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Clinical Case

Autonomy and Public Health: When the Patient is a Physician

Commentary by Parveen Parmar, MD

Twenty-four hours after his visit to the internal medicine clinic, Luc Aston was not surprised to discover a raised swelling on the inside of his forearm where the PPD test for tuberculosis had been administered. During his childhood in France he had received the Bacillus Calmette-Guerin TB vaccine. Then midway through the first year of his emergency medicine residency he was diagnosed with a case of active pulmonary TB, most likely acquired from patient exposure. Following his diagnosis, Luc took a leave of absence until chest x-rays confirmed his response to drug therapy. Now returning to finish his intern year, he was still required by hospital policy to receive an annual tuberculin skin test despite his past medical history and the likelihood of a false positive result.

"I've had positive skin tests before so I'm not worried," Luc said later that day over lunch, after he and 2 friends, also residents, claimed a table in the back corner of the cafeteria. "I just wish I could shake this cold—I haven't been able to run much lately. But anyway," he continued, "my last x-ray 6 months ago was fine and I don't want to alarm anyone at the clinic by telling them the skin test was positive. I mean isn't that what you'd expect?"

"Wait a minute Luc," Sriranjani Patel, a third-year emergency resident, interrupted. "You really need to have another x-ray just to make sure. Are you saying you're not going to follow through with that?"

"Well, I don't really want to," Luc replied, pausing for a moment to cough. "Sorry about that," he continued. "I'm already behind because I took time off. Besides, I really don't want to start taking meds again. The side effects are not something I want to go through a second time, especially when I really think medication isn't needed. I mean come on," he said, pausing to cough again deeply. "I had TB but it's fine now—I don't want to be taking isoniazid at 6-month intervals for the next 4 years just because some doctor at the clinic gets nervous."

"Luc," Sriranjani started cautiously, "how long have you been coughing?"

"Sri, please!" Luc exclaimed. "Don't start with that. I just have a bit of a cold. I'm fine!"

"Any pleuritic chest pain? Night sweats?" asked Mark Theophilus, the third member of the group, and a second-year resident.

"Will you 2 stop trying to diagnose me?" Luc asked, tossing a wadded-up napkin onto his half-empty plate in exasperation. "So I'm coughing and it's a little tight when I breathe. I have a cold! You know, those things called viruses? If I go in and make a big deal about this," he said, gesturing to his arm, "they might start me on meds again and I don't want that. I'm fine, trust me, and I'd really appreciate it if you both just stay quiet about this. I had an x-ray 6 months ago and I don't have time to get another one right now so I'm just not going to mention the PPD [purified protein derivative skin test] results. Once this cold goes away," he paused, coughing again, "I'll be fine!"

Commentary

As this vignette unfolds, Luc the coughing intern may very well have a simple upper respiratory infection. On the other hand, having recently completed a course of multi-drug therapy for pulmonary tuberculosis he may have also relapsed into another case of active tuberculosis. As an emergency medicine intern with exposure to hundreds of children and elderly and immunocompromised patients, certainly Luc has a responsibility to report his symptoms and agree to a repeat chest x-ray. Yet, one can understand why he might be reluctant to do so, having just spent several months away from work taking unpleasant, often toxic, medications. This case presents an interesting dilemma that illustrates the challenges when 2 worlds collide. As both a patient and a physician, does Luc have the right to refuse health care in this situation?

Luc's colleagues are also in a unique position. They have a responsibility to respect the judgment and wishes of their friend, but at the same time they are also accountable to their patients, other colleagues, and themselves to fulfill the professional obligations of physicians. In facilitating Luc's return to work as a medical professional, possibly with a communicable disease, are they complicit in endangering the health and even the lives of their own patients? Beyond questions of professional ethics, if Luc does in fact have TB, this group of interns—and all exposed employees of the hospital—may themselves end up needing several months of multi-drug therapy. Can loyalty and respect for their friend's wishes justify inaction?

The Right to Refuse Treatment

Under the basic principle of autonomy, it is everyone's right to ignore his or her own health, for better or worse. The American Medical Association's *Code of Medical Ethics* reflects this position when it states that, "The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment" [1]. Patients regularly refuse proven therapies in favor of alternative or natural therapies, even after being fully informed of the risks of doing so [2]. As a practicing physician, I have even had patients die as a result of such decisions.

However, except in extraordinary circumstances such as quarantine, physicians must respect the patient's right to autonomy and self-determination in making decisions regarding health care, no matter how difficult, and even when it can affect public health.

For example, under some circumstances we respect the right of parents to decide not to vaccinate their children—we pray that herd immunity protects these children and ours [3]. Similarly, physicians often come to work when they have communicable diseases, from the flu to gastroenteritis. These highly contagious viral illnesses can be transmitted easily from person to person in the process of routine care, even with vigorous hand washing. With these precedents, doesn't Luc also have the right to refuse further care for his symptoms, even if, like a simple viral illness, his condition could endanger his patients?

Patient Safety, the Prevailing Concern

Despite such arguments, the fact remains that tuberculosis is far beyond a simple viral illness. It is a chronic, life-threatening, debilitating illness that is extremely difficult to treat and poses a tremendous threat to the public health. While most patients have no problem getting over a cold, recovering from tuberculosis is no small matter. Furthermore, developing TB can be an immediate death sentence for a patient with HIV or other immune deficiency. Immunodeficient patients, including those with AIDS, those on chronic steroids because of autoimmune disease, transplant patients, and the elderly and chronically ill make up a large percentage of the patient population of the average emergency room.

Consequently, given the threat that TB poses to the lives of his patients, Luc has a responsibility to report his symptoms, regardless of the personal difficulty this will cause. Luc the patient has a right to refuse care, but Luc the physician has the privilege of being a physician only so long as he protects the health of his patients above all else. His patients' rights trump his rights as long as he works in a hospital. The level of danger posed to patients' health by their physician's communicable illness is what determines when symptoms must be reported.

The Role of Colleagues

Luc's colleagues, as physicians, must focus on the health of their patients, even if this means disregarding the wishes of their friend. Active tuberculosis is far too serious a disease to allow an intern to become an unreported case. Certainly, his friends should start by offering Luc the chance to report his symptoms on his own. But if he does not, they should clearly state that they will inform their hospital's occupational health department of his symptoms. They should emphasize that they do not wish to betray him, but they would like to feel assured that patients presenting to the emergency room will not be exposed to a life-threatening disease. As physicians themselves, Luc's friends also have a responsibility to protect their own health—sharing lunch with a hacking TB case is hardly the way to do that.

Although this situation is undoubtedly a difficult one for Luc's colleagues—Who wants to face the possibility of having to confront a friend?—it is not without precedent. If Luc's colleagues noticed that his ability to provide patient care was impaired secondary to a drug or alcohol addiction, they would be ethically if not legally obligated to report their suspicions in the interest of patient safety [4]. It can easily be argued that a physician with an active case of TB poses as serious a threat to patient welfare as a physician under the influence of drugs. And even if Luc does not have TB and is

suffering from something more innocuous such as a respiratory virus, it is perhaps still the role of his friends to promote physician wellness by encouraging him to consider his own health needs. Regardless of whether Luc is suffering from TB or a respiratory virus, he illustrates the reality that physicians are as human as the patients they treat and, at times, may even become patients themselves.

Being a physician is an honor, not a right. With this honor come several clear responsibilities that must be upheld—even if our own rights, beliefs, and desires conflict directly with what is best for our patients. In accepting the responsibilities of this profession, we have agreed that our patients' needs must always come first. When we feel that we are unable to put our patients first, it is our responsibility to excuse ourselves from patient care in their interest.

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Parveen Parmar, MD, a resident in emergency medicine at UCLA, is a graduate of Northwestern University's Feinberg School of Medicine where she helped found the school's chapter of Physicians for Human Rights.

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