Reading SAL Week 3: Professional Roles

Goldman: *Refutation of Medical Paternalism*

Goldman starts by asking if there is any reason a physician should be allowed to behave because of his professional role in a way we would not allow a non-professional to behave. [= "strong role differentiation"]

His assumption is that the person himself should have access to information vital to his own wellbeing. In the medical context this means the right to be told the truth about his condition, and the right to accept or refuse or withdraw tx on the basis of adequate information.

Premise: self determination is a primary right. Lying in the context of medical decision making is more critical than not telling the truth: it is interference with the patient's right of self determination: "analogous to the use of force, or more coercive."

Def. of paternalism: the overriding or restricting of rights or freedoms of individuals for their own good.

> Paternalistic measures may be invoked when either the individual in question [or any rational person with adequate knowledge of the situation] would choose a certain course of conduct, and yet this course is not taken by the individual— solely because of ignorance, fear, carelessness, depression or other uncontroversially irrational motives—**and** harm will result.

[The importance of harm is NOT a consequentialist one; but the magnitude of harm is rather evidence that the person is not acting according with his own values, so is not autonomous "in the deepest sense."]
Autonomy is a source of value for other goods.

Argument FOR medical paternalism:

1. Disclosure of information may increase the risk of depression or unoptimal tx
2. Disclosure of information may thus be detrimental to health
3. Health and long life can be assumed to be important for folks who consult docs
4. Worsening health or hastening death can be assumed to be contrary to the patient's own true value orderings.

So: paternalism is therefore justified; docs may sometimes override patients' prima facie rights to information.

Refutation of argument for medical paternalism:

Refute one of the premises: i.e., premise **3**. For instance: we do not design social policy to prevent death, nor spend lotsa money on health; we fight wars…Not fair to "assume" priorities of others.

So Goldman concludes that health and long life are less fundamental values than self-determination.

Ackerman: Why Doctors Should Intervene

1980 AMA Code of Ethics: Physicians MUST
.reveal all relevant information
.protect patient confidentiality

Current result: a morality of non-intervention (=E&E's 'informative' model).

But: patients are (categorically and to some extent situationally) ILL: with reduced physical (and mental / emotional) strength; often suffering from denial, depression, guilt, fear, anger…

Their most obvious needs: competent care and relevant information. But the psychological or social impediments require more explicit interventions to address fear, denial or other sources of distress. So the physician should explore those areas with the patient.

Does Ackerman's recommendation correspond to any of E&E's models?
E&E don't seem to pay much attention to the psychosocial corollaries to physical illness.
Does the usefulness of a model for Phn/Pt relationship depend upon the nature of the medical emergency? Consider what you might want from your physician if you have a broken leg. If you have a communicable disease. If you have a readily-cured disease. If you are going in for an annual physical…

Emanuel and Emanuel: *Four models of the physician patient relationship*

The models [='regulative ideals'] differ with respect to the
- Goals of the interaction
- Obligations of the physician
- Role played by patient values
- Conception of autonomy embodied in the model

I: paternalistic
- Goal: patient's compliance with recommended tx
- Physician's obligation: to know what is best for the patient's health
- Patient values: physician presupposes health is his preeminent value
- Conception of autonomy: assent to the physician's judgment
  - Problem: can't *presuppose* that values are shared ~ phn/pt

II: informative
- Goal: determining the course of tx
- Physician's obligation: source of technical / medical information
- Patient values: patient matches the information given to his preferences
- Conception of autonomy: patient controls the medical decision making
  - Problem: people can't know what they want in a vacuum

III: interpretive
- Goal: elucidation of patient values + map options on those values
- Physicians's obligation: to know and describe disease and tx options
- Patient values: physician also takes some responsibility for them. counsel.
- Conception of autonomy: self-understanding on the part of the patient
  - Problem: explores patient's desires, but excludes phn evaluative j's

IV: deliberative
- Goal: form patient values, insofar as they are health-related
- Physician's role: guide, counselor and friend [in health matters]
- Patient values: elaborated, improved and supplemented
- Conception of autonomy: moral self-development

A fifth model—instrumental—is not considered because it has a goal other than the patient's best interest.

Patient autonomy is currently defined as 'choice' and 'control.' The informative model ignores second-order desires. [?] The Deliberative model is risky, but E&E think it is best.
- --its understanding of 'autonomy' is closest to our ordinary understanding
- --it give the physician a role closest to the traditional one
- --persuasion is not = to coercion, so its not paternalistic
- --patients value physician's values
- --physicians are SUPPOSED to give advice

So: we need to make ethical values more salient in medical education, and reward time spent with patients.

Case: *Beneficence today or autonomy tomorrow?*

An unconscious patient has an inoperable, untreatable, respiration-obstructing tumor. The options are to: withdraw all tx; give comfort-care only; surgically intervene; or to wake her up and discuss the options with her.

Case: *Please Don't Tell!*

An HIV positive patient will be cared for by his sister. Do we have a duty to warn?

Reading SAL: Week 4: Communication, Truth, Disclosure

Benjamin Freedman: *Offering Truth*
Sometimes

(1) patients themselves don't want to know—and they have the right to remain uninformed.
(2) families want the patient to remain uninformed
--but the truth should still be offered to the patient—surrogates cannot remove from the physician his obligation to tell the truth.
--patients can defer information; but if they desire it, few families will resist.

Cultural or even individual differences may underlie different approaches to receiving truth about their own circumstances.

Jay Katz: Informed Consent. Must it Remain a Fairytale? (1990)

1. Prehistory: Some relevant court cases: *Salgo v. Leland Stanford University Board of Trustees* (Ca, 1957); *Nathan v. Kline* (Kansas, 1960)
Case law decreed through these and some subsequent cases that physicians must share decision making authority with their patients—a radical change from the ancient tradition. (For instance, the 1847 AMA code is much closer to the Hippocratic approach.)
The authority of the physician rested on (a) esoteric knowledge via education and experience (=knows more about illness and disease than the patient); (b) patients are ill, thus situationally and dispositionally non-autonomous; and (c) the assumption that professional ethics will prevent abuses, as well as encouraging beneficence. But those do not guarantee that the physician will have the same values (or priority among values) as the patient.

2. Medical technology: As medical technology improved and medical science advanced, more options became available. In the process the chart became an intermediary between the physician and the patient.

3. Impact of law: the court cases revealed the gap between old expectations and new reality. Some of the improvements in medicine exposed the patient to possible harms undreamed of by more primitive medical practice. So increased need to inform patients of possible harms and risks.

(It is interesting that failure to warn about risks, malpractice, is considered negligence, but not battery—a different category of offence.)

Arato v. Avedon (Ca, 1992) made specific the need to disclose prognosis.

Because it is a legal doctrine, the task of doing the work in a medical context remains to be done.

The underlying concept is that physicians and patients must make decisions jointly—and for that to work, physicians must change their current disclosure practices.
Only then will social policy be translated into medical policy.

4. But don't kid yourself that there are no barriers to joint decision making: (a) medical uncertainty: In the light of what modern medicine still does NOT know, physicians must be willing to admit ignorance, acknowledge alternatives, and pay more attention to how to talk about these things. (b) patient incompetence: it's not just condescension to acknowledge it; but we don't know enough about it, and the situation is complicated by bad communication and variability in situation. (c) patient autonomy: the teachings on this subject are ambiguous, and it is balanced (as for instance by B&C) by beneficence and non-malevolence as competing principles in a confusing way.

5. The current state of physician/patient decision making: physicians themselves are ambivalent about their own priorities (which include prominently the quest for diagnosis and cure).

Katz's summary: patients are adults, not children. It is not always the case that the best treatment is what is best. We need to acknowledge more openly the extent to which much remains uncertain. We need to recognize the possible merit in other views than our own. In short, trust your patients more.

Katz is a psychiatrist. Do you think that his professional specialty may affect his approach to this important ethical issue?

Francoise Baylis: *Errors in medicine: Nurturing truthfulness*
When errors lead to adverse [=bad] outcomes, physicians sometimes don't reveal them.
Why not?

1—causal chain may be uncertain; an adverse outcome is not necessarily due to an error, but may involve risk and chance as well.

2—may be overdetermined or multi-factorial

3—belief that disclosure does more harm than good

--increased anxiety

--loss of confidence in medicine or trust in physician

4—self-interest or protection of colleagues

5—fear of litigation

There is an institutionalization of denial, discounting causal role, and non-disclosure.
The professional acceptance of and encouraging of non-disclosure means that truth telling around errors is shunned, and disclosure becomes supererogatory rather than a duty.
The solution is to change the attitudes surrounding error from blaming to improving the systems or skills that led to the problem
We also need to correct a misapprehension about how truth is received: truth telling, even of unpleasant truths, enhances rather than eroding trust.
We need no-fault medical insurance and tort reform.
We need to institutionalize positive rewards for those who speak truth.

Lainie Friedman Ross: *Disclosing misattributed paternity*

When just mom comes to genetic counseling, she is the patient. But what are the obligations of genetic counselors for revealing misattributed paternity when it is the couple who are the patients?

. 96% believe confidentiality overrides disclosure: 'genetic counseling should not be used in ways that disrupt families.'

. LFR argues that NOT disclosing to the male wrongs him: it is deceptive and immoral.

Alternatives: not disclosing to either; disclosing to her, not him; saying "testing inconclusive." She disagrees with all these options.
Objections to her position:

.potential threat to mother and child

.psychological risks to family

.failure to respect mother's right to privacy

LFR argues that the obligation to disclose/ tell the truth overrides these concerns

Tarasoff

This is an important court case that mediates between the patient's 'right' to confidentiality in the phyn/pt relationship, and the duty to protect identifiable others.

Despite heated defense of the confidentiality obligation of physicians the defendants were sanctioned because of their failure to warn . The duty of confidentiality, in this case, was judged to be outweighed by the 'public interest in safety from violent assault', and "Tarasoff' laws were passed in many states making the exemption legal.

.