Session 7. The Interrelationship Between Legal and Ethical Issues in Medical Practice (9/29/15) – Note Room Change to Junker

Objectives:

At the end of this session, students will be able to:

- Describe major differences in orientation between ethics and the law
- Identify appropriate resources for addressing ethical and legal issues
- Describe the meaning and ethical implications of conflicts of interest in medicine

Lecture:

- Nicole Lehman, JD

Small Group Exercise:

- Q&A regarding lecture and readings
- Discuss case from lecture and readings

Required Readings:

- Deville. "What Does the Law Say"
- Green, "Inappropriate Requests for Medical Exemptions and Privileges"
- Case. "Parking Pass for Grandma"

Commentary

'What Does the Law Say?'
Law, Ethics, and Medical Decision Making

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Physicians and medical students are seldom tempted to act boldly where legal issues are concerned. Instead, the growing legal presence in medicine has generated resentment and confusion among physicians[1] and infused an element of hesitancy and caution into both medical practice and medical training. The effects of malpractice fears on medical practice and the physician-patient relationship have been widely documented,[2,3] and observers at many medical schools have reported that medicolegal anxieties have compromised students' professional training.[4] Legal concerns have intruded into physicians' and medical students' consciousness in other ways as well. Never before have there been as many regulations, statutes, and precedents affecting such a broad range of a physician's professional life. From the "Baby Doe" regulations to court rulings on the end-stage of life, from the subtleties of informed consent requirements to the legal intricacies of treating patients with the acquired immunodeficiency syndrome, medical professionals face a nearly overwhelming barrage of medicolegal concerns.

Although legal questions are profoundly important, physicians face an increasing number of equally complex ethical challenges. The profession has responded. Medical journals regularly publish ethical discussions, and medical schools now require some manner of formal training in ethics. Often, however, the subject matter of legal and ethical debates overlaps, and when it does, the ethical discussion is frequently infected by the legal concerns. The most common and often the first question posed by physicians and medical students in ethical discussions is, "What does the law say?"

Legal and ethical conclusions on biomedical issues are occasionally identical, and legal rulings have in some instances accelerated the scrupulous consideration of ethical problems in medicine. In addition, accurate knowledge of the law is sometimes necessary so that physicians will feel free to treat their patients in a more ethical manner.[5] The confluence of legal and ethical is far from complete, however, and a great danger arises when the two are conflated. When an ethical dilemma is framed first and primarily in legal terms, it risks dramatically skewing the inquiry from the outset and may allow inappropriate considerations and assumptions to guide the discussion. Physicians' interest in the law for self-protection is understandable and legitimate, but the fear of liability may lead to an overreliance on legal conclusions and approaches to moral problems. Medical professionals must recognize the limited goals and insights of the law and legal thought. As a rule, legal standards are unreliable guides to ethical conduct and should never be allowed to substitute for, or dominate, ethical analysis.

Law as a discipline and a body of knowledge is far from useless in the weighing of ethical options in medicine. Law has proved an effective discipline in the formal, institutionalized resolution of conflicts. Legal reasoning and argumentation are based on a vigorous and open debate of the alternatives of a position. They are an especially useful means of revealing weakness in opposing positions. In addition, the law is frequently viewed as an illustrative collection of beliefs and attitudes, "a cultural artifact, a moral deposit of society."[6,p4] As such, legal conclusions on various biomedical issues might occasionally serve as rough reflections of ordinary moral reasoning.

Despite these plaudits, legal tradition, legal argumentation, and the legal system of judges, juries, and courts do not guarantee a morally or socially correct result. Law, after all, has been used to support slavery, involuntary sterilization, and discriminatory practices and successfully used to delay or thwart a large number of ethical, beneficial, and just civil rights and social welfare policies. Legal reasoning is frequently nothing more than the playing out of a relatively mechanical, recurring set of arguments and counterarguments.[7] The legal adversarial format and sometimes abstract legal principles are seldom the most appropriate means of effectively and sensitively resolving the complex ethical challenges routinely generated by modern health care.[8]

In the interest of objectivity and consistency, the legal process, training, doctrine, and tradition have tended to downplay humanity and individuality. In fact, the law demonstrates its ostensible impartiality by focusing the bulk of its attention on the principles involved and not on the person.[9] While this jurisprudential approach may be successful in achieving some limited goals, namely consistency, it does not lead inevitably to just results, and it is a clearly inappropriate model for resolving bioethical dilemmas. The medical relationship consists of flesh-and-blood physicians and patients. Principles and doctrines

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may inform ethical deliberations, but they should never dominate them. For example, legal-style reasoning tends to focus ethical discussions on the relative rights and duties of the physician and patient. To some extent, a concern with rights-based duties is appropriate. But a myopic concentration on rights and duties may suppress other equally or more important sources of responsibility and ethical guidance. Moral problems might also be fruitfully analyzed in light of personal loyalties and professional expectations and informed by cultural conventions and religious traditions.[10] A legally dominated discussion could undervalue these other elements that are clearly relevant to the resolution of ethical problems. Finally, the "numbing and suppressing of emotion," a sometimes unfortunate side effect of dispassionate legal analysis, may work to impair one's moral sense. Some writers, and, I suspect, much of society, believe that the application of both heart and mind, intuition and reason, are required in moral inquiries.[11]

In addition, it is reasonable to ask whether judges are well suited or well situated to make decisions of great ethical magnitude and complexity. Typically, judges' talents and training are appropriate for the duties assigned them. The best judges have excellent "legal minds." They are careful, critical, and lucid thinkers ideally equipped to make legal decisions. But their education and experience—ordinarily three years of law school and a stint in academe or private practice—do not necessarily supply them with the array of resources necessary to identify, unravel, and reconcile the complexities of medical ethical situations. The judge's role, though sometimes ill defined, is ultimately circumscribed and limited by the facts and issues raised by a particular case. A court's first duty is to resolve the specific dispute presented for adjudication. The court's ruling on that case sometimes generates doctrine that can be applied in analogous situations. It is important to remember that the development of that doctrine, although general in applicability, was spawned in part by the particular facts of the original dispute. Consequently, the character of cases presented to judges and courts for adjudication may undermine the universality and utility of the resulting legal doctrine.

By their nature, courts deal with medical relationships gone wrong. This raw material for medicolegal doctrine engenders a frame of reference and precedents that frequently misapprehend the nature of the medical relationship.[12,13] For example, several observers have recognized the unintentionally baneful effect of legal doctrine on the practice of informed consent. Because the law primarily emphasizes the importance of informing patients of the risks of procedures, typically less attention has been focused on other aspects of physician-patient communication that are equally important for patient autonomy and well-being.[12] The President's Commission for the Study of Ethical Problems in Medicine concluded that "its vision of the patient-professional relationship" cannot be achieved "primarily through reliance on the law."[13(p152)]

As the 19th century jurisprudential adage notes, "Hard cases make bad law." Virtually all central bioethical issues represent hard cases, and it is arguable that there are numerous instances of "bad law" in biomedical jurisprudence. Legal decisions and statutory proclamations are subject to the vicissitudes of interest group politics, the personal philosophy of judges and legislatures, idiosyncratic viewpoints, bad research, and poor briefing. Not only do legal rules and conclusions regularly deviate from well-reasoned ethical precepts on the same subject, but some scholars argue that law typically lags substantially behind morality.[14(p196)] Consequently, it is sometimes uncertain whether a legal doctrine will even serve as a reliable reflection of collective cultural wisdom, let alone as an objective, well-reasoned, comprehensive ethical principle.

Real clinical situations typically present a complicated blend of ethical and legal concerns that are often difficult to consider in isolation. A particular treatment option or course of action may be legal and ethical, legal and unethical, illegal and ethical, or illegal and unethical. In addition, some medical decisions may be legal and ethical but place the physician at an increased risk of civil liability.[15] A clinical decision based solely or predominantly on legal considerations may in some cases yield an ethical result. That result, however, is not preordained, and in other cases an overreliance on the legal perspective undermines careful, complete, and subtle ethical analysis.

Consider for example a discussion of the ethics of a forced cesarean section. The hypothetical patient, a young woman, is 36 weeks' pregnant, with an undersized pelvic structure and an oversized fetus. Her physicians are convinced that the child cannot be delivered vaginally without severe injury or death to infant, mother, or both. The mother, however, fears surgery and is committed to a "natural" delivery. Discussions frequently focus first on the legal aspects: "Can I get a court order to do a cesarean?" "If I get a court order, am I immune from liability?" "If I do not get a court order and the child is delivered vaginally but is injured or dead, can I be held liable?"[16,17]

These are important questions, but they largely miss and clearly distort the ethical component of the problem. Doing a court-sanctioned cesarean section may be legal, but unethical.[18] Honoring the woman's wishes and attempting a vaginal delivery may be legal and ethical, but could subject the physician to a risk of suit if the child is injured during delivery. Doing a cesarean section against the woman's will without a court order could be both illegal and unethical. In deciding the core ethical question—whether to operate against the woman's will, to risk the health of the fetus, or both—the legal questions confuse rather than aid the ethical reasoning process. As Mattingly has explained, we need ". . . to gain a fresh perspective on this issue by stepping back from the legal debate and considering in a systematic way how ethical guidelines for prenatal medical care are altered by transition to the two-patient obstetric model."[19(p14)] The initial relevant question for physicians in such cases should not be, "Can I get a court order, and will it protect me?" but rather, "Should I operate against the will of the patient?"[17]

Other scenarios raise similar questions. For example,

a group of physicians are treating an unconscious, 72-year-old man with long-term diabetes mellitus diagnosed with gangrene of the toes. The medical staff recommends amputation of the foot to improve the patient's condition and save his life. The patient's wife, a university professor, reports that her husband has explicitly told her that he would rather die than undergo an amputation, and she refuses to permit the operation. The hospital petitions the local court to sanction the operation. The court agrees with the physicians, and the amputation is performed. Although it is clear that the physicians who amputated the elderly patient's foot were acting legally and enjoyed a certain degree of legal protection, it is not as certain that they acted ethically in pursuing a court order to defy what appeared to be a patient's wishes reliably relayed by a close family representative.

How should physicians act in situations where legally correct practice is not necessarily synonymous with ethically correct practice? Should the law be bent or legal dangers ignored to provide better and more ethical medical care? It has been suggested that "[S]ometimes it may be necessary for the health care professional to violate the duty to obey the law in order to fulfill his responsibility to his patient."[20(pp214-215)] Conversely, are there instances in which what is otherwise the most ethically and clinically proper course of action can be legitimately influenced by certain legal considerations? For example, are some instances of defensive medical practice justifiable even though they are not otherwise indicated?

The answers to these questions will depend on the facts of the specific case and are best left to the clinical decision makers and their patients. Individual physicians will have to make personal decisions on how they will weigh and balance patients' needs, ethical duties, and legal requirements and risk. Whatever their decision, it is imperative that they do not mistake law for ethics, nor ethics for law. Physicians are entitled and required to know what the law says about relevant topics. But they must also be prepared to analyze the most profound issues facing their profession without being diverted by sometimes irrelevant legal questions.

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Michael J. Green

Chapter 2

Inappropriate Requests for Medical Exemptions and Privileges

Ralph Potter, a 42 year-old businessman who is an occasional golfing partner of Dr. Osborne, comes to the medical office 2 days before he is scheduled to take a long airplane trip. For personal reasons, Mr. Potter wishes to reschedule his flight. He tells Dr. Osborne that the airline will not refund his ticket unless he has a medical excuse from a physician. Although he is not sick, Mr. Potter asks Dr. Osborne to write a note to the airline stating that he has an acute illness and is unable to fly.

Regina Swift is a 53-year-old patient with non-insulin-dependent diabetes. She recently lost her job as a teacher and no longer has health benefits. She tells her primary care clinician that she has run out of glipizide and metformin, both of which are needed to control her blood sugars. She says that without health insurance, she can no longer afford to purchase her medications. Since she was still employed last month, she asks the clinician to back-date a couple of prescriptions so that her previous insurance policy will pay for the medications.

Albert Holt, a 38-year-old construction worker, is new to the area. He presents to a physician's office reporting low back pain. Mr. Holt says he has had this low back pain on and off for many months and it has been evaluated in detail elsewhere. A physical exam is normal and a review of Mr. Holt's medical records does not reveal a reason for the pain. Mr. Holt is applying for disability compensation, and he wants the physician to fill out some forms to help him receive disability benefits. The physician does not believe that Mr. Holt is unable to work and suspects that he is not being completely forthright.

Alicia Kaplan, a 62-year old patient, has bunions on both feet. These have been chronic and stable and are mild in severity. One day, she tells her primary care clinician that a friend of hers with bunions received a "handicapped" sticker from her doctor that allows her to park her car in parking zones set aside for the handicapped. Mrs. Kaplan says it would make her life much easier if she too had such a sticker for her license plate. She asks the clinician to help her obtain one.

Scope of the Problem

In primary care settings, patients frequently ask clinicians to use their medical authority to help them get special exemptions or privileges from third parties. Sometimes these requests are straightforward and reasonable, as when a patient seeks a release from work during an acute episode of pneumonia. Other times, however, clinicians may consider the requests to be inappropriate for a variety of reasons. This chapter addresses the question of how to recognize and deal with these "inappropriate requests," concluding that to deceive others in order to help resolve such issues for patients is unwarranted.

Defining the Problems and Terms

According to the *Oxford English Dictionary*, something is "inappropriate" if it is "unsuitable to the particular case, unfitting, improper."[1] The

process of determining whether a particular request is unfitting or improper is not always straightforward, however, in part because there is no consensus about what the goals of medicine ought to be. Although it seems appropriate for medicine to aim to prevent disease and injury, relieve pain and suffering, care for the ill, and avoid premature death,[2] questions arise about other goals. Is it the job of a clinician to make people happy? To ensure "customer satisfaction"? To solve a person's financial problems? To ensure access to medical care? Disagreement about these other goals can lead to significant confusion within the medical profession, as can disagreement about whether and how clinicians ought to act to help patients achieve them.

Some might argue that any time clinicians are asked to use their medical expertise and authority to serve social rather than medical ends, an inappropriate request is being made. For example, in a well-known speech before the Association of American Physicians in 1981, Donald Seldin claimed that medicine is a narrow profession, and problems faced by people "are medical problems and medical illnesses only when they can be approached by the theories and techniques of biomedical science."[3] By extension, the physician's only legitimate role is to make diagnoses and initiate treatments based on their expertise in science and pathology. Becoming involved in social, cultural, or personal issues is outside the physician's role and thereby inappropriate.

A broader view of medicine holds that these types of requests are not necessarily inappropriate, since clinicians would be unable to do their jobs well if the focus of their work were limited to addressing derangements of physiologic function. In the real world, clinicians must also contend with a variety of social, cultural, and political problems that affect patients' health. For example, of what use would it be to diagnose and treat childhood lead poisoning if the child then returns to the environment where lead poisoning is certain to recur? As noted by Perkoff, while conceiving physicians' role narrowly might make their work easier, it does not result in better doctors.[4]

In this chapter, I assume the broader view of medicine. The implication of this view is that the *types* of requests exemplified by the above cases are not necessarily inappropriate. Specifically, a patient may legitimately ask a clinician for a medical excuse to change an airline flight, to help obtain medications, to complete a disability assessment, or to acquire a handicapped parking sticker. The central challenge is to distinguish those particular instances that are appropriate from those that are not and to determine what a clinician should do when confronted with the inappropriate ones.

Kinds of Inappropriate Requests

Requests can be inappropriate in several different ways. First, the request may raise questions about boundaries to the clinician-patient relationship. For example, a patient who asks the clinician for money to buy medications for his wife or to borrow the clinician's car to drive her to the emergency room, may be transgressing some undefined but important social boundary. Second, a request may be inappropriate because it requires the clinician to act outside his or her area of medical expertise, as when an internist is asked to take over the medical care of an infant. Third, as discussed in Chap. 1, a request may be inappropriate when there is disagreement about what constitutes a necessary as opposed to desired medical intervention. An example would be a patient who says she needs to undergo magnetic resonance imaging (MRI) of the head to confirm a clinical diagnosis of a tension headache, or a patient who requests gastric stapling so he can lose 20 pounds. Finally, a request may be inappropriate because it requires a clinician to use deception to meet the patient's goals, as exemplified in the representative vignettes above.

Those requests that challenge boundaries or expertise are not necessarily of moral significance but may be primarily issues of medical etiquette and practice. Requests that raise questions about medical necessity or the need to deceive others may be morally inappropriate, since they are about conflicts of values, preferences, and obligations. Because of the central moral importance of the questions it raises, this chapter focuses exclusively on inappropriate requests that would require clinicians to use deception or misrepresentation of a medical condition in order to pursue a specific end desired by a patient. In particular, it addresses the question of how a clinician should respond to such requests, especially when there may be good reasons to acquiesce.

Prevalence

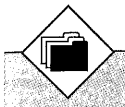
Little is known about either the frequency of inappropriate requests in primary care or clinicians' responses to them. However, judging from the titles of some recent journal articles, the issue appears to be of substantial concern to clinicians (see for example, "How Patients Stress, Con, and Intimidate Physicians to File Dubious Disability Reports,"[5] "The Detection of Deception,"[6] and "Defrocking the Fraud: the Detection of Malingering."[7])

Several empirical investigations may provide additional insight about how clinicians respond to these issues in medical practice. Novack and colleagues surveyed 407 practicing physicians to determine[8] how willing they would be to use deception. One scenario presented in their survey involved a woman whose insurance would not pay for a mammogram unless a breast mass were present or if there were other objective evidence of the possibility of cancer. Respondents were asked whether they would contend falsely that the mammogram was performed to "rule out cancer" rather than for screening, so that the procedure would be reimbursed. Of the 199 who responded to this question, almost 70 percent indicated they would mark "rule out cancer" on the form. Of particular interest, Novack found that physicians indicated they were opposed to deception in general, but felt an overriding concern for their patients' welfare and would deceive if necessary to protect that welfare.

A second study was reported in a 1998 *Washington Post* investigative story on lying in medicine.[9] The article cites an informal survey conducted at a leadership conference of the American Medical Association in 1997. Of the 134 physician attendees who returned a questionnaire, more than a quarter said they had fabricated a medical finding to help a patient secure coverage for treatment during the past year, 60 percent said they had changed a diagnosis on the billing records to help someone get insurance coverage, and 70 percent said they had exaggerated the severity of a patient's condition to prevent early discharge from the hospital. A follow-up national study using a more rigorous methodology is currently under way.[10]

Third, Farber and colleagues surveyed 1000 physicians about their attitudes toward reporting patient-initiated insurance fraud to insurance companies.[11] Case vignettes of patients who used a relative's insurance to obtain health care were presented. Of the 307 physicians who responded, 15 percent indicated that *none* of the patients presented in the vignettes should be reported, while only 20 percent indicated that *all* should be reported. Further, the majority indicated that their willingness to report fraud would be influenced by factors such as the patient's wealth, severity of illness, or prior history of fraud.

These studies suggest that clinicians have a high tolerance for using deception in certain circumstances. Below, I will examine why this may be the case and whether such behavior is justifiable.



Background Theory and Context

Although survey findings are helpful for understanding how clinicians say they would act when faced with certain dilemmas, these data do not resolve normative questions about what clinicians *ought* to do in such circumstances. It seems clear that dealing with inappropriate requests in primary care can be awkward, yet it is not clear that awkwardness is a sufficiently good reason to misrepresent a patient's condition. But before dismissing efforts to placate a patient's inappropriate requests, it is useful to look at reasons clinicians might put forth in favor of using deception on behalf of their patients.

Reasons for Using Deception

There are a variety of reasons a clinician may be inclined to do as a patient asks in response to an inappropriate request. First, in these situations, it is often easier to say yes than to say no. Although a purist might declare that a virtuous clinician should simply refuse all requests that would compromise his or her personal integrity, in practice, doing so can have consequences that are difficult to endure. For example, Mr. Potter, the golfing buddy who is denied an airline excuse, may wonder why Dr. Osborne shows so little loyalty to his friends; Ms. Swift, the patient with diabetes, may be outraged that the clinician seems unconcerned with her well-being; Mr. Holt, the construction worker with back pain, may become angry that his doctor has so little compassion for his suffering; and Mrs. Kaplan, the woman with bunions, may change clinicians, telling her friends that her primary care clinician was not a patient advocate. Particularly in a litigious society such as ours, clinicians want to please their patients, and they may perceive that using deception on their patients' behalf can go a long way toward achieving this short-term goal. The impulse to satisfy patients may be even stronger in settings where clinicians and patients must interact outside the office or where clinician compensation is influenced by patient satisfaction data, all which add to the motivation for clinicians to accommodate patients' requests.

Second, clinicians may believe that some of the policies set forth about work excuses, disability determination, access to medications, or parking sticker distribution are unfair. In the United States, millions of people lack access to affordable insurance to cover the cost of medical care—a situation many clinicians find morally unacceptable. In this context, if a policy is unfair, some clinicians may feel justified in skirting the rules, even if this involves the use of deception. For some, it represents an act of civil disobedience. A similar phenomenon occasionally occurs in criminal trials, when a jury's overriding distrust of the criminal justice system triggers them to acquit a defendant whom they believe committed a crime.

Third, clinicians may justify complying with an inappropriate request on the belief that doing so serves the medical interests of their patients. Perhaps Ms. Swift's short- and long-term health would be improved by having access to diabetic medications, Mr. Holt would have a more satisfying family life if he did not work in construction, and Mrs. Kaplan would have less foot pain if she had access to easier parking spaces. Although all requests are not equally compelling, when the health of a patient is at stake and a small deception may significantly improve a patient's physical and psychological well-being, some clinicians may feel justified (and even duty-bound) to use deception.

Fourth, a clinician may feel that misrepresenting a patient's condition to a third party would contribute to a therapeutic and trusting relation-

ship with the patient. Once again, if the harms are small and the benefits great, using a little deception on behalf of a patient may be perceived as going a long way toward assuring a positive future relationship.

Underlying Ethical Issues

The above justifications are by no means complete arguments in defense of deception, but they do illustrate that clinicians in medical practice have conflicting obligations and divided loyalties. Balancing various competing duties can be difficult and the manner in which clinicians decide to act is often related to how they understand professional roles and responsibilities in relation to individual patients and to society. To further clarify these conflicts, it may be useful to examine some of the assumptions underlying deceptive actions. The fundamental ethical issues can be addressed by responding to three basic questions: Whom do clinicians serve? What are the limits to a doctor's obligations to patients? What other obligations do clinicians have?

Whom Do Clinicians Serve?

It has become almost reflexive to say that clinicians are duty-bound to serve the interests of patients above all others. Dating back to the times of Hippocrates, clinicians have been admonished not to permit self-interest or the interests of others to interfere with their primary responsibility to serve the patient.[12] The service of patients' interests is one of the core values on which the medical profession is based and is at the heart of this fiduciary relationship.

Although the interests of patients are central to the medical task, it would be wrong to assume that these are the only interests served by clinicians. As Leon Kass has pointed out,[13] there always have been other potential beneficiaries of physicians' services, including the physicians themselves, insurers, and the public Some of these are parties to whom physicians have binding obligations. Any attempt by a physician to benefit sick patients may be constrained and shaped by these other obligations.

Furthermore, depending on the particular task at hand, the patient may not even be the *primary* beneficiary of the clinician's service. For example, in the hypothetical case of Mr. Holt, who is applying for disability benefits, or Mrs. Kaplan, who wants a handicap parking sticker, the clinicians who are asked to complete these forms are actually being asked to act on behalf of another party, not the patient.[14] That is, in completing such forms, clinicians are investigators and recorders for third parties—roles that are often inadequately understood and that can involve divided loyalties and role conflicts for the clinician.[15]

When the interests of the patient and the third parties are congruent (for example, if a bus driver with an uncontrolled seizure disorder requests permission to avoid driving), there is no conflict between serving the interests of the patient and the third party. However, when the interests of the patient are at odds with those of third parties, conflict is inevitable. In the case of Mrs. Kaplan, while she may benefit from having a handicapped parking sticker, it would not be in the interests of society to provide such a sticker to someone who does not meet the criteria for obtaining one. If these stickers were distributed without regard to actual need, then people with legitimate claims to limited parking spaces might be denied access to parking, and this would be unfair. The clinician must decide, in such cases, which is more important—to make a patient's life easier by helping her obtain a parking sticker for which she does not qualify or to pursue a just allocation of stickers, which would involve making decisions about which patients do and do not deserve them.

The main point here is that patients and clinicians both need to understand that the clinician's obligations are affected by the role he or she assumes at given times. When a patient

seeks the advice of a clinician for diagnostic or therapeutic purposes, the patient may presume that the clinician's recommendations and actions are based primarily on a judgment of what is best for the patient. On the other hand, such a presumption may be erroneous when a patient asks a clinician to complete a work-release or parking permit form. For, in this role, the clinician is acting as an agent of the work place or society and not necessarily as an advocate of the patient's best interests.

What Are the Limits to a Doctor's Obligations to Patients?

Although doctors may have obligations to third parties that are in conflict with their obligations to patients, some would argue that these other concerns should always be subordinate to the patient's interests. Pellegrino and Thomasma describe this view:

> The patient ordinarily assumes that the physician is his agent and will take all measures which may benefit the patient. The physician is expected to do everything possible for the good of the patient. . . . But the essential matter is the patient's expectation that the physician, and the hospital, will act in his behalf. This is, in fact, the moral center of medicine, the moment of clinical truth, that which makes medicine what it is. It is the point of convergence of the sciences and the arts of medicine. It is expressed in a decision to take this rather than that action for the good of *this* patient.[16]

This perspective is also reflected in the *American College of Physicians Ethics Manual*:

> The physician's primary commitment must always be to the patient's welfare and best interests, whether the physician is preventing or treating illness or helping patients to cope with illness, disability, and death. . . .The interests of the patient should always be promoted regardless of financial arrangements; the health care setting; and patient characteristics, such as decision-making capacity or social status.[17]

In asserting that a patient's health interests come first, several questions arise about the limits of a clinician's advocacy duties. For instance, should clinicians be bound to provide only what patients need medically (e.g., surgery for appendicitis) or also what they want or desire for other reasons (e.g., airline excuses, handicapped parking stickers, liposuction, tattoos, etc.)? If a patient will receive only marginal medical benefit from a procedure that is expensive, dangerous, or difficult to come by, is a clinician obliged to offer it as an option? If the clinician and patient disagree about what constitutes a medical need, who should decide? If it is a patient's desire that the clinician use deception to further nonmedical interests, should the clinician do so? These questions are not simple, and some are addressed in other chapters (see Chaps. 1 and 11). In analyzing these issues, it is reasonable to assume that a physician's obligation to any individual patient has limits. Determining where those limits lie, however, is subject to debate.

What Other Obligations Do Clinicians Have?

While a commitment to a patient's health is an important consideration, it is not the only one. Sometimes, other concerns take precedence over an individual patient's health—for instance, mandatory reporting of certain infectious diseases emphasizes the welfare of the public over that of individuals (see Chaps. 4 and 12). Furthermore, clinicians, like other moral agents, have fundamental obligations (sometimes known as *prima facie* duties) to be honest, to keep promises, and to be fair. To justify skirting these duties requires morally compelling arguments. For example, all would likely agree that a clinician should not be untruthful or break a promise when no conceivable benefit would occur and the damage to others would be significant. Further, most would agree that clinicians ought not deceive or break promises to serve their own self-interests. However, there may not be consensus about what clinicians ought to do in the

event that they are asked by a patient to commit a small deception or breach of promise that would greatly benefit the patient without causing immediate harm to innocent third parties. Fundamentally, the issue comes down to this: Under what circumstances (if any) is a clinician justified in stretching the truth, bending the rules, or otherwise using his or her influence to help a patient?

Returning to the vignettes at the beginning of this chapter, each involves a patient who asks the clinician to engage in a deception, but for slightly different reasons. Mr. Potter wishes to benefit financially; Ms. Swift wants to avoid a serious medical complication; Mr. Holt desires an exemption from work responsibilities; and Mrs. Kaplan wants to make her life more convenient. The ethical issues raised by each are somewhat different, but only in Ms. Swift's case can a morally compelling argument be made that a clinician's obligation to the patient's health may outweigh the duty to be truthful.

Gaming the System

Morreim uses the expression *gaming the system* to address this issue.[18] She argues that despite myriad incentives to game the system in order to help patients, there are at least seven reasons clinicians ought to avoid the temptation to misrepresent the truth in their dealings with third parties:

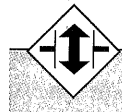
1. It can harm the doctor-patient relationship. Lying, even when well intended, can lead to an erosion of trust between the clinician and patient, since lying inevitably undermines a person's credibility. Patients who observe that a clinician is willing to lie *for* them may legitimately wonder whether, under different circumstances, the clinician might be equally willing to lie *to* them.
2. It can harm the patients it intends to help. Even when the goal of "gaming" is to help a patient, doing so can paradoxically harm those it intends to help. For instance, if a clinician were to exaggerate the extent of Mrs. Kaplan's debility in order to qualify her for a handicapped parking sticker, this would be documented in the medical record. If Mrs. Kaplan were to apply for health, life, or disability insurance in the future, the exaggeration could jeopardize her insurability.
3. It can harm other patients. In any system where resources are finite, unfairly benefiting one individual can harm another. For instance, if a patient is admitted to the intensive care unit as a result of deceptively substituting a diagnosis of "unstable angina" for its stable counterpart, a needier patient might be denied admission to intensive care at a crucial moment. Other patients might also be harmed if patterns of deception were discovered. For example, if airline executives come to believe that clinicians generally lie about medical illnesses so that passengers can alter their travel arrangements without cost, then the airlines could decide that clinicians should not be trusted to play a role in these matters, and some patients with legitimate medical excuses would not be able to reschedule their flights without penalties.
4. It can harm clinicians. When an individual clinician is untruthful, this can have a harmful effect on the entire medical profession. The trust that has been given to all clinicians would be undermined if the public were to view clinicians as deceptive or dishonest. This could play out in a number of ways. For example, if a clinician were to be involved in a legal proceeding, his or her credibility in the eyes of a jury would be severely eroded if it were thought that clinicians tend to misrepresent medical information.

These four arguments against the use of deception are based on utilitarian reasoning—such deceptions are considered ethically trou-

bling because the overall harms of the action outweigh the benefits. But arguments that depend on the outcomes are not the only way to view such issues; there are other reasons to object to the use of deception that have nothing to do with undesirable consequences.

5. It offends veracity. Theologians such as St. Augustine and philosophers such as Immanuel Kant have argued that being untruthful, whether by overt lying or subtle deception, is always wrong. While St. Augustine objected to lying on the ground that God forbids lies and therefore liars endanger the liars' souls, Kant's objections are secular. He contends that truthfulness is a formal duty of all individuals, which must be upheld under all circumstances, because lying offends human dignity.[19] According to this reasoning, gaming is morally problematic even if motivated by good intentions, since it relies on duplicity and misrepresentation. Although clinicians may reject such absolute prohibitions against lying, there is a basic presumption that lying is generally unethical, whether or not it is motivated by good intentions.
6. It offends contractual justice. In addition to the moral obligation to be truthful, clinicians also have contractual obligations to various third parties (such as insurers, employers, and government agencies) that would be broken by making intentionally inaccurate statements. Even when the agreements are implied rather than overt, breaches of contract are problematic because they represent broken promises, and promises should be kept unless there are very compelling moral reasons to do otherwise.
7. It offends distributive justice. A final argument against misrepresenting a patient's condition is that the practice is unjust. If medical and other social resources are to be distributed fairly throughout society, we must have a system in which all members cooperate. If some members cooperate while others do not, then those who cheat the system gain unfair advantage by free-loading off those who adhere to the rules. Doing so undermines a system that is designed to be fair to all participants. Of course all systems are not fair. But gaming an unfair system is neither the only nor most ethical way to correct a perceived injustice. Alternatively, dissent in form of political activism, letters to medical journals, and speeches before learned societies would promote change and be open to public scrutiny without giving an unfair advantage to particular patients.

In summary, when approached with an inappropriate request, a clinician is faced with numerous competing obligations and responsibilities. These include the desire to please patients; a concern about unfair policies and rules, obligations to serve patients' best medical interests, the need to establish trusting relationships with patients, responsibilities to third parties, the duty not to engage in lying, and the responsibility not to harm patients. Data suggest that physicians are willing to use deception when they perceive that the overall benefits to patients outweigh the harms. On the other hand, some medical ethicists have argued that the long-term harms of deception outweigh any short-term benefits and that, regardless of the consequences, clinicians have a fundamental moral responsibility to be truthful, to keep promises, and to be fair.



Toward Resolution

Diagnosing an Inappropriate Request

As a practical matter, how is a clinician to proceed when confronted with what may be an

inappropriate request? In general, the first step toward resolving an ethical problem is to recognize that one exists. As Lo showed a number of years ago, physicians underidentify ethical problems, and physicians who do not look are not likely to find them.[20] One simple way to identify an ethical problem is to pay attention to one's moral intuitions or to use what may be called the "sniff test." When a request "smells funny," elicits uneasiness, or just seems wrong, the clinician should take notice and think more carefully about the situation. Moral intuition has long been recognized as an important way to recognize ethical issues.[21] As articulated by Laurence Tribe,

> Wisdom often outpaces our ability to capture its essence in verbal formulas, and those who automatically dismiss deeply felt misgivings as insubstantial or as irrationally sentimental whenever we have not [yet] been able to capture those misgivings in a rigorous argument underestimate the profundity of human intuition—and overestimate the power of cold logic.[22]

A second way to identify an inappropriate request is to use the "village green" standard.* Whenever clinicians are considering complying with a questionable request, they should be willing to stand on the village green and do so publicly. If a clinician is not comfortable with openly sharing his or her behavior with colleagues or with openly explaining his or her reasoning to the administrative organization that is being gamed, chances are that either the request or the anticipated response to it is not appropriate.

A third way to identify and understand an inappropriate request is to reflect on which particular aspect of the request seems to be problematic. What specifically is being requested, and to what extent does the request require the clinician to violate a prima facie obligation such as honesty, promise keeping, or fairness? To help clarify what is being asked, the clinician can integrate a series of questions into the medical interview:

- What is the nature of the problem you are having?
- What is your objective in having me do the requested action?
- If I do what you ask of me, would this be honest?
- Are there other ways to meet your goals that do not require me to be untruthful?

Asking patients to respond to such open-ended questions can not only provide valuable insight into how patients think, but will also transfer some of the burden of truth telling from the clinician back to the patient by requiring reflection about how the request may affect others. Some patients, upon realizing that they are asking someone else to be untruthful on their behalf, may withdraw or modify their requests.

After obtaining information from the patient, it may be helpful for the clinician to gather supplementary information. For example, the physical exam may help to determine whether the request is consistent with actual physical findings. In this regard, excellent guidelines for disability or impairment evaluations are available.[23–25] If the request does not seem to correlate with physical findings, the clinician should think about what makes the request inappropriate. Are boundaries between the clinician and patient being transgressed? Is the clinician being asked to assume a professional role that is outside his or her expertise? Is there a disagreement about what constitutes a needed intervention? Is the clinician being asked to misrepresent a patient's condition? Clarifying the nature of the problem can help with its resolution.

Responding to an Inappropriate Request

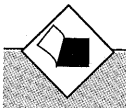
After clarifying the nature of the request and gathering relevant medical information, the clini-

* I am grateful to Norman Fost for his insight into this matter.

cian can proceed in a variety of ways. The following suggestions (modified from Lo)[26] may be helpful:

1. Document findings. Clinicians should document findings accurately, since lying in the medical record is not only unethical, but also prohibited by law and subject to legal penalty. Some have suggested that documenting the "literal truth" could help resolve the dilemma. For example, if it is not intended to mislead, stating that "Mrs. Kaplan reports that she has pain in her feet that makes it difficult for her to walk distances," might allow the physician to address Mrs. Kaplan's concerns while avoiding false statements. While such an approach may appear to resolve an ethical dilemma, this type of reporting has been criticized because no medical expertise is needed for a clinician to simply repeat what a patient says, and because it skirts, rather than addresses, the underlying problem.[15]
2. Determine alternatives to deception. Since it is important for clinicians to address their patients' concerns without using deception, doctors should attempt to find creative alternatives to misrepresenting a medical condition. For instance, a patient like Ms. Swift, who cannot afford to purchase her diabetes medications, can be given free samples. The clinician can appeal to the pharmaceutical manufacturer for free medications or help Ms. Swift apply for public assistance. Likewise, a patient like Mr. Holt can be referred to physical therapy to help him learn how to strengthen his back to prevent future injuries. While these alternatives may require additional time and effort from the clinician, they help achieve the goal of benefiting the patient while avoiding the pitfalls of deception. Of course, this also raises questions about the limits of a clinician's obligations to help a patient obtain expensive medications or prevent illness, a topic that is beyond the scope of this chapter.
3. Involve the patient. Clinicians need not bear the sole burden for resolving the ethical problems raised by inappropriate requests. Clinicians can tell patients of their desire to help while being firm about the obligation to be truthful. Clinicians should inform patients about potential role conflicts and the competing obligations this presents. Together, physicians and patients can explore alternative solutions that may help accomplish the patients' goals.

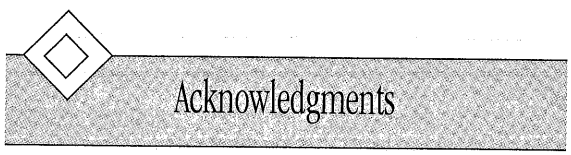
Primary care clinicians should be able to handle most inappropriate requests without outside assistance. But in difficult cases involving complex work-impairment problems, specialists in occupational and environmental medicine may be helpful. If there are questions about legal issues, a physician should consult with the appropriate legal counsel. If the physician remains uncertain about how to proceed, he or she may wish to ask a trusted colleague for advice. While this by no means guarantees a resolution to the problem, it might help. If still confused about what to do, one could consider seeking an ethics consultation or searching the relevant literature.



Closing Comments

Inappropriate requests for the use of his or her authority to obtain medical exemptions and privileges raise difficult ethical issues for the primary care clinician. While complying with such requests may offer the path of least resistance, doing so is problematic when it requires the clinician to deceive, misrepresent, or alter the truth. Clinicians have a *prima facie* responsibility to be truthful; to act otherwise requires strong moral justification. Saving a patient money, making his or her life more convenient,

or helping to avoid an unpleasant task are not particularly compelling reasons to deceive, and the use of deception in these circumstances is inappropriate. On the other hand, many clinicians believe that the clinician's commitment to his or her patients' health is of such primary importance that, when this is at stake, it could justify acts of minor deception. There is no consensus about the use of deception in these circumstances. An alternative response is to openly oppose unfair policies that jeopardize a patient's health. This may incur some risk to the clinician, but it avoids the use of deception and subjects the policy (and the clinician's actions) to the scrutiny of peers.



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Case: Parking Pass for Grandma

You are in your first year of residency and are home for Thanksgiving. Your favorite grandmother tells you that her best friend recently received a handicap parking pass because of difficulty walking. Grandma says you could make her life much easier if you would fill out a form of medical necessity so she too could receive a handicap parking pass. When you ask her what the problem is, she explains that she has bunions, and though they aren't terribly painful, it would be nice to park closer to the stores when she goes shopping.

You know that from a legal standpoint you have the authority to complete such a form. What do you think you should do and why? What do you think you would do and why?