

Medical Ethics



By Jonathan Evans, MD, MPH, CMD

When Patient Rights and Physician Beliefs Collide

A 78-year-old married woman with dementia who had been cared for at home by her spouse was recently admitted to a skilled nursing facility for respite care after her spouse fell on the ice and sustained a hip fracture. The medical director of the facility was assigned to be her physician. The medical director in this case was the attending physician for all 92 residents of this particular Medicare certified nursing facility, which was located in a rural community. No other physicians were credentialed by the facility.

Ten days later, another 78-year-old woman was admitted to the facility (and assigned the same room as the previous patient) for skilled care following surgical repair of a hip fracture that she sustained as a result of falling on the ice. She was assigned to the same physician. The physician performed a comprehensive history and physical examination and provided orders for care. Three days later, the physician overheard nursing staff talking about the two new female residents who were married to one another. Upon learning of this, he became visibly upset. He immediately sought out his newest patient and found her in the physical therapy gym, where he promptly informed her that “with all due respect, I don’t go in for that sort of thing.” He added further that he would no longer be her or her wife’s physician because he disapproved of their lifestyle.

This case involves the refusal of a physician to provide ongoing care to two of his patients because they are a same sex couple. It is further complicated by the facts that they are Medicare beneficiaries, no other physicians were available to provide care for them in the nursing facility, and the attending physician is also the facility medical director and thus has additional legal responsibilities, in addition to his obligations as attending physician. This case also raises questions about whether patients’ rights can be trumped by their practitioner’s personal or religious beliefs.

Nursing Home Regulations

As Medicare providers, both the physician and the facility are contractually obligated to abide by all of Medicare’s “Conditions of Participation” (essentially, the terms of the contract). This means the physician and the facility agree to provide services to any Medicare beneficiary whose care needs they can meet. Both the facility and the physician have provided care to thousands of patients with the same medical diagnoses and the same care needs as the patients in this case. There is no reason to think that the physician is unable to provide the necessary services, merely unwilling.

The medical director is responsible, under federal nursing home regulations for, among other things, “assuring the availability of physician services.” In this particular facility, the medical director has historically met this obligation by serving as the attending physician for every patient. Refusing medical care to either of these patients requires their transfer to another facility outside of their community because the facility cannot provide other physicians for these patients. Involuntarily discharging them from the facility in this case can likely be construed as causing harm.

Ethical Principles

Physicians and other clinicians are expected to uphold moral principles in the performance of their duties. These moral principles form an ethical basis for professional standards, which also include clinical competence.

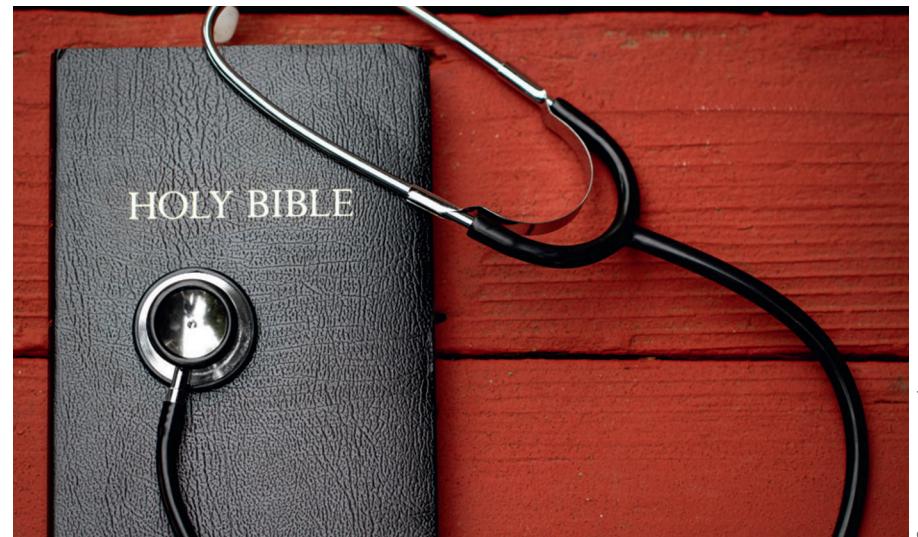
The primary ethical principle that is intended to guide physician and, hopefully, all of human behavior, is beneficence – the obligation to do good. Nonmaleficence, described by the Hippocratic admonition *primum non nocere*, or “first, do no harm,” is a sub-component of beneficence.

In his 1910 address to graduates of Rush Medical College, William Mayo, MD, emphasized the primacy of beneficence as our guiding ethical principle with his admonition to future generations of physicians that “the interests of the patient are the only interests to be considered.” In a nation founded on the principles of freedom and the individual right of self-determination, or autonomy, it could also be added today that the wishes of the patient are the only wishes to be considered.

Respect for Clinicians’ Beliefs

Physicians and other clinicians have great latitude to avoid compromising their own personal or religious beliefs. They can abstain from performing certain procedures such as abortions, for example, and can even be exempted from having to learn how to perform them. They can discharge patients from their practices (i.e., fire their patients) for a whole host of reasons and don’t even have to give a reason, except that they must not breach professional standards of care, they must not abandon their patients, they must not cause harm as a result of their refusal to provide care, and they must not break the law.

In this case, the physician cannot fire his patients because there is no one to take his place. He has created a situation, however, where his patients would probably like to fire him. Moreover, he has a contractual obligation to Medicare as a



Although physicians have some latitude to avoid compromising their beliefs, they cannot leave a patient without care options if they choose not to treat.

Medicare provider to provide services to these patients, and he is further bound by federal regulations (OBRA ’87) to ensure that these patients have a physician.

Medical Privileges

The privilege of practicing medicine carries with it a number of important obligations. To whom much is given, much is required. The ethical principle of justice requires that the knowledge, skills, and experience that individual clinicians possess must be shared justly among all who seek their care.

If the best we can do as a profession is to be critical of our patients, then we deserve even greater criticism. We do not deserve the privilege of caring for others.

The admonition “do no harm” has guided physicians for millennia. Harm takes many forms beyond the physical. A more complete retranslation of *primum non nocere* may also include the admonition: “First, do not judge.”

Judging patients is doing harm. And judging patients is an ugly and accepted everyday part of the health care culture. Insurance companies have historically made it their business model to discriminate against, exclude, or economically penalize patients based on their age, their habits, or their diagnosis. Medicare itself would not exist today but for the unwillingness of the private insurance market to insure older Americans in the

1960s. Yet even today, patients are often blamed for their problems: for being fat, for being addicted to medications that a doctor prescribed, for not getting better, or for not having the most lucrative payer source or the most attractive diagnosis. Patients are not infrequently fired from outpatient practice for noncompliance, for failure to conform, or for failure to do what they are told. Discrimination is a fact of life for Americans seeking health care. It is likely to get worse as pay-for-performance takes greater hold. Patients who don’t “perform” well enough will find it harder to get the care they need.

We don’t need to blame our patients. They routinely blame themselves.

Rarely, if ever, does someone with a horrible diagnosis like cancer not ask themselves what they did wrong that may have caused it. No patient anywhere needs our help to feel bad. We are all trained as critical thinkers. But if the best we can do as a profession is to be critical of our patients, then we deserve even greater criticism. We do not deserve the privilege of caring for others.

We shouldn’t be concerned about whether our patients are worthy of our care; we should be concerned that we are worthy of the privilege of caring for them. Our worth as care providers is not measured by who our patients are. Our worth is measured by what we do for our patients and by how much we care about them.

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