified by using multiple reference systems. For that purpose, the literature in the field presents beneficence: (1) as a manner of expressing personal benevolence, (2) as a utilitarian concept or (3) as a consequence of the individual autonomy.

The distinction between beneficence and benevolence has been drawn by many of the bioethics founders. David Hume (1711-1776) considers benevolence as being naturally implanted in the human being and therefore in the human moral topography, beneficence being the pure manifestation of the benevolent virtues and of the human common sense (Churchill, 1995). Consequently, beneficence is seen as an individual duty and responsibility, as there is always someone next to us for whom we can do good things, thus reaching to do good things for the entire humankind (Ross, 1930).

The utilitarian vision regarding the concept of beneficence concept is based on its deeply relational nature. We can find the explanation in the philosophical vision of John Stuart Mill (1806-1873) who states that beneficence derives from the feeling of intrinsic usefulness of any of us, because the common welfare of the majority takes advantage (Mill, 1979). The vision of Stuart Mill did not lack in criticism, mainly regarding the deep idealistic nature, without any trace of pragmatism, of his philosophy. Indeed, beneficence does not necessarily mean achieving common welfare, but rather promoting certain common values, and within the context of biomedical sciences, these values mean most of the times only avoiding and fighting against certain imminent or intercurrent menaces. For this particular reason, the modern attitude towards beneficence is to place it in direct interdependence with the much more pragmatic principle of the individual autonomy.

On this line, contrary to a history of medicine governed by a paternalist spirit, beneficence is seen more and more frequently as one’s right towards which an action is directed, namely a professional medical act (Churchill, 1995). Promoting autonomy as a moral fundamental principle is not at all an attribute of modernity. Autonomy has its roots in the definition of the concept of freedom, theorized for the first time at the end of the 17th century by John Locke (1632-1704) in the *Second Treatise of Government* (1690). An important contribution to the acceptance of autonomy as a fundamental ethic and political principle is brought by the Kantian philosophy, by introducing the notion of individual intrinsic free will. In the virtue of the autonomy principle, the human being has a rational nature, the finality of his/her freedom being precisely the capacity of existing by him- or herself. As a result, there appears the conflict between beneficence and autonomy, as the individual often proves to be incapable of taking care of himself, an external intervention being sometimes compulsory. Therefore, beneficence stands before autonomy, being seen as a professional obligation by most of the biomedical deontological codes, starting with the Hippocratic Oath. Solving the conflict between these two principles can even be seen from the point of view of the finality of the informed consent – it can be received as an expression of the free and independent decisions of the patient, that characterize his individual welfare and therefore justifiable for an external intervention by virtue of the beneficence principle.

Hence, we noticed that at fundamental theoretical level, beneficence is related to the essence of each medical act. Moreover, the patient establishing a professional relationship with the practitioner defines his own context of beneficence and presents his own needs. But is the patient still autonomous once involved in a professional interaction, or more specifically from the moment of the therapeutic interaction?

Behaviorist theories come to solve these dilemmas, even more as it is unanimously recognized by the bioethicists the fact that a preservation of the individual welfare and autonomy is finally the only goal of medical intervention. In the light of these behaviorist theories, individuals are strictly controlled by extrinsic factors, entirely distinct from their own being, that are generally called environmental stimuli (Edwards, 1995). Therefore, a negation of the individual intrinsic will take place. Accepting these as being valid would turn them incompatible with the recognition of the classical bioethical values, as the latter are based on the recognition of the individual self-fatality, the ethics being a problem of the consciousness, intrinsic to the person (Skinner, 1974). Subsequently, consent seen from the point of view of the behavior is deprived of the values of autonomy, freedom, dignity or individual consciousness, representing only a manner of recording certain different behavior control methods. Within this context, we become the witnesses of a process of behavior reduction of freedom, justified by the fact that the human being would be incapable of controlling him-/herself through his/her own efforts and knowledge, the external stimuli being necessary for that purpose. These therapeutic manipulation methods were pragmatically explained by means of the preventive anesthetic procedures for the conscious pain, but which places medicine outside the patient's consciousness (Edwards, 1995). A range of dilemmas regarding the control mechanisms appear. Who detains the control of the regulation of these behavioral mechanisms? Is there a feedback during this entire process?

Theoreticians' solutions consist in delineating a faint context of behavioral control, namely the behavior therapy. This type of therapy is meant to satisfy the rigors of biomedical ethics, maintaining therefore the principled contribution of the behavior control methods. The behavior therapy is on the one hand based on cognition – aiming at the self-guided change of the individual behavior, by restructuring the irrational beliefs and by promoting behavior of exercises, and on the other hand on the imminent interaction between the human being and the environment – the individual behavior being an answer to the requirements of the external environment (Rotgers & Franks, 1995). One tries therefore to enforce the classical behavior principles within the context of the ethical and deontological rigors of a relationship physician-patient based on beneficence and freely expressed individual consent. The individual can be taught to outlast the environment; he does not react to the extrinsic stimuli, but acquires techniques which can prevent his vulnerability. The criticisms brought to this type of behavior therapeutic practices consist in the impossibility of ensuring a perceptive equilibrium between punishment and reward within the interaction with the environment.

Equilibrium is obviously necessary among beneficence, autonomy and behavior control. This relation of forces defines the ethical structure of the relationship physician-patient. According to the weight offered to any of these principles and to the adhesion of the actors to the personal ethical values, different professional relationship models may occur (Oprea, 2009b), having diverse practical finalities, versatile in time and space and having an important cultural-dependent component.

The Physician – Patient Relationship in Gastroenterology: Between Paternalism, Autonomy and Evidence Based Medicine

If medicine has been considered an art until recently, nowadays more and more attention is placed (maybe as an answer to the attitude generated by the sometimes uninformed actions if not even clearly deprived of professionalism in the informational environments) upon evidence based medicine, which should be offered without discrimination in the physician-patient relationship. Rendered in registers based on the equality between physician and patient, this kind of evidence is more and more frequently requested by the patients more or less, more accurately or more tangentially informed with regard to medicine. As a reaction, maybe with regard to the preservation instinct, the physician often chooses to make available the patients the scientific medical evidence rather than his personal experience (Feinstein & Horwitz, 1997). Last but not least, additional to the professional information received in the relationship with the practitioner, a significant number of patients choose media and internet information sources (O'Connor & Johanson, 2000), which are often unofficial, and generate risks regarding the stability of the relationship between the physician and the patient as to what the adhesion and compliance of the patients are concerned.

But shall this evidence deemed certain today be equally solid tomorrow? Medicine evolution has shown us that anything is possible in the medical practice: evidence deemed indestructible in the past, can be proven as being false at present or in the future. When the physician is permanently conscious of this relativity of knowledge, how can he present it to the patient without transmitting him incertitude too? Is it to the benefit of the patient that the incertitude regarding these proofs should not be transmitted? Is it preferable for the patient to have a medical reference point with high stability or a vague statement received as a concession making him wait certain results or medical prognoses? Nevertheless, with strict regard to the information register specific to the Evidence Based Medicine, it implies mainly aspects of a biomedical scientific nature; in its turn, the comprehension of these professional details requires the command of an advanced medical language. Therefore, the medical metalanguage, nowadays extremely sophisticated, with semiologic notions semantically defined by specific terms with heteromorphic etymology (terms which added up can equal to the learning of a foreign language) is not understood at subtlety level by most of the patients, a situation which determines the appearance in practice of an intermediary language (Dorgan, Lang, Floyd & Kemp, 2009). It combines elements of conversational language with elements of the medical register. It employs in excess partial synonyms or expressions from the popular, regional, archaic language, combined sometimes in an uninspired manner with untranslatable neologisms of the respective medical field. All these attributes of the verbal communication can influence the perception manner of the patient, so sometimes there is a great semantic discrepancy between the transmitted message and the received one. Taking into account this apparent obstacle in communication, we deem necessary to search for a potential solution. The professional relationship should be characterized by good communication and decision versatility, at least from the point of view of the physician. Therefore, we cannot ignore the possibility that a relationship physician-patient initially materialized according to paternalist principles evolves in time towards responsibilizing the patient and therefore towards exercising more and more visibly his/her autonomy. The professional relationship acquires in this case a pseudo-didactic nature, the patient learning to make informed decisions for himself. On the other hand, the doctor can gradually know his patient, so that he will be able to adapt in time the communication register according to the degree of the patient's involvement. This aspect does not exclude a reverse phenomenon to the one subsequently presented, namely the transgression from a professional relationship based mainly on autonomy to a paternal one, as a process of deterioration occurs because of the patient who does not demonstrate thorough willingness. As in many other types of communication, the non-verbal language has an overwhelming influence in this professional relationship too. The information transmitted non- or para-verbally is effectively internalized by the patient, even if it apparently seems dissonant with the verbal. Therefore, a clever physician will be able to manipulate the nonverbal in a manner in which he can transmit the patient subtle information. In his turn, the physician is affected by the attitude of the patient: his emotional condition, the level of understanding of the events reported to the relationship with the medical staff, the quality of communication, the observed or supposed level of understanding and the anticipated confidence degree. This causal chain can finally affect both the professional relationships based on autonomy and the paternalist ones.

Various aspects of the communication, susceptible of difficult interpretations within the physician-patient relationship, are encountered during the interaction between professionals from the medical services and beneficiary. There are also the interpretative phenomena that the patient can develop subsequent to the contact with the physician, by means of new knowledge or doubt appeared in time, within the context of his own expectations, of certain secondary professional opinions, or subsequently to the contact with other groups. Then, one reaches the moment when a professional decision is taken influenced more or less by a collective sub consciousness of the physician-patient relationship, rather than by factual data assumed by the parties of the medical relationship.

Finally, the suspicion of a diagnostic is often prudently communicated to the patient. But, if from the first medical contact the physician suspects a serious trouble with a vital impact, he should not hesitate in informing the patient, as the delay can have an unpleasant effect on the evolution and prognostic of the disease. For this purpose, it is advisable that the physician should insist that the diagnostic established during the first examination is only a diagnostic supposition and not a certainty, so as to persuade the patient of the importance of continuing the investigations (if the patient is not convinced, he can abandon these investigations, considering them useless or an insignificant supplement once the physician presented the diagnostic, without taking into account that the diagnostic is a presumptive diagnostic) and on the other hand so as not to induce panic to the patient.

The Informed Consent: Professional Restraint vs. Manipulation in the Gastroenterological Practice

Patient's consent and the documents subsequent to the procedure of obtaining an informed medical consent represents one of the fundamental concerns in the scientific study of biomedical ethics, being recognized from the ancient times as a form of respect for the patient, but also as a factor imposed by the social cohabitation norms (Gavrilovici, 2007). This represents a bridge between the medical ethical obligations, the deontological professional and the duties that the law stipulates for the medical practice (Goicovici, 2012). At theoretical level, consent has its origin in the bioethical fundamental principle of autonomy. Regardless of the fact that we either objectively refer to the rigors of the autonomy – rationally, or we make reference to a subjective autonomy – individual freedom (Jennings, 2007), the medical consent appears as an *ad validitatem* condition for the existence of a professional relationship. This ethical fund is also consolidated by the positive right rigors which place the consent as one of the general conditions of existence of the medical legal act (Tudor, 2010). Hence, the consent must be regarded both at a fundamentalist level – as an expression of patient's autonomy within the clinical professional relationship, and at an objective level – as a legally recognized document, characterized by the literature of the field as informed, written, and freely expressed (Gore, 2001).

But, in practice, the written informed consent documents, drafted in medical terms, with statements having the tendency of approaching as wide as possible mainly the complications of the procedures seem to often scare the patient. That is why, in the practical relationship with the patient, before the moment the patient reads and signs the document, the physician should present an abstract in less formal terms, using mainly words belonging to the common language or comparisons which can be understood by the patient (at a level which can be variable according to the formal training level). A physician is considered honest when he/she informs the patient on the reference points which determined the formulation of a diagnostic suspicion, on certain possible differential diagnostics, and on the investigations needed for the purpose of confirming the diagnostic, but also on his perspective, in terms of his own experience. Obviously, such a relationship is extremely time consuming, and consequently rarely observed in the current medical practice.

Professional associations, various medical institutions and subsequently the World Health Organization developed several informed consent models, specific to each procedure. The fact that they become longer and longer, and more and more difficult to understand determined the appearance of a polarizing phenomenon. The patient may possibly read in detail the informed consent document, addressing a large number of questions whose elucidation requires a significant time period; there is the risk that the physician perceives this attitude as a lack of confidence of the patient. On the other hand, the patient may state that he signs the medical document without reading it, highlighting the fact that he agrees with everything, a situation which shall impose at least the verbal presentation by the physician of an abstract of the consent (which shall omit certain details) so as to achieve a procedure within deontological conditions. Rarely, there is also the possibility that the patient declares that he does not sign the consent, which shall force the physician to abstain from performing the procedure, even if he is certain that the respective procedure is extremely useful for the patient. He shall try again to explain the patient the usefulness of the procedure, obviously in other words than in the initial presentation, repeating but avoiding the use of the same words, as it can determine a result similar to the previous one.

If a physician is strongly confident of the usefulness of a certain investigation, then he shall easily persuade the patient, but if the physician himself has doubts, then the patient shall "take over" these doubts and shall have hesitations (Christy & Rawl, 2013). The physician who is absolutely sure about the usefulness of a procedure shall use a concise, and clear language, while the undecided one shall betray his doubt and behave hesitantly (again transmitting this to the patient) foreseeing the usefulness of a procedure. The same physician, who is firmly convinced of the usefulness of the procedure, shall present the patient in the abstract mainly the benefits of that procedure and shall minimize the risks; sometimes, if the physician has many doubts on a procedure that is a must within the current protocols, he can talk the patient (by his attitude rather than by words) into refusing it; generally speaking, this is achieved by amplifying the risks of the procedure, its unpleasant or painful nature and by minimizing the diagnostic benefit. If he is not persuaded or more than that, he is convinced of the futility of the intervention, then he shall present mainly the risks and possible complications in detail, doubting the benefits (e.g. an intervention for an event ration of an obese patient with high relapse risk shall be presented as a procedure with high anesthetic risks of local or general complications, of disinsertion of the mesh, of local cellulites, of relapse beyond the mesh; the benefit shall be presented as arguable and uncertain).

As regards to the need for a risky intervention (diagnostic or therapeutic) the patient shall be informed on the: usefulness of the procedure, type of the procedure, expected benefits, risks, possible complications, type of anesthesia, special warnings or interactions. The patient must also be informed with regard to the expected evolution of the disease if he refuses the procedure. This information is extremely useful in obtaining an informed consent for the procedure and in diminishing the anxiety of the patient, who, once informed, might have a certain feeling of safety when he learns in detail the steps he must follow. This aspect is even more valid when we talk about an asymptomatic patient included in a screening program (McQueen *et al.,* 2009). If the physician neglects this stage (or appoints another participant for this purpose in the medical undertaking: nurse or collaborator) then the final results can materialize either in the refusal of the patient to accept the procedure, or in a poorer quality of the result (e.g. a patient who must perform a colonoscopy without sedation and who is informed in advance on the fact that the procedure is painful will tolerate it much better than a patient who does not know the possible manifestations determined by the procedure). If the physician is convinced of the need of an intervention, he shall present the patient mainly the benefits and shall only mention the risks and the possible complications.

Last but not least, if the patient declares that he does not want to know the diagnosis, the physician should find an alternative language for describing the disease without using a certain word which represents a phobia for the patient (for instance, the neoplastic patients often do not want to hear the word "cancer" but the physician may use the word "mass" or "tumor"). If the patient refuses to hear a certain diagnostic word, it is not ethical not to offer him the possibility of knowing details on his disease, which shall also be offered without disturbing the patient's inner affective psychic insight (Morioka, 1991). Subsequently, within the conditions of a firm refusal of the patient to read the informed consent document and sign it, there appears the question whether the physician has the right to perform that particular medical procedure or not. This must be balanced with the refusal of the physician of performing the procedure (an attitude legally covered by the refusal of the patient to read the consent before signing it) or there is enough that he signed without knowing what is all about (the benefits but also the risks of the procedure). Most of the physicians accept to perform a procedure within these conditions, considering that the legal formalities needed for carrying out the procedure have been met.

On the other hand, if no physician, with regard to an extremely atypical or heteromorphic symptoms, has diagnostic suspicions (a situation often met in the clinical practice and which is a great consumer of paraclinical medical services) is it ethical that this aspect be communicated to the patient who understands and easily accepts the paraclinical investigations indicated for the purpose of establishing the diagnostic? The need for investigations is compulsory nowadays and it reflects the need for a near if not perfect accuracy of the diagnosis, which would mean a better therapeutic approach, but at the same time would satisfy the physician's need of scientific support in case of medical disputes. Most of the investigations present risks and this implies that each intervention requires its own procedure of obtaining an informed consent.

Peculiar patterns of communication in Gastroenterology and Hepatology

Delicate problems regarding the communication between physician and patient appear when the physician must present a diagnostic conclusion resulting from a diagnostic algorithm, including clinical-anamnesis and investigational elements. The diagnostic can be presented in strictly medical terms (e.g. "hepatocellular carcinoma stage IV with portal and biliary invasion; pulmonary metastases"), in exact terms, but avoiding semantic notions that often morally destabilize the patient, who gives up at times fighting against the disease (e.g. "a tumor hepatic formation which causes pulmonary trouble") or in popular terms when the medical knowledge level of the patient is below the average understanding level (e.g. "an abnormal meat elevation in the liver”). The physician often chooses such a formulation so as to be understood by the patient, and might not create a major conflict with his/her psycho-emotional status. It is obvious that the rigid ethical norms always require the first statement, but is it to the benefit of the patient? More than that, are there physicians who, before a serious case such as the previously mentioned one, when realizing that the patient is above the current therapeutic resources, adopt phrases which are obviously far apart from the real diagnostic (ex. “chronic hepatic disease” or “nodular chronic hepatitis”), contrary to the current ethical norms which require the explicit formulation of the diagnostic presented to the patient. In other situations, the families or the caregivers of the patient, more or less concerned about his condition, require the physician not to communicate the diagnostic to the patient unless the condition is extremely serious and with an unpleasant prognostic; this type of request is often performed for the purpose of protecting the patient from the probable psychological consequences that might occur after listening this kind of information. However, the physician cannot trust that this is the only reason for the request. That is why it is advisable not to answer the request, but to find a direct communication variant with the patient. A subtle attitude must be taken into account when a pediatric patient is involved; the sometimes excessive paternalism within the therapy of the pediatric neoplastic diseases justifies in terms of a deeply utilitarian attitude relative to the binome formed of the reserved prognostic and the young age (McCoy, 2008). This context is related to the legal frame of the infancy, based on the developing judgment of the minor, for whom the parents or the legal representatives are to give the consent.

A particular dialogue is the one carried out by the physician with himself, a dialogue subject to the same general principles of the communication. For the procedures with different finality (e.g. a total colonoscopy versus an incomplete one), the motivation of the physician is one of the strongest in its complete performance; obviously, this is possible only if the same physician is the one who consulted the patient and performed the procedure (e.g. if the physician suspects a caecum cancer then the colonoscopy, even if it is a difficult one, shall be often performed, but if the physician suspects, based on clinical criteria, a hemorrhoid bleeding and the colonoscopy is difficult, then the physician has the tendency of giving up carrying out the procedure after the performance of a partial colonoscopy). The appearance of complications in the evolution process of a disease shall be communicated to the patient by the attending physician. The communication method should include the specification of the respective complication, the formulation of certain possible causes of occurrence, but also the therapeutic measures which have to become a must for solving it within maximum safety conditions for the patient. In these situations, the choice of the type of communication is extremely important. It should be characterized by calmness and certainty (even if the physician does not truly feel this) so as to encourage the patient. He must communicate with calm and equilibrium the failure of a previously prescribed treatment, insisting on the manners of approaching other therapeutic means; the presentation must be optimistic, by highlighting the obvious possibilities and the future therapeutic resources, avoiding the reference to past unpleasant events.

Conclusions

Belief in certain classical rigors, with value of principles, confers a basic and temporal unity to biomedical ethics. These principles often become axioms accepted by long use and visibility within the activities of biomedical professions since ancient times. However, these ethical standards cannot be deprived of adaptations, according to the moral and social-cultural values of each doctor and patient involved in a given medical professional relationship. Obviously, regardless of the particular aspects of his own value system, the physician is obliged from a deontological point of view to be aware of the needs of each patient and to act as a professional for this purpose. This deontological obligation makes the architecture of the patient-physician relationship become a dynamic one. Moreover, even within the same professional relationship, we can notice a transgression in time from paternal attitudes to contractual legal rigors and essentialist pragmatic actions, up to the deliberative bilateral active participation. For these reasons, we may state that the relationship physician-patient characterizes the involved parties, without an imposed pattern acting as a professional directive.

We cannot neglect that the principles of beneficence and autonomy remain ethical and deontological pillars of the medical profession. Their historical bases, and the philosophical complexity revealed in several well known studies require their acquisition by any professional in the biomedical field. However, one must also be aware of the cases where the rigors of medical profession, or even the law, particularize the practical cohesion of these principles: for instance the attenuation of autonomy in the case of minors, in major adults deprived by a court of their capacity of taking decisions, in emergency situations, or the diminishment of the interventions on behalf of the principle of beneficence regarding therapeutic abstinence in terminal cases. In such situations, as in the case of a new contact with the patient, the physician must observe the professional, legal, and deontological norms, even at the risk of stumping his/her personal moral values, or of those of the caregivers, or of the patient.

It follows that beneficence and autonomy regarded in a pragmatic manner are characterized by variability. More than that, they characterize each individual patient, this fact being testified and defined at material level, but also at legal level by the repeated sampling of the informed consent. Despite the verbosity of the legal information and terminology, the informed consent documents aim at placing the parties of the medical act, legally regarded, on a position of equality regarding the actions or inactions defining the reciprocal rights and obligations within this kind of professional relationship. The ambivalence in professional and legal-probatory meaning of these acts or undertakings of sampling the consent can determine manipulatory finalities when it comes about the comprehension and acceptance by the patient of certain medical professional information. This risk becomes manifest mainly when consent sampling is consensual within the verbal, non-verbal and para-verbal communication between the practitioner and the patient.

Therefore, the professional techniques that sometimes have an unpleasant connotation, e.g. suggestion or persuasion, can be medically and scientifically justified as an integrating part of a behavior therapy. Even if they belong to the field of psychotherapy, behaviorism and consequently behavior therapies are among the therapeutic bases in many of the intercurrent medical specialties. However, behavior control is not deprived of risks, even more when it acts on the cognition systems of the patients, altering sometimes in a discrete manner their intelligential and volitive attitudes.

In summary, based on the common gastroenterological and hepatological practice, this paper tried to raise the awareness of physicians about the instability of the beneficence attitudes specific to the common medical activities, within the context of the vulnerability and of the predisposition to behavior control and even manipulation specific to most patients. These ethical dilemmas regarding the promotion of beneficence and the background of the attempts to preserve the bilateral autonomy within the professional relationship often remain unnoticed. An important part of the classical or modern specialty studies is included in the references that accompany this paper for the purpose of supporting our practical hypotheses with a theoretical critical repertoire. We consider that the ethical dilemmas of the field discussed in this paper are important and we must endeavour to develop practitioners' awareness about their answers so that each of them might adapt them to the required moral, deontological and legal standards.

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