False belief and the refusal of medical treatment

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May a doctor treat a patient, despite that patient's refusal, when in his professional opinion treatment is necessary? This is the dilemma which must from time to time confront most physicians. An examination of the validity of such a refusal is provided by the present authors who use the case history of a patient refusing treatment, for cancer as well as for a fractured hip, to evaluate the grounds for intervention in such circumstances. In such a situation the patient is said to have a 'false belief' and it is the doctor's duty to try to change that belief in the patient's interest. The false belief is considered here in terms of the liberty principle, the patient's mental competence and on what is called the 'harm principle' (harm to other individuals or to society). Finally the concept of paternalism is examined. The authors conclude that the doctor must attempt to change a false belief, and if this fails he must examine the patient's mental competence to make the decision to refuse treatment. But in the last analysis the doctor may be under an obligation to respect the patient's refusal.

Readers might like to look at (or read again) the papers on 'Liberty' and 'Conscience' published in this Journal under the heading Analysis.

In recent years there has been substantial discussion of the conditions under which a consent to medical treatment or a refusal of medical treatment should be considered valid. Commentators¹ have stressed such issues as the adequacy of the disclosure, the patient's capacity for understanding and responsible decision making,^{2,3,4} and sources of influence on the decision-making process⁵. However, recently we were confronted with a patient whose refusal to accept recommended medical treatment raised an issue which has not previously been discussed, namely, should a physician respect a patient's refusal of treatment, where the decision is predicated on a false belief, even though the patient may be 'informed' insofar as he or she received and understood an adequate disclosure? The purpose of this paper is to explore the conditions under which a physician's intervention contrary to a patient's decision can be morally justified.

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Case report

A 57-year-old woman was admitted to hospital because of a fractured hip. Surgery, which involved pinning the hip, was strongly recommended but was refused by the patient. Her major reason for refusing the procedure was that she could not tolerate the postoperative pain. While she recognized that surgery could mean the difference between being able to walk and remaining bedfast, she preferred to remain bedfast but free of pain.

During the course of the hospitalization, a Papanicolaou test and biopsy revealed stage I A carcinoma of the cervix. Again surgery was strongly recommended, since the cancer was almost certainly curable by a hysterectomy. Again, the patient refused the procedure.

The patient's treating physicians at this point felt that she was mentally incompetent. Psychiatric and neurological consultations were requested to determine the possibility of dementia and/or mental incompetency. The psychiatric consultant felt that the patient was demented and not mentally competent to make decisions regarding her own care. This determination was based in large measure on the patient's steadfast 'unreasonable' refusal to undergo surgery. The neurologist disagreed, finding no evidence of dementia. On questioning, the patient stated that she was refusing the hysterectomy because she *did not believe* she had cancer. 'Anyone knows', she said, 'that people with cancer are sick, feel bad and lose weight', while she felt quite well. The patient continued to hold this view despite the results of the biopsy and her physicians' persistent arguments to the contrary.

Grounds for intervention: Voluntariness and the liberty principle

In the western tradition, it is often an assumption of moral discourse that freedom is a good to be preserved and that any limitation of freedom requires moral justification (the liberty principle). Central to the concept of freedom is that of 'voluntariness' which is usually defined as the absence of internal or external constraints. Often included as an additional requirement for voluntariness is that a person be fully informed of the facts relating to a proposed action. Such requirement for information for voluntariness goes back to Aristotle who said that 'ignorance of the circumstances of the act and

of things affected by it renders an act involuntary' ⁶. John Stuart Mill held a similar view, maintaining that the state had a right to protect an individual from his own ignorance:

'If either a public officer or anyone else saw a person attempting to cross a bridge which had been ascertained to be unsafe, and there were no time to warn him of this danger, they might seize him and turn him back, without any real infringement of his liberty; for liberty consists in doing what one desires, and he does not desire to fall into the river' ⁷.

More recently, Feinberg ⁸ has adopted a position similar to Mill's, arguing that for an act to be fully voluntary there must not only be an absence of all coercive pressure but also that the person must be 'informed of all relevant facts and contingencies'. We agree with the positions expressed by Aristotle, Mill and Feinberg and believe that they also justify intervention in the case of a false belief, to the extent that holding a false belief parallels ignorance as a condition limiting voluntariness.

Moreover, it would seem that these arguments not only justify intervention, but that they also imply a moral obligation to attempt to disabuse a person of a false belief to the degree that such action increases a person's freedom.

Commentary on informed consent has similarly recognized that a person ignorant of material facts cannot make a truly voluntary decision ^{2,3}. This requirement of comprehension as a necessary condition for meaningful consent has not, however, been examined *vis à vis* the relationship of a false belief to a true understanding. The question is whether, for meaningful consent, a person has to understand only what has been disclosed or whether he also has to understand or believe that what was said is *true*. Accepting the latter view implies that the obligation to ensure understanding in relation to informed consent should also include an obligation to disabuse an individual of even a resolutely held false belief. Clearly this obligation would apply as well to informed refusal as to informed consent, these being alternative decisions reached after the informing process.

In the above discussion, two lines of argument have been used to justify an obligation to intervene to change a false belief, where such a belief forms the basis for refusal of medical treatment. However, this obligation is not an unrestricted one. It is limited by the very freedom principle on which it is based since interventions (both coercive and non-coercive) are justified only if the amount of freedom lost through the intervention does not outweigh that gained through increased freedom of choice. Where alternative interventions are available, this principle would also require the selection of the one yielding the greatest freedom.

Such a moral calculus is useful in determining whether there exists an obligation to attempt to change a false belief. Two other factors may,

however, affect the amount of effort expended in meeting this obligation, namely, the probability (*P*) that the belief is false and the severity of consequences pursuant to holding the false belief. In relation to the probability issue, consider the following examples:

EXAMPLE 1

The patient does not believe she has cancer despite what are considered unequivocal biopsy findings (our case).

EXAMPLE 2

The patient does not believe she has cancer when the diagnosis is based on more equivocal evidence, such as subtle changes on a diagnostic procedure.

Other factors being equal, it would seem that stronger efforts should be made to alter a false belief where *P* approaches 1 (example 1) than where *P* is substantially less than 1 (example 2).^{*} In addition, for any given value of *P*, the efforts expended to alter a false belief may be greater when the consequences of holding the belief are more severe.

Consider two other examples:

EXAMPLE 3

The patient refuses to believe that she has a malignant breast mass.

EXAMPLE 4

The patient refuses to believe that she has a benign breast mass.

Assuming *P* to be the same in both cases, it seems obvious that more resources should be directed towards changing the patient's belief in example 3 as compared to example 4.

Other potential grounds for intervention

In the previous discussion, justification for intervention was based exclusively on the liberty principle.^{**} But the enhancement of freedom need not be the sole justification for intervention since freedom is not the only, nor is it necessarily the highest,

^{*}It is, however, important to point out that the obligation in example 2 is not to convince the patient that she has cancer but only to convince the patient that she *may* have cancer at the probability level accepted by the medical community. In other words, the patient should be disabused of the following belief: 'there is no increased (above random average) chance of my having cancer'. There are, of course, epistemological problems in referring to such examples as 'false belief' cases since it is certainly possible that the patient's belief may be true in the absolute sense.

^{**}Another distinction might conveniently be drawn at this point. The liberty principle is more likely to be invoked as justification for interventions to change belief, while the harm principle and incompetency more likely apply to justify unauthorized procedures.

moral good. There may be competing values in addition to freedom such as social welfare or justice, one or more of which may be used to justify coercive intervention.

COMPETENCY

It is widely held that society has a moral obligation to protect the interests of those incapable of reasoned judgment, for example, children and the mentally incompetent. Where a person persists in holding a false belief despite reasonable efforts to change that belief, the issue of mental competency may well arise, as it did in our case.

However, it is important to distinguish false belief as grounds for incompetency from the issue of 'irrationality' of the decision. Although the psychiatric consultant in our case based his determination of incompetency in part on the 'unreasonableness' of the patient's decision to refuse surgery†, it has been strongly argued that competency regarding capacity to give meaningful consent must be distinguished from the seeming 'unreasonableness' of the decision and should instead be based on the patient's understanding of the consequences of the options available to him⁹. Thus, any argument relating incompetency and false belief should be based on a lack of understanding rather than the 'reasonableness' of the patient's decision.

A persistently held belief with $P = 1$ falseness, not based on ignorance, might be considered grounds for incompetency. But, because in actuality P is always less than 1, an argument in favour of incompetency based on a persistent false belief should be entertained very cautiously and only where the probability of falseness is very high. Even then, alternative explanations other than incompetency should be considered, such as religious beliefs or the patient's distrust of the source of the information.

HARM PRINCIPLE

If a person who is deemed competent persists despite reasonable efforts in refusing a medical procedure based on a false belief, coercive intervention not justified by the liberty principle might still be justified if the patient's decision would result in significant harm to other individuals or society. In our case, for example, both the hip and cancer operations might be justified in terms of a public harm principle by appealing to the costs to health and welfare institutions resulting from the patient's failure to accept treatment. It should be recognized, however, that this line of argument is somewhat independent of the question of the false belief. Rather it reflects the weighing of two conflicting duties – to respect personal autonomy and to prevent public harm.

†In this discussion, we have purposely sidestepped the option of seeking a court order as this manoeuvre serves only to delay but not resolve the moral issues.

PATERNALISM

Assume that a patient refuses a procedure based on a false belief. All legitimate interventions to change that belief have failed, the patient is considered competent and the harm principle cannot be justified. A physician intervening under these circumstances would be acting paternalistically, since the justification for such intervention would be only to prevent the patient from harming herself.

There is a longstanding controversy concerning the moral justification of paternalistic intervention. Some have argued that such actions are never justified¹⁰, while others have accepted paternalistic intervention under specified circumstances¹¹. A review of these positions is beyond the scope of this paper. It is our feeling, however, that the arguments against paternalism are the more persuasive for two reasons. First, because the acceptance of even limited paternalistic intervention opens a Pandora's box which could substantially threaten personal freedom. Second, because recent reformulations of the harm principle have been shown to handle the questionable case satisfactorily¹⁰.

Conclusion

We have argued that a physician has a moral obligation to attempt to change a patient's false belief, and that this obligation is both justified and limited by the liberty principle. The efforts expended in meeting that obligation are tempered by the probability of falseness of the belief and by the severity of the consequences which follow from holding the belief. Where justified interventions to change belief fail, and when the probability of the falseness of the belief is high, the physician may appropriately raise the question of mental competency. The physician may also consider intervention based on the justification of the harm principle, but it should be recognized that, in using this justification for intervention, the false belief becomes a secondary issue. If the patient does not yield to justifiable interventions to change belief, is competent, and the harm principle cannot be legitimately invoked, we feel that the physician is obliged to respect the patient's refusal.

Epilogue to the case report

A complicating factor in our case was the patient's social history. She was a poor white from Appalachia with a third-grade education. The fact that her treating physician was black was a major reason for her not believing that she had cancer. Discussions with another physician (who was white) and with her daughter resulted in a change in belief. Subsequently the patient consented to and successfully underwent a hysterectomy. She has continued to refuse hip surgery, but there are no plans to intervene coercively in this regard.

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