

Can a physician refuse to help a patient? American perspective*

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Abstract: *Refusal to help* means for most people declining to accept *the duty to treat*. The reasons for *refusing to help* and how we think about these reasons from an ethical and professional viewpoint are outlined by considering ethical principles, an historical perspective, the law, societal contracts, medicine as a moral enterprise, professional codes, a physician's personal beliefs, reasons for *refusing to help* and physician discretion. *Refusing to help* a patient is not consistent with the ethical principle of beneficence, the concept of the primacy of patient welfare or the obligation of the profession to care for the sick. However *duty to treat* should not be exploited by institutions or place physicians in circumstances that they consider morally, psychologically or physically unacceptable. Following the principle of distributive justice, physicians are obligated to participate in the public debate to ensure that all patients have their needs met by developing or improving health care systems and addressing the new ethical questions that are likely to be generated.

Key words: duty to treat, ethical obligation to care for the sick, refusal to help

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INTRODUCTION

Despite the generally held sentiment that physicians should and will always be available to provide care to patients when needed, there is an increasing perception that this is not happening consistently in the USA. Unfortunately it is hard to get numerical information on this topic. It is well known that institutions refuse care to patients who cannot pay in some parts of the country. It is also well documented that individual physicians and group practices refuse to treat patients covered by Medicaid, a state government program for the poor, because the payment for physician services is lower than their administrative costs. In addition, many among the over 40 million residents of the USA who have no health insurance and/or little access to health care do not seek health care or indeed choose to do without treatment because of a perception that they would be refused treatment or that they would not be able to pay for it. However in most of these circumstances, there is an assumption by physicians in general that if a person is really in need of care for a life threatening illness, care will be provided by someone, somewhere, in an emergency room, a free clinic, some other doctor's office or hospital.

Thus most physicians who think of themselves as embracing the belief in the "duty to treat a sick person" would not see these day to day practices as *refusal to help* and would not consider themselves or their behavior to be "unethical". The following discussion looks at the ethical principles of these attitudes in a little more depth.

Meaning of duty to treat or refusal to help

According to Webster's New World Dictionary, *duty* means "any action required by one's position or by moral or legal considerations"; *refuse* means "decline to accept". So *refusal to help* means for most people, *declining to accept the duty to treat*. How does this fit in with the ethical values we tout as the basis of our behavior as physicians and from where did these values come? If we accept the *duty to treat*, could there be limitations on this duty? If so, what would be the reasons for *refusing to help* and how can we think about these reasons in an ethical and professional framework.

Basis for the duty to treat or refusal to help

Ethical principles

The ethical principles that are generally taught in USA medical schools [1] and frame the discussion used by clinical ethicists and ethics committees during decision making about clinical ethical dilemmas in the USA are: respect for patient autonomy; doing good (beneficence); doing no harm (non maleficence); and just distribution of finite resources (jus-

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tics). The principles of professionalism outlined in the Physician Charter, a recently formulated document through the efforts of the American Board of Internal Medicine Foundation, American College of Physicians Foundation and the European Federation of Internal Medicine, published in 2002 [2,3] include primacy of patient welfare as well as patient autonomy and social justice.

Lessons from history

History tells us there is no consistent tradition of a *duty to treat* but over the centuries there has been a growing consensus for the notion of “*debent curare infirmos*” (must care for the sick) [4]. In Europe before the 14th century, physicians, who were self designated as providers of medical care, decided individually whether or not to treat a patient. In the 14th century the occurrence of the bubonic plague led to laws and societal expectations for physicians to care for the sick – those not doing so lost social standing [4]. In the USA during the 1793 yellow fever epidemic, newspapers described a *public duty* for the medical profession in addition to the individual physician’s acceptance of a *private duty* to treat the sick: “Physicians are justly considered as public property, and like military men, it pertains to their profession to be occasionally in the way of danger.” (*Philadelphia Federal Gazette*, 2 Oct, 1793) [4,5].

With the AIDS epidemic in the USA in the 1980’s, there was a fierce debate about the legitimacy of physician autonomy which up until then had supported the physician’s right to choose which patients to treat. This discussion resulted in the development of unambiguous statements on the *duty to treat* by most professional societies [5-7]. Following 9/11 2001, the American Medical Association adopted new language in 2004 for “Physician Obligation in Disaster Preparedness and Response” supporting the medical professions obligations in the face of a public health emergency [8] while retaining wording that supports a physicians right to choose which patients to accept into their practice.

USA law

USA law does not recognize medicine as a moral enterprise. Any legal obligations reflect a contractual model. Thus individual physicians are free to accept or decline individual persons as patients. This is well illustrated by the growing popularity of what is known as “boutique medicine” which involves a patient paying a retainer fee to a physician in return for the physician agreeing to be available on demand to serve the patient’s needs via email, cell phone or in person consultation. Patients who cannot or do not wish to pay the retainer fee are no longer treated by the physician. However, there are two legal exceptions to the use of physician autonomy as a basis for deselection of patients. In any established physician patient relationship, a contract has been made, so terminating the relationship must be mutually agreed to or the physician

could be held accountable for “abandonment”. Thus a physician cannot unilaterally break the relationship with a patient without transferring care to another provider. The other exception to the lack of legal obligation to treat is the USA federal American with Disabilities Act of 1991 which prohibits physicians from refusing to care for patients on the basis of a disability [9,10].

Societal contract

Physicians have been given a privileged place in society by recognition of their professional status, subsidized education, and being provided with monopolistic licenses. Their obligation in this social contract is to self regulate and care for those who are sick. No other group can provide the services that their licensing and training permits [4,10,11].

Medicine as a moral enterprise

Medicine is a moral enterprise. The mission of the profession is to care for patients. The Physician Charter describes the principle of the *primacy of patient welfare* as follows. “Altruism contributes to the trust that is central to the physician-patient relationship. Market forces, societal pressures, and administrative exigencies must not compromise this principle” [2]. Some would go as far as to say that a person who is not willing to fulfill the obligations to place patient welfare before physician comfort when needed should not have chosen this profession as a vocation [5].

Professional codes

As medical professional consciousness emerged in Europe in the fifteenth to seventeenth centuries, the concepts of rights and responsibilities evolved and oaths and codes multiplied. This same professional consciousness appeared in the USA during the eighteenth and nineteenth centuries [5].

American Medical Association (AMA)

The first code was documented by the AMA in 1847 and included the statement: “In regard to measures for the prevention of epidemic and contagious diseases; and when pestilence prevails, it is their duty to face the danger, and to continue their labors for the alleviation of suffering, even at the jeopardy of their own lives” [4,5].

A caveat added in 1912 stated: “A physician shall in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve” [5,6].

An addition issued in July 1986 noted: “However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, or any other basis that would constitute invidious discrimination” [12].

American Board of Internal Medicine

It is unethical “to refuse to treat a patient solely on the basis of that patient’s disease when the disease is within the physician’s area of competence” [10].

American College of Physicians

“The denial of appropriate care to patients for any reason is unethical” [10,13].

Association of American Medical Colleges

“Medical students, residents and faculty have a fundamental responsibility to provide care for all patients assigned to them, regardless of diagnosis. A failure to accept this responsibility violates a basic tenet of the medical profession – to place the patient’s interest and welfare first. Faculty members [should] model the professional behavior and attitudes expected...” [11].

Personal beliefs

Those who choose medicine as a profession do so to serve the needs of the sick. This action is grounded in the ethical principle of beneficence – doing good and the ethical value of virtue – doing what is right. We have all experienced the feeling of irritation when patients come late to appointments, the sinking feeling when an extra person needs to be seen urgently in an already overbooked clinic, and the despair when woken one more time at night knowing you must get up out of your warm bed. But we do what is needed because of our empathy for the sick patient as well as a personal understanding that we would feel worse if we did not do it. Incidentally we are usually rewarded by having helped a person or family in distress.

Physician discretion

Physicians, being under no absolute obligation to care for all persons in need or all the needs of an individual patient do in fact choose whom to treat and whom not to treat on a regular basis. The ethical implications of *refusal to help* vary with the reasons for not doing so.

Reasons for refusal to help

- 1) Physician is not competent. If a patient has a problem outside the area of physician expertise in terms of knowledge or skills, inappropriate treatment may do no good and could cause harm.
- 2) Physician or institution has no space or time or triage is necessary when resources are limited. If all hospital beds are in use or an office schedule is full, harm could be caused to the needy patient and/or other patients from disruption of optimal care systems. On the other hand, there is often a way to squeeze in another person without doing harm. The primacy of patient care puts this action above that of a tired physician. Nevertheless, these decisions should be made as a result of physician discretion and not through exploitation by an institution. In a disaster situation where there is overwhelming need, tough decisions must be made so as to treat those most likely to be able to benefit.
- 3) Patient is hostile. If a patient cannot pay, does not follow the care plan, takes too much time, etc, there is no ethical justification for refusing to help and there may be a legal obligation once a relationship has been established to continue treatment. There are instances when a hostile patient poses a serious physical threat to either the physician or other health care personnel that may necessitate terminating the patient/physician relationship. In general however, physicians and patients are best served by physicians using their skills of persuasion, tolerance, patience and the patient’s option to seek another provider if there is dissatisfaction on either side. Beneficence and the primacy of patient welfare should prevail whenever possible.
- 4) Physician has a moral or religious objection to the kind of treatment the patient is seeking. This issue has sparked great debate in the US over the past several years not just for physicians but also for other health care providers such as pharmacists [10,12,14]. The topic is too big for this forum but suffice it to say that issues such as the abuse of public trust when physicians hold monopolistic licenses and the threat to patient welfare must be considered when physicians put their own personal beliefs or interests above those of their patients. In 2006, a survey was conducted in a random sample of 2000 practicing US physicians to understand their attitudes about physicians refusing to provide treatments to which the physician objects on moral grounds [15]. Of the 1144 who responded, 63% believed it ethically permissible to explain moral objections to a patient, 86% that a physician is obligated to present all available and legal treatment options and 71% that a physician is obligated to refer the patient to another physician who does not object to providing the service in question. These results show, however, that up to 100 million Americans may be being treated by physicians who do not believe they have an obligation to refer to another provider under such circumstances. It would seem that patient autonomy is threatened by not being informed about a physician’s position on certain treatment options. It would be in the best interests of patients to ensure that they are aware of a physician’s attitudes and beliefs before seeking advice about certain controversial procedures. Should the objection be on the grounds of medical futility, care should be taken by the physician not to abandon the patient while helping them seek other advice.
- 5) Physician is at risk. Over the centuries there has been a societal expectation that physicians should care for the sick even in situations when their own life or health may be

put at risk. The obligation is considered greater for emergency situations for both individuals and groups than in more chronic conditions. For example, a physician's donating a kidney to one of her patients in 2003 was considered a most unusual act and there were some negative comments. On the other hand, after 9/11, the AMA added specific language to their ethics statements supporting physician altruism.

"Because of their commitment to care for the sick and injured, individual physicians have an obligation to provide urgent medical care during disasters. This ethical obligation holds even in the face of greater than usual risks to their own safety, health or life."

Nevertheless, personal choice seems to be the determining force for physicians caring for patients with highly infectious diseases such as Ebola virus and SARS [8].

- 6) Physician puts a patient at risk. If a physician is infected with a contagious disease such as AIDS or hepatitis C, they are obligated to not put patients at risk by performing procedures that could allow transfer of infection. In addition there may be legal implications should a patient become infected. The ethical implications of an impaired physician continuing to treat a patient when his or her judgment is compromised should not be ignored but is beyond the scope of this discussion.

Ethical framework for current and future practices in America

We are left with more questions than answers. Can we rely on existing laws, institutional policies and current codes of ethics to ensure that those who need care are not refused by the medical profession and/or health care institutions? As new models of care are developed that rely more on teams of providers than individual physicians, are current codes and ethical frameworks still relevant or adequate?

SUMMARY

Refusing to help a patient is not consistent with the ethical principle of beneficence, the concept of the primacy of patient welfare or the obligation of the profession to care for the sick. Although *duty to treat* should not be exploited by institutions to place physicians in circumstances that they consider morally, psychologically or physically unacceptable, all efforts should be made to find alternative care providers. Following the principle of distributive justice, physicians are obligated to participate in the public debate to ensure that all patients have their needs met by developing or improving systems to allow this to happen. However such systems are likely to generate new ethical questions which we must be prepared to address.

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