Patients’ autonomy and medical benefit: ethical reasoning among GPs

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Background. During the last decades, the traditional role of GPs as decision-makers for their patients has been questioned.

Objectives. The aim of this study was to identify and discuss how GPs deal with and how they reason in situations where there is a possible tension between the obligation to respect the patients’ right to self-determination and the obligation to promote their health.

Methods. One hundred and twenty randomly selected Swedish GPs received a mailed questionnaire with two vignettes, one describing a patient reluctant to have a medically motivated intervention, the other describing a patient requesting a medically doubtful intervention. Forty seven of these GPs subsequently were interviewed by telephone.

Results. With regard to the first vignette, approximately two-thirds of respondents to the questionnaire (n = 82) answered that they would not accept the patient’s reluctance. Older GPs were somewhat more inclined to try to persuade the patient to come to their surgery than were younger colleagues. In the interview, most respondents answered that the right to self-determination ought to be given priority, but the obligation to promote health had a greater influence on their behaviour. Regarding the second vignette, two-thirds of respondents to the questionnaire answered that they would not give way to the patient’s request for intervention. Younger GPs said “No” more often than did their older colleagues. In the interviews, justifications for their response referred to medical benefit, uneasy patients, self-protection and justice.

Conclusion. When facing such conflicts in everyday practice, the ethical codes of medicine are often too categorical to give any guidance. The situational ideal of covenant would be more helpful, and ought to be emphasized by medical teachers as well as tutoring older colleagues.

Keywords. Autonomy, decision-making, ethics, general practice, medical benefit.

Introduction

By tradition, physicians have focused on promoting the medical benefit of their patients but, during the last few decades, the patient’s right to self-determination has been emphasized more. These two requirements, the obligation of medical benefit and respect for autonomy, give rise to tension in the patient–physician relationship. On the one hand, the principle of autonomy urges GPs to respect the patient’s right to self-determination, but the principle sometimes makes it difficult to alleviate and prevent their patient’s suffering. On the other hand, the principle of beneficence urges them to act in accordance with responsible medical practice, but they do not want to be accused of ‘Big Brotherism’.

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Subjects and methods

The sampling frame was obtained from Läkemedelsstatistik AB (Swedish Pharmaceutical Statistics). Among physicians, authorized and classified as GPs (a total of ~4000), four groups were selected according to gender and age (born 1931–1945 and 1951–1965, respectively). In each of the groups, a random sample of 30 was taken.

During the spring of 1996, a questionnaire with two vignettes, one for each type of situation (see Fig. 1), accompanied by a signed covering letter, was mailed to the 120 selected GPs. One follow-up letter was sent 3 weeks later to the non-respondents. The GPs were asked to answer one question related to each of the two vignettes (possible answers being “Yes”, “No” and “Uncertain”). They were also asked if they would agree to take part in a subsequent interview.

During the winter of 1996/97, the interviews were performed by telephone, audio-taped and transcribed by one of the authors (SB). A technique with open-ended questions was used. Each interview lasted for about 35 min.

Results

Responses to the questionnaire

Eighty-two of the 120 questionnaires were answered, which gives a response rate of 68%. Almost two-thirds of respondents answered “Yes” to the first vignette question, i.e. they would continue offering the patient an appointment or otherwise try to contact him despite his apparent reluctance (see Table 1). Even though the sample is small, it is possible to identify a pattern with respect to age and gender. Older GPs answered “Yes” somewhat more frequently than did younger colleagues. Female GPs answered “No” most frequently.

Two-thirds of respondents answered “No” to the second vignette, i.e. they would not accept the patient’s request for an examination (see Table 2). This scenario created more uncertainty than did the former. Younger GPs were more reluctant to accept the patient’s request than older GPs. With regard to gender, there were no differences, except that female GPs more often answered that they were uncertain.

Responses to interviews

Forty-nine of the 82 respondents agreed to take part in the subsequent interview. One interview was not conducted due to the respondent’s lack of time, and one interview was lost due to a technical problem.

Using the two vignettes as a point of departure, the GPs were reminded of the reluctant patient and the soliciting patient. They were then invited to give their own examples of similar situations, to comment and speak openly about their own reasoning and behaviour.

The reluctant patient

Facing a hesitant patient, two different types of reactions were identified among the respondents. According to the first, the physician’s obligation to promote health was given priority; according to the second, the patient’s autonomy was emphasized.

(i) The physician’s obligation to promote health. The first group of respondents said that promoting health is the overriding obligation. This obligation is an inborn role of the physician. The GP should strive for the patient’s best interest. It is most important to prevent, or at least mitigate, serious complications of diseases. If the GP finds an intervention necessary in order to promote health, he or she would fight for it, although the patient is reluctant or even refuses. A few of the respondents

First vignette:

Male, 55 years old. Smoker. Financial manager. He is found to have hypertension (190/105 mmHg) at a medical check. Blood pressure control by the occupational health service shows diastolic BP of 100–105 mmHg. The patient is referred to your surgery but he has cancelled two scheduled appointments, he is very busy. You have called him by phone, but you only spoke to his secretary and you have not heard from him anymore.

Will you as a physician continue offering him new appointments or try to get in contact with him in any other way?

☐ Yes ☐ No ☐ Uncertain

Second vignette:

Female, 23 years old. Regular exerciser. Visited her GP 1 month ago, complaining of low back pain. Examination without neurological signs. Symptoms and physical findings as poor back muscle tonus. She was referred for physiotherapy. The patient calls you and ask for a referral for a lumbar MRT. A new and careful examination gives the same results as at the first examination, except for a minimal sensibility impairment laterally on the right foot. The patient insists on a referral for MRT, but you find no medical reason for such an examination.

Will you as a physician refer the patient for a lumbar MRT?

☐ Yes ☐ No ☐ Uncertain

Figure 1  The two vignettes presented in the questionnaire
said that they look upon themselves as the expert and expect the patient to follow their recommendations. Sometimes the GP found it necessary to try to convince his or her patient to accept an intervention. With reference to circumstances, such as malignancies, diabetes and chronic heart failure, many GPs emphasized the need to be sure that the patient is fully informed and has made a well-informed decision. Age is also considered to be a factor of importance; a younger, not retired, patient would require the GP to be more active. Some respondents gave examples of situations where children and adolescents may be abused by their parents or other adults, and emphasized that they have an obligation to promote the minor’s best interest and sometimes even report the case to the social welfare authority. The patient may also, due to an illness (e.g. drug or alcohol abuse and mental disorders), have a reduced ability to make a well-informed decision. Such circumstances should increase the physician’s effort to promote health.

(ii) Respect for the patient’s autonomy. This position was emphasized by the second group of respondents. Many of them emphasized the obligation to respect the patient’s integrity. Immigrants and refugees in particular may have other views on health and illness. One respondent said, “. . . nowadays you tend to be everyone’s mum”, implying that the patient is responsible for his or her health, a responsibility that the modern health care system tends to take over.

A patient who apparently neglects his or her health will reduce the level of commitment of the GP. Some respondents said they were less motivated to become involved in a patient’s health if the examination or treatment is of minor benefit or, indeed, may cause harm to the patient. Age is also an important factor for this group of respondents. As one of the respondents said “A 60-year-old patient with chronic heart failure refused treatment . . . She died and I remember that I felt comfortable with it. The patient has a right to say no”.

The soliciting patient
Facing a patient demanding intervention, the physicians’ answers are more complex. The different positions taken by the GPs are therefore presented under four different headings: medical benefit, uneasy patient, defensive physician and justice.
(i) Medical benefit. Regarding a patient requiring a medically doubtful intervention, most respondents answered that they became distressed, especially if clinical signs are lacking or are subtle. Some of the GPs said that they refer to established guidelines when they have to argue with such a patient. There is a risk of doing more harm than benefit, or as one GP said, “It is an omission of the art to accept a patient’s stubborn request, which will support the patient remaining in his somatization”.

A few respondents said that an established relationship with the patient would make it easier to say no. One GP said, “I’m well aware that I have difficulties saying no to a patient. In that case you expose yourself to the anger of the patient”.

(ii) The uneasy patient. If the patient is worried or anxious, it will strengthen the effort of the GP to meet the patient’s request. Such a patient may start ‘shopping around’ for a doctor if the GP refuses. One of the GPs gave this example, “A patient who has been examined twice due to diffuse muscular pain asked for antibiotics [erythromycin], which she believes will relieve her symptoms . . . and she got the prescription.” Another respondent described a male immigrant from Turkey who suffered from diabetes. He did not see his diabetes as an illness. “When I came to Sweden I was told that I was ill, but I was healthy . . . Formerly I loved my wife, nowadays we just argue about what the dipstick shows.”

(iii) The defensive physician. In some situations, the GP's own uneasiness came in focus. For instance, he or she may miss the diagnosis or be reported to the Swedish Medical Responsibility Board. As one respondent, who had been reported twice, said, “it depends on how many times you have been reported”. Some of them said that the GP has no right to deny any patient a request for medication or examination.

Sometimes relatives try to manipulate or control the physician. “A 95-year-old woman was living at a home for the aged where she wanted to die. She got pneumonia and I wanted to treat her without referring her to the hospital. But her daughter, a retired nurse complained, ‘how do you know that she won’t get worse?’ and I could imagine the headlines in the evening papers.” This GP gave in, and a few days later the woman died in hospital.

The GPs working in private practice emphasized the respect for patient’s autonomy, if for no other reason than to keep the patient. One said, “A patient who doesn’t like me, doesn’t visit me twice.”

(iv) Justice. In this situation with a soliciting patient, most of the respondents emphasized that they also had responsibilities to other patients. These GPs often look upon themselves as gate-keepers and feel obliged to contribute to a fair distribution of the medical goods benefiting those most in need. However, this role as gate-keeper is sometimes difficult. As one respondent said, “well informed patients will [independent of needs] often get what they want, especially new and potent drugs”.

Almost everyone emphasized their special responsibility for vulnerable groups of patients, e.g. the chronically diseased, children, drug abusers, old folks and patients with senile dementia.

Ideal versus reality
During the interview, the GPs were asked both how they ought to act and how they would act when the patient’s right to self-determination came in conflict with the obligation to promote medical benefit.

In a situation where the patient is reluctant to accept a medically motivated intervention, a majority answered that the patient’s right to self-determination ought to be the overriding factor. Despite this, a majority of the GPs answered that they would continue to contact the reluctant patient (see Table 3). Younger GPs gave priority to autonomy as the overriding principle more often than older colleagues. Older female GPs were more in favour of medical benefit as the overriding principle.

In a situation where the patient solicits a medically doubtful intervention, there is better conformity between values and practice. A majority of the GPs answered that the obligation to promote medical benefit ought to be the overriding principle. A majority also said that they would not accept the patient’s request for intervention (see Table 4). Female GPs were more inclined to give priority to medical benefit as the overriding principle than male colleagues, who were more uncertain.

Concluding remarks
Ethical guidelines are far too categorical to be of any help when facing this tension in everyday practice. For instance, to give priority to medical benefit over the patient’s right to autonomy may be described as expressing solidarity, but also as expressing an overprotective attitude. Correspondingly, giving priority to respect for a
patient’s right to self-determination may also be understood in two different ways: as expressing respect for the patient or as indifference to his or her medical needs.

A situational model for the patient–physician relationship will be more helpful than guidelines. William F. May’s ideal of covenant is a step in the right direction. He writes:

“Covenant ethics is responsive in character . . . It reminds the professional community that it is not good enough for the individual doctor to be a good friend or parent to the patient; that it is important also for whole institutions—the hospital, the clinic, the professional group—to keep covenant with those who seek their assistance and sanctuary . . .

At the same time, however, the notion of covenant also permits one to set professional responsibility for this one human good (health) within social limits. The professional covenant concerning health should be situated within a larger set of covenant obligations that both the doctor and patient have toward other institutions and priorities within the society at large.”

Medical students and younger colleagues may, to some extent, have lost sight of this ideal of covenant. If this is correct, teachers in medical schools and older colleagues in their role as tutors, have a special responsibility to reestablish this ideal. We believe that a general acceptance of this ideal will enhance the professionals’ ability to identify and handle such tensions in everyday practice.

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References