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Physicians' Responsibility and Patient Autonomy: Must one come at the expense of the other?

“Forced medical treatment is not a rare occurrence confined to grimy hospitals in totalitarian regimes,” according to Eve Hillary, author of the article “Forced Medical Treatment and Denying Parental Rights - Sarah's Last Wish.” Medical ethicists claim this occurs thousands of times daily even in first-world nations with complex health care systems. Especially prevalent are situations in which children are forced into or denied medical treatments against the will of both the child and their parents. For example, Hillary describes how in a single month one hospital documented 314 “involuntary treatment orders,” of which only half were psychiatric admissions that could be accounted for by a patient’s inability to make an informed, rational decision. Although current medical ethics policies dictate that mentally competent individuals can make their own medical decisions, parents whose choices differ from those of their children’s physicians are increasingly being forced by law to give up their decision-making power.

Hillary details the case of one eleven-year-old child, Sarah, whose parents desired to take her to a specialized hospital for cancer treatment after her cancerous tumor had been misdiagnosed as a pregnancy and they lost confidence in the local hospital. However, the suspected pregnancy had been reported to child protection services, and a social worker obtained a court order that “authorized police to use ‘any force necessary’ to apprehend Sarah” so that the

doctors at the local hospital could administer whatever treatment they thought was indicated. Sarah was like a pawn in a game of chess. She and her parents had no control over her treatment. The physicians at the local hospital carried out a six-month treatment plan, including forced chemotherapy and surgery, which proved fatally unsuccessful and violated the rights of both the patient and her parents.

Historically in the healthcare system of the United States, physicians made decisions about the proper care for their patients and carried out what they saw as the correct treatment choice with little to no input from the patient. Physicians generally did not inform their patients about their care options, nor did they give them a choice concerning whether to receive a treatment. Often called paternalistic medicine, this system of care enabled physicians to follow their morals and consciences in regards to the care they provided. However, it meant that patients gave up their free will once they entered under the care of a physician.

As Azgad Gold outlines in his journal article “Physicians' Right of Conscience— Beyond Politics,” this standard practice changed dramatically during the 1960’s through the “informed consent revolution.” During this revolution of the healthcare system, it was recognized that patients have a right to make decisions concerning their care to a greater extent than simply choosing a provider. Healthcare professionals began to better explain to patients the causes of their symptoms and possible treatment options. While still given recommendations concerning various treatments, the patient gained the role of making the final choice of treatment and could give or withhold their consent for a treatment to be performed. This important increase in patients’ rights, however, was offset by a decrease in the rights of the care providers.

As the value placed on the right of patients to make decisions concerning their care increased, the care provided was no longer solely the choice of the provider. Thus, a patient could refuse a treatment suggested by the physician as the best option and request a treatment that the physician thought less effective, or possibly even harmful. This raises the question of whether a healthcare provider should be required to provide any treatment that a patient chooses, even if they do not agree with the patient's choice.

This issue is at the heart of the current debate over the balance between physicians' right of conscience (their right to choose whether to perform treatments) and patients' autonomy (their right to choose whether a treatment is performed on them). Both are important, and it seems that an increase in one might necessarily cause a decrease in the other. If there truly is a negative correlation, where should the balance be struck between the rights of the patient and those of the provider? Who should decide this balance legally, and how should it be enforced? Or, is there a system in which both parties could have full autonomy and right of conscience?

Decisions concerning the relative importance of the rights of the patient versus those of the provider affect many healthcare areas. These range from reproductive technology, abortion and sterilization to euthanasia, end-of-life care and access to controlled substances such as opioids. Historically, the Oath of Hippocrates has guided physicians in their decisions, and even today most graduating medical students take a modernized version of the oath. As outlined in a presentation on physician ethics by Weber State University, the oath was revised to be made more relevant to today's medical practitioners. For example, it adds a promise to maintain an awareness of advances in the practice of medicine and to "treat all without exception" as long as doing so does not compromise the treatment of others.

There are now numerous versions of the Hippocratic Oath, some of which still prohibit prescribing drugs or performing acts with the intent to “deliberately end a human life” including “life from fertilization to natural death” as did the original oath (as translated by Ludwig Edelstein). Given the fact that many physicians do perform abortive procedures, is taking the oath now solely symbolic and for tradition’s sake? Is the integrity of the Hippocratic Oath diminished by removing certain vows? Are the remaining elements of the oath still honored by physicians although some disregard this section? Has an increased respect for patients’ right to autonomy become more important to physicians than following the stipulations of the original Hippocratic Oath?

Some versions of the oath now include a promise to not treat a patient without their “valid informed consent” (or that of their legal guardian) and to abstain from any “corruption or seduction” of a patient. Physicians not only have the responsibility to educate patients on their medical condition and treatment options, but also have the further responsibility to do so in a manner that does not attempt to unduly emotionally influence patients’ choices. As all physicians in the United States, except for those who opt out, take this oath upon their graduation from medical school, it is worth considering how seriously they take these promises concerning the principles that should guide their practice of medicine and view of physician responsibility.

For many physicians, being forced to carry out a procedure they think is not in the best interest of their patient is not a viable option, as this would be violating the “do no harm” clause of the Hippocratic oath. Some might choose to give up their medical careers rather than knowingly hurt a patient. Other physicians with strong morals or faith might be placed in a position of either violating their conscience or facing legal proceedings, fines, and the possibility of losing their job. Physicians desire a broad right of conscience; however, for patients, greater

physician right of conscience leads to a probable decrease in their autonomy. For example, should a patient be able to insist on a treatment being performed or a drug being prescribed even if the physician recommends against it? It may have a huge impact on their health and they should have control over their own bodies. Although most patients respect the knowledge of physicians and support the physician's treatment recommendation in the majority of cases, they are in favor of greater patient autonomy.

Legally, according to an article entitled, "Healthcare - Patient Rights," in the *Encyclopedia of Everyday Law*, there is no overarching document detailing patient rights nationwide. Each hospital has its own "Patient Bill of Rights." However, the majority of hospitals use a document from the American Medical Association which includes guidelines for the right to privacy in a doctor-patient relationship. While important, in certain situations such as the prescription of controlled substances, the doctor may be legally required to share information about patient care with the government. Information that the patient shares with the doctor, however, may only be disclosed in cases of suspected abuse, communicable diseases, and threats of harm. In terms of right to treatment, no patient may be turned away from a hospital in the United States if they are in an emergency condition, even if they cannot pay for treatment. Once a patient's condition is stabilized, the hospital is not required to provide further free treatment. Another important aspect in the guidelines hospitals follow is the right of a patient to pre-determination of medical care. In this scenario, a patient creates a formal document to outline their preferred medical choices in advance while they are still able to make rational decisions. Thus, a patient's right of choice can be maintained even if they lose rational mental capacity in the future.

This document succinctly explains patient rights; however, it is shocking that there are not yet nationwide legal stipulations on patient rights concerning choice of and access to medical care. In many situations, it is still left up to an individual physician to make the choice of whether a patient has the right to choice of care given the particular situation. If a physician works for a hospital that chooses to abide by the American Medical Association guidelines, the physician must follow them in making this judgment call or risk losing their job. In the previously described situation that Sarah faced, due to government involvement, the legal right of her parents to make healthcare choices for her was taken away. The hospital was granted the legal power to choose her treatment plan. In this extreme case of paternalistic medicine, despite the failure of the treatment in save Sarah's life, the physicians involved in her care were legally justified to deny her and her parents any choice of care. However, the question of whether they were ethically justified remains. This example highlights the importance of protecting patient autonomy, so that a patient (or their legal guardian) is not unnecessarily denied their right to choose what is done to their own body.

If a physician runs a private practice, a situation in which they would override patient choice is not likely to occur because cases in which there is limited rational mental capacity or government involvement are generally referred to a hospital. If a physician limited patient choice in a case where it was not warranted, they could face legal action and the possibility of having their license revoked. In an article for the *Ethics Journal of the American Medical Association*, Marco describes a situation in which the patient's rational mental capacity and right to autonomy was not clear. A patient was admitted to an emergency room with a cut on his forehead and significant swelling on his head and around his eyes. The emergency room physician wanted to check for bleeding in the brain and skull fractures using a CT scan and explained to the patient

the strong possibility that these injuries could be fatal if left undiagnosed and untreated. The patient refused, and the doctor struggled with whether it was her responsibility as a physician to nonetheless carry out the diagnostic test. Most physicians agree that if someone “possesses appropriate decisional capacity,” then they have the right to make life-altering choices concerning medical treatment. However, given the dynamic nature of this capacity, which is affected by many things from alcohol to stress to mental illness to head trauma, how can a physician be sure that the patient has the “level of needed capacity” for a decision?

Marco writes that if determination of decisional capacity cannot be carried out, that detaining the patient is appropriate. She makes this claim as a recognized expert in the field of medical ethics; however, she does not provide evidence to support her stance. Indeed, throughout the article Marco uses the words “must” and “should” many times, in a sense placing her decision making skills over those of the physicians reading the article, whom she encourages to place their decision making skills over those of their patients. While this patronizing tone prompts readers to accept her expert opinion, it also demonstrates her stance that limited paternalism should still play a role in modern medicine.

On the other end of the spectrum, the passionate patient care advocate Trisha Torrey wrote an article inspired by her personal experience of misdiagnosis within the healthcare system. Torrey argues that “the savviest of patients should be able to bypass seeing doctors to access the care they need” with the rationale that these patients have greater knowledge of their disease than doctors usually do and so should be in control of the treatment plan to manage their disease. She goes so far as to say that at times doctors “actually get in the way” and prevent the patient from improving their own health. She proposes that highly informed patients should have the right to self-prescribe, which would save them time and money along with doing the same for

the healthcare system by freeing up doctors' time to see other patients. She clarifies her proposal by writing that "should [the patient] actually want to see a doctor," they could, and there would need to be limited oversight by a physician to verify that the patient is sufficiently informed and able to self-medicate.

An attitude that doctors are only necessary for informed patients due to the constraints of the current healthcare system's structure prevails among many people in favor of greater patient autonomy. However, I think it is important to consider the interrelatedness of the many organ systems in the body, and the possibility of drug interactions. While physicians and pharmacists do make errors, especially when overworked, they are more likely to catch possible negative interactions than would most patients. This is due to their education concerning the chemistry of pharmaceutical drugs and how they affect patients biologically. Most self-medicating patients would need to rely solely on sourcing information from a database, which might not list all interactions. A physician who has gone through a minimum of seven years of medical training preceded by an undergraduate education including chemistry and biology coursework has a greater understanding of the complexities of human physiology than someone who has researched in depth only a single disease. While doctors still do misdiagnose and make errors in carrying out treatment plans, they are more likely to make the right decision than an untrained individual. However, if a patient would prefer to risk incorrect treatment due to their own mistake rather than a mistake made by a physician, who is the doctor to say they should not be able to?

Marco, writing from the perspective of a physician, acknowledges that patients have the right to choose to decline a treatment if they have full decisional capacity, but does not discuss whether a patient has the right to choose a treatment not proposed by the physician, as Torrey

suggests. Further complicating the situation is the reality that health insurance companies can refuse to pay for treatments they do not think are medically warranted, which can leave a patient unable to afford a desired treatment. Marco's categorization of the physician as a "gatekeeper" of access to medical treatments could also be applied to health insurance companies. Who should judge whether a patient has the understanding and critical thinking abilities needed to make their own medical decisions, possibly contrary to medical advice? Could we trust insurance companies to authorize the most effective medical treatments, which can be quite expensive, without a physician advising the treatments? This scenario can be visualized as a patient standing on the opposite side of a fence from their health, while a physician and an insurance company decide what treatments and drugs are passed across.

Torrey agrees that the doctor should act as a gatekeeper; however, she views this as a necessary limitation given the current medical system, and thinks that patients would have improved access to what they need with as little physician interference as possible. Torrey places a high priority on patients who understand their conditions and treatment options being granted access to easily obtain the medications they desire. Still, she recognizes the need to regulate access to drugs for those who are not as informed about their condition and available treatment methods. Thus, while both authors acknowledge the right of patients to choice of care and the responsibility of physicians to regulate those choices, Torrey places greater importance on patients' right to choose, whereas Marco places it on physicians' responsibility.

The perspectives of the physician and patient as understood from these spokeswomen are more similar than I had expected. Both Torrey and Marco argue that the patient should have control over their medical treatments to the extent that the patient understands the potential benefits and risks involved and has the capability to make a rational decision. Similarly, they

agree that the physician must maintain the role of a gatekeeper, at times limiting the choices of the patient, for the patients' own welfare. However, neither of these articles discussed whether the physician has a right of refusal equal to that of a patient if they personally are not in support of a possible treatment option.

The topic of how to juggle the responsibility of physicians to provide proper care and the right of patients to choose their care is studied by medical students nationwide as they prepare to enter the medical profession. The Ethics in Medicine class taken by medical students at the University of Washington explains the method of care accepted by the majority of physicians today. As the physician-patient relationship became less paternalistic over the past century, the issue of how to determine situations when it may still be appropriate to override patient preferences became increasingly important. According to Ludwig from the University of Washington, the physician should preferably "attempt, without coercion or manipulation, to persuade the patient of the harmful nature of choosing to avoid treatment." The opinion of the university is that if the patient objects to treatment, "disregard for the patient's right to noninterference is rarely indicated," but in certain circumstances may be considered, such as during pregnancy and in cases of mental incompetency. The University of Washington promotes patient autonomy, with rare exceptions in which physician responsibility to "do no harm" dominates.

I wonder how these medical ethics professors would respond to Sarah's situation from the story previously summarized, in which her parents were denied their request to transfer their daughter to a specialized facility for cancer treatment. The discrepancy between the current paternalistic practices of some physicians and what is being taught in medical school is distinct. Still, even in the current medical curriculum, while the right of patients to decline treatment is

accepted, the concept of a patient's right to suggest alternative treatments or self-treat is not addressed. Thus, while the information presented points to a perspective of increasing respect for patient autonomy among physicians of the new generation, it does not yet defend a patient's right to truly be in charge of their own care. I hope this current trend towards autonomy continues, and that in the future there will be more open communication in considering both treatments desired by the patient and those suggested by the physician. I look forward to a future in which physicians and patients are colleagues on a team, working together with the goal of improving and protecting the patient's health. In a collaborative relationship built on trust and mutual respect, a physician and patient can equally participate in solving existing medical problems and promoting a patient's future health.

Works Cited

- Gold, A. "Physicians' Right of Conscience— Beyond Politics." *The Journal of Law, Medicine & Ethics* 38: 134–142 (2010).
- Hillary, Eve. "Forced Medical Treatment and Denying Parental Rights - Sarah's Last Wish" *Signs of the Times*. 30 May 2012. <<http://www.sott.net/articles/show/246096-Forced-Medical-Treatment-and-Denying-Parental-Rights-Sarah-s-Last-Wish>> Web. 2 July 2012.
- Ludwig, MaryJo. "Physician-Patient Relationship." *University of Washington School of Medicine: Ethics in Medicine*. 11 April 2008. <<http://depts.washington.edu/bioethx/topics/physpt.html>> Web. 30 June 2012.
- Marco, Catherine A. "Does Patient Autonomy Outweigh Duty to Treat?" *American Medical Association Journal of Ethics* 5.2 (2003). Web. 22 June 2012.
- Phelps, Shirelle. "Healthcare - Patient Rights." *Encyclopedia of Everyday Law* (2003). <<http://www.enotes.com/healthcare-reference>> Web. 1 July 2012.
- "Physician Issues." Weber State University. <faculty.weber.edu/lburton/4400/Physician%20Issues.ppt> Web. 22 February 2013.
- "The 1995 Restatement of the Oath of Hippocrates" *Value of Life Committee, Inc.* June 1995.
- Torrey, Trisha. "Maybe Some of Us Just Don't Need Doctors." *About.com*. 19 June 2012. <<http://patients.about.com/b/2012/06/19/maybe-some-of-us-just-dont-need-doctors.htm>> Web. 22 June 2012.