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Obligation To Provide Services: A Physician-Public Defender Comparison

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Right to Medical Treatment in Emergencies

In 1986 Congress enacted the federal Emergency Medical Treatment and Active Labor Act (EMTALA) in response to a surge of “patient dumping” by hospitals that refused to treat individuals who were unable to pay for medical care. Under EMTALA, all hospitals that participate in Medicare and their physicians are duty bound to stabilize and provide medical screening examinations for each patient who comes to the facility for emergency care, regardless of the patient’s ability to pay. While EMTALA does not expose individual physicians to direct liability for failure to comply, repeated violations of the act may lead to exclusion from participation in Medicare and Medicaid and to civil monetary damages.

Treatment in the Absence of Emergency

Obligation to treat patients in nonemergent situations is not clear-cut. Principle VI of the American Medical Association’s (AMA) “Principles of Medical Ethics,” states that a “physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care” [1]. Hence, no common law duty or ethical imperative exists outside of EMTALA or a patient-physician relationship that requires a physician to treat every patient. While the AMA Council on Ethical and Judicial Affairs has deemed it unethical to refuse to treat patients based on certain disease states such as HIV, that ruling is not instructive of whether physicians are wrong in refusing patients without specified conditions or disabilities [2].

Right to Legal Representation

The Sixth Amendment of the United States Constitution guarantees everyone charged with a criminal offense certain rights, such as the right to be represented by an attorney. For those who are poor, this representative is a public defender whose duty it is to provide adequate legal counsel. Forty years ago, US Attorney General Robert Kennedy said: “The poor man charged with crime has no lobby. Ensuring fairness and equal treatment in criminal trials is the responsibility of us all” [3]. Additionally, in the 1963 *Gideon v Wainwright* ruling, the US Supreme Court held that every defendant facing the threat of imprisonment is entitled to an attorney, regardless of ability to pay [4]. There is no corresponding constitutional mandate for people in need of nonemergency health care.

In the context of the indigent, the public defender's mandate to preserve the legal rights of clients is heightened. On the face of it, then, justifications for advocacy within the medical arena should take on added meaning in the context of the uninsured and the underinsured; patients who are already socially displaced by their inability to pay or their alternate lifestyles are further alienated when physicians refuse them care. The physician and the public defender each plays a unique role in society; the physician heals the body, while the public defender is a healer of conflicts. Both work to advance social justice. But the representation public defenders are obligated to provide is paid in fixed salaries from either state or federal governments. Physicians do not make their choices of whom to treat in the context of fixed salaries and must factor financial constraints and emotional expenditure into the equation.

The Refusing Physician's Moral Crisis

Unlike the public defender, the physician confronts a moral dilemma: conscience urges that he or she treat all patients, no matter what, but a convergence of health system factors such as rising medical liability premiums, stagnant reimbursement from commercial insurers, escalating overhead, and personal moral beliefs can make following one's conscience costly. The patient-physician relationship is different than the client-public defender relationship. The physician must obtain a tremendous amount of information about a patient's personal life and background in order to provide effective care. Trust and honesty lie at the core of the relationship. The public defender does not ask and in all probability does not care whether his client is guilty or not. Therefore, even though fiduciary relationships exist in both medicine and law, a public defender's personal values are of far less consequence to his or her client. Confidence and trust are critical in diagnosis and treatment. If the physician harbors resentment against the patient because of lifestyle or failure to comply with treatment, the patient-physician alliance is compromised and, thus, care is ultimately compromised.

The Model of Cure: Does it Promote Refusal?

Medical care in the United States focuses increasingly on successful treatment outcomes. That is what evidence-based practice is all about. Regrettably, when a physician perceives that positive outcomes may be jeopardized in certain patient groups or that these certain groups have medical problems that are too overwhelming, that physician may refuse care to members of the group. So, in essence, the medical model that lauds cure over care may be the same model that leads physicians to refuse to treat members of certain populations.

Justice dictates that physicians provide care to all who need it, and it is illegal for a physician to refuse services based on race, ethnicity, gender, religion, or sexual orientation. But sometimes patients request services that are antithetical to the physician's personal beliefs. Abortion is the most obvious example. In such instances, the complexities of balancing the physician's personal beliefs and internal value system make it almost impossible for him or her to accept every patient. How far should the physician's ethical and social responsibility extend? Does an ethic of care demand that a physician accept every patient? There are no clear answers to these questions.

Should Society's Investment in Medical Education Dictate a Duty to Treat?

The US system of health care is a product primarily of the free market. Most of those who seek care pay for it out-of-pocket or through some form of private benefit plan reimbursement. Medical students bear the major portion of the cost of their medical education. In the postgraduate years, hospitals recoup costs for residents' salaries from Medicare, but this, after all, is salary for services that residents deliver. The development of a medical education financing system that, subject to government oversight, would cover medical students' enormous debt might provide incentive for more physicians to repay society by treating all patients. Arguably, since it does not bear the medical student's financial burden, society should remain silent on the issue of whether physicians have the right to refuse patients.

In sum, a duty to treat beyond the emergency arena may only come with publicly financed medical education, through legislation, from the courts, or in ethics guidelines promulgated by individual medical societies. Such guidelines currently call upon physicians to commit to providing care and healing to all patients who seek it from them and underscore the duty to treat. But they do so only on professional, altruistic ccwgrounds and without legal force.

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