

The morality of coercion

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Abstract

The author congratulates Dr Brian Hurwitz, who recently reported the successful “intimidation” of an elderly competent widow into accepting badly needed therapy for a huge ulcerated carcinoma. He reports approvingly of the Israeli Patients’ Rights Law, enacted in 1996, which demands detailed informed consent from competent patients before permitting treatment. But the law also provides an escape clause which permits coercing a competent patient into accepting life-saving therapy if an ethics committee feels that if treatment is imposed the patient will give his/her consent retroactively. He suggests this approach as an appropriate middle road between overbearing paternalism and untrammelled autonomy.

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Dr Brian Hurwitz, in a recent issue of the journal,¹ almost apologetically reported the successful intimidation of an elderly competent widow into accepting badly needed therapy for a huge ulcerated basal cell carcinoma. He placed great emphasis on the unreasonable wasting of valuable scarce resources, and these considerations pushed him into what ultimately spared this woman much suffering and possibly death. Yet in spite of this courageous step on his part, Dr Hurwitz, in his reflection, still is agonising: “Did I apply undue pressure upon Mrs Thomas?”

Dr Hurwitz’s hesitation is indeed justified, if looked at in light of the priority placed upon autonomy in today’s Western medical ethics.² He might well be accused by many ethicists of paternalistically violating this woman’s precious autonomy.

I would like to suggest rather that Dr Hurwitz is to be congratulated for his courage, and that it is high time that the pendulum which has swung from overbearing, autocratic and insensitive paternalism to an often cruel and dangerous autonomy, be allowed to swing back to a more moderate and sensible balance between autonomy and beneficence.

I would like to use the current Israeli patients’ rights law, as perhaps one possible example of a sensible, sensitive and nuanced middle-of-the-road position.

Israel, in 1996, became one of the few nations to enact national patients’ rights legislation.³ The law covers a wide variety of patient rights, but I shall focus here only on the issue of informed consent. The law specifies quite explicitly that prior to any

treatment, a competent patient’s consent must be obtained, and that in the process of obtaining such consent the physician must provide the patient with information about:

- 1) Diagnosis and prognosis of his/her condition.
- 2) Description of the nature, the process, the goal, the expected benefit and the chances of success of the proposed treatment.
- 3) The dangers of the treatment, including side effects, pain and discomfort.
- 4) Risks and benefits of alternate forms of therapy or of no therapy at all.

In this legislation the Israeli legislators clearly came down firmly in favour of the American courts’ standard of the “reasonable patient”,⁴ rather than the British standard of the “reasonable physician”.⁵

Yet when the issue of the possibility of treatment of a competent patient against his/her will was considered the Israeli law-makers hesitated. On the one hand there is virtual unanimity in the West that no competent patient may be forced to accept even life-saving therapy. But here the strong “sanctity of life” Jewish tradition could not accept so lightly permitting a salvageable patient to die.

Faced with this dilemma, the attorney general of the state of Israel convened a meeting of some 30 experts, including physicians, lawyers, rabbis and philosophers, to advise him on this vexing dilemma. As might be expected, the civil libertarians argued vigorously for the Western view that no competent person could ever be treated against his/her will. On the other hand religious leaders spoke out against permitting a patient to die, even if this was his/her express wish. One of Israel’s leading philosophers characterised his own dilemma by stating: “I have a conflict between my head and my heart. The former tells me not to treat the patient, but my heart does not permit me to let him die. I am unable to stand by and watch a man who wants to commit suicide by lying on the railroad tracks, to remain there, without pushing him off even against his will”. At the end of a long discussion period, a compromise was reached. The law now reads that if there is serious risk of death or permanent major disability in the absence of treatment, the treatment is clearly beneficial, the patient refuses therapy, and the hospital ethics committee feels that if treatment is imposed the patient will later give his consent retroactively, treatment may be imposed.

I must confess that my initial reaction to the compromise was one of derision. While the Holy Land has a long tradition of prophecy, it seemed, on

first thought, to be unreasonable to expect an ethics committee to exercise such powers.

But on further thought, and stimulated by an actual case, I have come to conclude that the Israeli compromise has Solomonic wisdom, and indeed merits consideration by other societies as well.

In a recent case at one of Israel's hospitals a young Bedouin man was admitted with pneumococcal pneumonia (generally a highly treatable disease in this age group, with reasonable expectation of complete recovery). He was having trouble with adequate oxygenation and was tiring. Intubation and mechanical respiration were medically indicated. The patient, fully "competent" by the usual standards, was adamant in his refusal to be intubated. The physicians attempted to persuade the patient, using family members as well as interpreters, but to no avail. The physicians did not take advantage of the clause in the law permitting the possible imposition of treatment in this case, but accepted the patient's refusal and treated him without intubation. The patient died.

Surprising ending

Ironically a recent article by a physician in a non-medical magazine⁶ describes an almost identical case in the United States, with an opposite, and surprising ending. A man, in his late thirties, with bacterial pneumonia, in serious respiratory distress, refused intubation in spite of all efforts to persuade him. The physicians in this case also honoured his refusal, but immediately upon the patient's loss of consciousness intubated him, attached him to a respirator and sedated him. When his condition improved, some 24 hours later, the sedation was stopped, and the tube removed. The patient's first words were "Thank you".

The Israeli patient's death would be considered perfectly acceptable by many Western ethicists. But I would disagree strongly, and consider the death an unnecessary and preventable tragedy. Here was a patient, acutely ill, with a curable disease. The physicians were not dealing with a patient who was suffering with a terminal illness, who was looking forward to death as a salvation and about whom I would agree that imposition of mechanical respiration to prolong his suffering would be unconscionable. This patient, while technically and legally competent, obviously feared the intubation. But had his life been saved by several hours of mechanical respiration, he would have undoubtedly been eternally grateful to a Dr Hurwitz, who might have had the courage to act decisively. Under the new Israeli law, such a step would have been perfectly legal, and Dr Hurwitz would not have had to feel guilty about his actions. But the Western influence of autonomy, reigning supreme, influenced this man's physicians to accept his tragic choice.

The American physicians who violated American legal and ethical norms, I believe acted appropriately, in accord with the spirit of the Israeli law.

I believe that a more careful examination of the specific cases in the casuistic tradition,⁷ and a more nuanced application of terms such as competence

and autonomy are indicated. If competence is regarded as an all or none phenomenon and autonomy as an absolute trump over all other values, obviously the Israeli law is unethical. But in evaluating a specific case, even according to the "four principles" method, which in its original form, does not necessarily give automatic priority of one principle over another, the relative magnitude of each principle should be taken into consideration.

The degree of competence of patients, all of whom are certified as "competent" by a psychiatrist, may vary from patient to patient. Autonomy is predicated on a rational determination free of coercion, not just coercion by a physician but also by the overall circumstances. The reasoned, repeated, well thought out decision by a chronically ill cancer patient should be given greater weight than a hasty decision by an acutely ill frightened, although technically competent, patient.

On the other hand the refusal to submit to a major operation with great risk, pain and suffering or to a dangerous treatment should carry greater weight than the refusal of a procedure with relatively trivial risk and with virtually guaranteed certainty of life-saving.

Retroactive consent is not automatically superior to proactive consent and indeed it is often identical in its conclusion. But oftentimes individuals under acute stress may make hasty tragic decisions which they subsequently, under more careful consideration, regret. Hindsight, or the "retrospectroscope", using additional data, beyond those present at the time of the original decision, may result in a decision more acceptable *to the patient himself/herself*. It is perhaps equivalent to the decision of an appeals court which reverses the decision of a lower court after considering it in light of additional evidence.

The ethics committee is called upon to weigh the quality of the competence of the patient, the degree of his/her autonomy, the potential for risk and suffering in the procedure, the likelihood of its success, the danger of refusal and the likelihood of the patient's subsequent reversal of his earlier refusal. If on balance the scales tip towards imposing treatment on a currently unwilling patient they may so decide.

'Escape clause'

This "escape clause" is not intended for frequent or routine use. Far from it, and as the case of the Bedouin patient indicates, it may be underused. But when the magnitude of the beneficence is huge, and the weight of the autonomy consideration weak, why not let beneficence "override" autonomy?

I would hope that even the most devoted advocates of autonomy might accept the premise that a patient who is frightened and stressed, may not be fully autonomous; his/her refusal should therefore be assigned less weight.

It is tragic to accept such a patient's refusal automatically at face value, even if a team of

psychiatrists and lawyers judge that person legally competent. Competence and autonomy must be evaluated on a continuum and not as simplistic all-or-none phenomena.

In addition, autonomy is of no value to a dead person. By permitting a patient to die avoidably, when it is virtually certain that were he saved against his present protest he would be grateful, one is granting that person his short term “autonomous” wish while depriving him of his long term autonomy. The Israeli law’s line of reasoning is similar to J Stuart Mill’s refusal to permit an individual to sell himself into slavery,⁸ because he thereby uses his freedom, to deprive himself of freedom which is the ultimate *raison d’être* of autonomy.

Obviously the present situation is not identical to Mill’s example. Nor do I contend that in keeping with the analogy one should never accept a patient’s autonomous decision to let him die. But the analogy does emphasise the principle that autonomy is not the ultimate end and that it does not always “trump” all other values. It must be considered in the context of its broader goals and evaluated on a case by case basis.

If the ethics committee errs in coercing the patient who subsequently persists in his/her withholding consent the patient’s autonomy has been violated, which is not a matter to be taken lightly. On the other hand if the ethics committee errs in the other direction and permits the patient to die, in a situation where the patient might in retrospect have wanted to live, the damage would seem to be infinitely greater; there is no reversal of death.

I am not advocating a return to insensitive, arrogant paternalism, which places little or no value on individual patients’ opinions and values, and arrogates to the physician the absolute right to select therapy, under the guise of always knowing what is best for the patient. But when a thoughtful ethics committee listens carefully to a patient’s viewpoint, and is convinced that the patient’s welfare demands a particular treatment, and that the patient, too, will subsequently be grateful for such intervention, I believe it to be ethically appropriate to overrule the patient’s objections.

The proposed position would obviously be opposed by the most militant exponents of autonomy such as Robert Veatch⁹ who states categorically that he knows of no case in which patient welfare is so weighty that it could outweigh autonomy, and who claims that “no competent patient in the United States has ever been forced to undergo medical treatment for his or her own good. No matter how tragic, autonomy should always win

if its only competitor is the paternalistic form of beneficence.”

There have been several more moderate voices¹⁰⁻¹² suggesting that there are situations, particularly in the area of public policy, where the common good should override personal autonomy. However, they have not publicly crossed the Rubicon to suggest that treatment be imposed on an unwilling, competent individual patient for his or her own good.

But in the moving exchange between Dax Stewart and Robert Burt¹³ about the imposition of therapy on the devastatingly burnt Dax and in the subsequent article¹⁴ commenting on the exchange, a view similar to the one expressed here comes to the fore. For even Dax who has fought so eloquently and vigorously and helped create the famous “Please Let Me Die” and “Dax’s Case” videos, accepted the possibility of not acquiescing immediately to an acutely ill patient’s request to die, but entering into negotiations on the matter.

I believe there are sound ethical and humanitarian grounds for a retreat from the absolutism of autonomy, and I congratulate Dr Hurwitz for acting bravely and for raising the issue publicly.

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