Philosophy Study, September 2016, Vol. 6, No. 9, 528-533
doi: 10.17265/2159-5313/2016.09.003

DAVID PUBLISHING

Patients' Responsibilities in Medical Ethics

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There has been a shift from the general presumption that "doctor knows best" to a heightened respect for patient autonomy. Medical ethics remains one-sided, however. It tends (incorrectly) to interpret patient autonomy as mere participation in decisions, rather than a willingness to take the consequences. In this respect, medical ethics remains largely paternalistic, requiring doctors to protect patients from the consequences of their decisions. This is reflected in a one-sided account of duties in medical ethics. Medical ethics may exempt patients from obligations because they are the weaker or more vulnerable party in the doctor-patient relationship. We argue that vulnerability does not exclude obligation. We also look at others ways in which patients' responsibilities flow from general ethics: for instance, from responsibilities to others and to the self, from duties of citizens, and from the responsibilities of those who solicit advice. Finally, we argue that certain duties of patients counterbalance an otherwise unfair captivity of doctors as helpers.

Keywords: patients' responsibility, medical ethical, mainstream medical ethics, patient, doctor

1. Introduction

Medical ethics is one-sided. It dwells on the ethical obligations of doctors to the exclusion of those of patients. This one-sidedness may have something to do with the use in standard medical ethics of the concept of autonomy. We begin by calling attention to some of the limitations of that use of the concept. We then turn to the responsibilities that we think patients have to doctors: those that arise from general ethical obligations, and those that arise from the doctor-patient relationship. Finally, we consider how doctors ought to respond when patients fail in their duties to them.

2. The One-Sidedness of Medical Ethics

Medical ethics tends to focus on only one side of the doctor-patient relationship. One reason for this is that standard writing in medical ethics is directed at a professional audience. The one-sidedness of mainstream medical ethics in respect of the doctor-patient relationship is more than a matter of being directed at an overly narrow audience. There is also an unevenness in the distribution of the moral burdens. Mainstream medical ethics puts a big and largely unconditional responsibility on doctors to treat patients "no questions asked." This obligation can take either of two forms. In wartime, doctors are obliged to treat everyone equally—friend or foe. The peacetime counterpart of this is that paedophiles, rapists, and murders are supposed to be treated without reference to their crimes or moral character. Again, doctors treat patients without making judgments about the cause of their illness. What is learned during the history taking should not be permitted to color the doctor's

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view of the patient, who must be treated impartially. Nor can doctors turn away patients who are in acute need of treatment but who cannot pay.

In comparison to what it asks of doctors, mainstream medical ethics makes very few demands of patients, and these usually begin and end with consent. Traditionally, medical ethics has asserted that, as autonomous agents, competent patients must be allowed to decide for themselves the course of their medical treatment, and even whether to be treated at all. It is for the doctor to communicate effectively all the relevant information, assess the patient's competence, persuade without coercing, and abide by whatever decision the patient makes. Little or nothing is said about what kinds of decisions patients ought to make. Nor is much said about their responsibilities for making good rather than bad decisions. Indeed, with the exception of recent literature on responsible uses of resources (a topic to which we will return), mainstream medical ethics implies that a competent patient's decision is good simply by virtue of having been made by the patient. At times, it seems as though patients never make, or cannot make, bad decisions. Bad decisions may be explained away—sometimes by the courts—as the doctor's failure to gain proper consent or failing this, the doctor's failure to override the wishes of the patient and act in her best interests instead!

Yet if autonomy in medical ethics is to mean the same as in general ethics—and surely it is supposed to—autonomy must go hand in hand with taking responsibility for what is chosen. In particular, if things go badly, a decision made by a patient cannot suddenly turn into a piece of negligence on the doctor's part. But in medical ethics, the duty of care often trumps the need for autonomous patients to take the bad consequences of the bad choices they knowingly make. Even though one of the justifications for obtaining patient consent is that it is the patient.

Is there any moral basis for this approach to patients? There is the undoubted vulnerability of patients to negligent or incompetent or insensitive treatment by doctors, and their relative powerlessness and ignorance when it comes to certain decisions about their treatment. These things call for the protection of patients against those treating them, or perhaps for measures—legal and educational—that make patients more equal in decision-making processes affecting them. But the key thing—the thing that seems to make intelligible the kinds of moral duties that doctors have to inform patients and to act only when necessary and on the best information—is the vulnerability of patients. There is sometimes a blind spot in moral thinking with regard to the vulnerable and weak. The blind spot manifests itself in a certain pattern of suspicion that seems natural when something goes wrong and the weak or vulnerable suffer as a result. The presumption is that when the weak or vulnerable suffer in a transaction in which the strong are also involved, the weak are innocent, and the strong are probably responsible or should be foremost in offering to compensate the weak or vulnerable for what has happened. But there are many counter-examples to this way of thinking. The vulnerability of patients does not mean that they cannot be negligent and contribute significantly to bad health outcomes, even though it is much easier for a negligent or incompetent doctor to do much more harm. Relative vulnerability does not confer inability to do wrong.

The vulnerability of patients does not confer innocence on them either. Nor does the autonomy of vulnerable people insulate them from responsibility for the consequences of decisions made jointly with doctors. This is indirectly acknowledged even by the conception of autonomy in mainstream medical ethics. The mainstream conception calls for the full consultation of patients by doctors in clinical decisions, and for the participation in clinical decision-making of patient advocates, and disinterested third parties—people who can make patients' views better heard and respected and who can prevent their being paternalistically overridden.

The ideal that these arrangements apparently attempt to capture is that of a genuine partnership between clinician and patient in a course of treatment. The other side of the coin of treatment decisions reached in partnership, however, is joint responsibility for the outcomes, including cases where things go badly wholly as a result of these decisions, and the patient turns out to be harmed or disappointed. But, as we have already suggested, in actual cases where things go badly, the solidarity in decision-making is likely to break down: The fact that it is the patient and not the doctor who feels the bad effects, and the doctor and not the patient who emerges intact, seems to undo the partnership. A presumption of negligence can grow up that apparently frees the patient to sue, even when she is responsible for making the decisions that led to things going badly.

3. Patients and General Ethics: Respect for Persons and Duties of Citizens

3.1. Respect for Persons

Some of the duties which patients have to their doctors (and other health care workers) come from a general obligation upon everyone to respect other people. One example of bad patient behaviors serves to illustrate: Whilst waiting for treatment in accident and emergency, a patient complains constantly and abusively to the nurses and reception staff about having to wait his turn. When he sees the doctor, he begins to swear again and finally punches the doctor.

In this case, the wrongdoing is the same and is of a kind dealt with in general ethics: The patient fails to show the respect for persons that is due to anyone, not just health care professionals. Anyone who swears at others or hits them without provocation is doing something wrong, regardless of the role of the person sworn at or attacked. And the basis of the wrong is disrespect.

3.2. Patients as Citizens

Patients may attempt to justify their negligence by saying that the taxes they pay on cigarettes or their contributions to national insurance mean that they have paid for the treatment they need as the result of ignoring medical advice. This argument is often used in an unsophisticated way, for it overlooks all the tax-financed benefits that go beyond health care that people enjoy. But even if all patients who ignored medical advice were net contributors to the welfare state, the argument would still be flawed. The justification for the welfare state is not only that of egoism (I pay my taxes so that I will benefit if the need arises). It is also justified by the belief that a decent society ought to use what resources it can to support the weakest and the poorest.

There are good reasons why the distribution of medical resources cannot be treated in every respect like the distribution of housing and unemployment insurance. For one thing, it would be difficult to prove in all cases that neglect was the source of ill-health. The more we understand about genetics, the more we know that environmental factors are only partly to blame for ill-health, and it would be wrong to penalize an individual for her genes since her genetic make-up is beyond her control. It is also difficult to prove that an individual knowingly endangered her health. This might be offered as a partial defense for smokers, who might argue that at the time they started smoking the harmful effects were unknown. Moreover, the penalty that may be paid by those who have contributed to their own ill-health could be out of proportion to the wrongdoing—a delay in medical treatment may not just cause short-term inconvenience or straightened circumstances. None of this, however, justifies people in contributing knowingly to a deterioration in their health and expecting everyone else to pay the bill.

3.3. The Counseling Relationship

Doctor-patient relationships in general practice are certainly changing. Patients register with the whole practice, rather than with a particular doctor, and which doctor they see may depend crucially on availability in an appointment system. Nonetheless, perhaps the greatest continuity of care is still provided in general practice. For even if the entire history of the patient is not personally known to a general practitioner (GP), the GP notes generally offer by the far the most complete patient history. Suppose that the patient is becoming obese and is in danger of developing diabetes, for example. He is advised to diet, but ignores the advice. Or suppose that a patient is sent for tests to establish whether or not he is suffering from bowel cancer, and is too embarrassed to go. Let us assume that there is no doubt in either the patient's or the health care practitioner's mind that the course of action recommended makes sense. There is simply a failure on the patient's part to follow through. Is this another case of patient wrong-doing? Yes, because not only does he knowingly aggravate his own condition, doing himself harm, but he unreasonably refuses to play by the rules of situations in which people seek and are given medical advice. These rules can be taken to assume that both patient and doctor have a serious stake in some sort of health gain for the patient, and that so long as the means of achieving the gain seem reasonable to both parties, the patient will fall in with them. This is another duty that the patient has that flows from general ethics. This duty is not just another version of the duty to self; it is also a duty owed to the doctor. This duty may have something in common with a duty; it is arguable people have in counseling relationships in general, at least where there is no doubt that the counselor puts the best interests of the advice-seeker foremost. If the advice-seeker asks for advice, then he should be prepared to listen seriously to it. That is why it is wrong, and not just imprudent, for someone who asks for advice to dismiss, it angrily when he does not like what he hears—because he has asked for advice and not e.g., flattery. The advisee should take what he hears seriously if there is no reason to think it is not offered in good faith. And if he genuinely agrees with the advice, and is not just saying he does, he should—morally should—follow through with it, other things being equal.

Perhaps only the listening is strictly owed to the counselor in the counseling situation, while the following through is owed to oneself. But in the medical situation, it may be different. The same GP who gives the advice that is apparently accepted and not acted upon may have to pick up the pieces when, as a result, the condition of the patient worsens later. And picking up the pieces may consist in trying to get a patient to take advice a second or third or fourth time. The worse the condition becomes, the more the duty of care limits the room for manoeuvre of the doctor. He becomes a sort of captive helper. And so the duty of the patient may be a duty not to conspire in bringing this captivity about. In this sense, the duty that one has as an advisee in a doctor-patient. Relationship begins in general ethics, and, as a result of the ethical constraints upon doctors, ends up in medical ethics.

4. Patients' Duties to Doctors as Captive Helpers

The captivity of doctors works on two levels: On the one hand, individual doctors are only exceptionally allowed to break off a relationship with a patient; on the other hand, even if a particular doctor-patient relationship proves impossible or is brought to an end, the profession as a whole will continue to provide care for the patient.

What duties for patients flow from benefiting from a captive relationship?

The analogy between doctors' captivity and the captivity of friends and relations extends to the limits on

this captivity. For there are limits. The devotion of friends and relations can be strained to breaking point, and the people who make use of it are under some obligation to try and limit their calls on it and return to the adult norm of looking after themselves as far as possible. The captivity of the nearest and dearest is not then an unconditional and permanent captivity. Neither should the captivity of doctors be: As adults who can be expected to regain or acquire their independence and keep to a minimum the burdens they avoidably create, autonomous patients are under an obligation to do what they can to limit the captivity of doctors.

The upshot of this is that in medical ethics, patients should have an obligation to follow reasonable medical advice—especially the kind of medical advice we referred to earlier, namely that with which the patient actually agrees before something like weakness of will sets in. Doctors, like the friends and relations, have an obligation to persevere in the hope that patients will eventually be able to achieve or return to the norm of taking proper care of their own health. But patients also have an obligation to enable doctors whose sound advice is ignored to withdraw from this obligation. The main duty of patients who need care from doctors they keep captive is to do their part in reducing their need for medical care and in co-operating with doctors so that doctors are willing rather than captive helpers in the doctor-patient relationship.

5. Doctors' Responsibilities to Patients' Failing in Duties

If patients also have duties in medical ethics, then presumably doctors should have some recourse when patients fail in these duties, just as patients do when doctors fail. The difficulty here is that, in releasing themselves from the role of captive helper, doctors abandon patients to their fate, and there will inevitably be hard cases.

Let us suppose that the patient has no good reason for his failure to comply with the advice to limit his fluid intake; he just keeps giving into the temptation to drink. What action could the doctors reasonably take against this patient? One possibility is that they could issue an ultimatum: Since he is persistently not complying with the recommendations for fluid intake, they will no longer be providing him with additional sessions. They would have to explain that the consequences of continuing to abuse fluids without the additional sessions would be discomfort and eventually heart failure. Such an ultimatum would force the patient to accept the consequences of his autonomous behavior. In effect, the patient would be required to act as the responsible adult he is. Arguably this action shows greater respect for his autonomy then does providing the additional sessions. But what if, after several months of adult behavior, the resolve of our patient begins to weaken, his fluid retention gradually worsens and he is eventually admitted to accident and emergency with heart failure for which immediate dialysis is the obvious solution? Under these circumstances would it be ethical for the doctors to continue to refuse to give additional dialysis? In this case, we have to conclude that it would not. In an acute, life-threatening situation, the safety net of captivity would return because it would be wrong not to save a life, even one endangered through stupidity or weakness of will.

6. Conclusion

Autonomous patients do have duties—most of which are left out of mainstream medical ethics. Some of these duties flow from the obligations all persons have to each other; others are the responsibilities citizens have in a welfare state. More specifically, patients have duties corresponding to those that render doctors captive helpers. Patients have to—morally have to—do their best to ensure that they minimize this captivity and enable doctors to be willing helpers. Although doctors remain captive in the face of acute or

life-threatening illness, it is not unethical for doctors to free themselves from this captivity in cases that fall short of life or death.

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