Office Hours: **Provider Autonomy**

Thanks for all your questions and thoughts on this week's material.

»»» A number of you asked how a physician's **duties to help** relate to his or her own **autonomy**.

Let me say some things to clarify that.

Duties to help people fall under what is called the principle of **beneficence**. There is a lot of debate among ethicists about what the principle of beneficence requires of us and how it relates to autonomy. I can't cover all of that debate here, but I can say a little bit more about how it might work in this context.

Traditionally, medical ethics has focused on the clinician's duty of beneficence toward the patient. This is usually interpreted as a duty to act in the patient's best interests. Acting in the patient's best interests means delivering the best medical care possible in the circumstances, and refusing to act in ways that undermine the patient's interests. Just about everyone thinks that clinicians have a very strong duty of beneficence toward their patients. This duty is what underlies what I described in the videos as a duty not to abandon patients who need them.

But if we just focus on the clinician's duty of beneficence, we run into problems about **paternalism** — a clinician imposing her or his view about what's best for the patient, independent of what the patient thinks. And this looks like a violation of the patient's autonomy. The great Prussian philosopher Immanuel Kant, about whom I'll say more in week 4, solved this problem by subsuming the duty of beneficence under the duty to respect others' autonomy. In Kant's view, a helping action doesn't even count as beneficence if it's not what the other person wants. If you "help" me by doing something I don't want you to do, you're actually disrespecting me.

Now of course in emergencies, there isn't always time to find out what a patient wants. Clinicians may have to make assumptions about what treatments an unconscious or seriously ill patient would agree to have done. And in the case of young children or patients with significant cognitive impairment, it may not even make sense to ask what the patient would want. But when it is possible, respect for patient autonomy requires that the clinician find out.

Many of you thought that the psychiatrist who, because of his commitment to Scientology,

wouldn't prescribe psychiatric drugs, would actually be harming his patients. That's an extremely important consideration, but we should also take into account the fact that there may well be patients out there who share his beliefs and want to be treated by a clinician like him. But surely he has has a duty to present his beliefs upfront (and how they depart from the prevailing standards of psychiatric practice) so that patients can decide for themselves whether they want to be under his care. To withhold that information from patients is to fail to respect their autonomy.

I suggested in the videos that respecting a patient's autonomy can require the clinicians do things to help them act on their decisions and carry out their projects. In Kant's view, helping people is just a way of respecting them. But we do normally get to exercise our own autonomy when deciding whether or when to help people. I don't have to help people do things that are morally wrong or that I think will harm them or even that are pointless.This is why the clinician doesn't have to help a patient obtain an unnecessary MRI. But the special role of a clinician does generate a parallel special duty to help patients in need of their care. So the duty of beneficence is especially strong for clinicians when it comes to helping their patients.

»»» **JenChapman** asked about how the **presence of other people**affects the duty to help.

This is actually a big topic of debate among philosophers! If I'm the only one around, then obviously the entire duty falls on me. But if others are present, it seems reasonable for them to step up and help too. This is how issues of conscientious objection are often handled in practice. If one clinician is unwilling to help because of a conscientious objection, another clinician can help instead. It becomes more complicated in cases where, although the other people present could help, they aren't helping. So if there are 50 of us on the side of the pool while you're drowning and the other 49 aren't planning to do anything, it seems like the duty does fall entirely on me. It's not fair, but it's not an excuse to let you drown.

»»» A number of you wondered about how **financial considerations** affect the physician's duty to act in her patient's best interests.

Of course it's okay for a clinician to get paid for her services, but most ethicists agree that it's a violation of beneficence if a clinician orders tests or does procedures that the patient doesn't really need, and that earn a profit for the clinician. So the clinician cannot put her own financial interests above the needs of her patients. This doesn't mean that she can ignore the overall costs of care. Physicians do have responsibilities toward society when it comes to health care costs. But that's a bigger topic than we can address here.

»»» Finally, **Suirsuss** asked about whether we can be considered**complicit** in things that we aren't actively seeking to prevent or change.

That's a great question that takes us into important philosophical territory about **responsibility**. Adherents of the moral theory calledutilitarianism believe that we are just as morally responsible for what we fail to prevent as for what we actually do. That has really significant implications because there's a whole lot of stuff we're all failing to prevent all the time! Utilitarians would argue that we have a strict moral duty to change systems if doing so would prevent bad things from happening. Others think that the duty to prevent bad stuff is important, but that the duty not to do bad stuff ourselves is more stringent. On this view, a clinician's duty not to be complicit in wrongdoing through his own actions is different, and more pressing than his duty to go out and work for changes in a system.

I look forward to talking with you all again in Week 4.