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## SOME PHILOSOPHICAL ISSUES OF THE RIGHTS OF PATIENTS

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### Quality Of General Practice Care

Recent studies concerning the quality of general practice care in the Netherlands showed that both technical and interpersonal quality are important for patients (Jung, 1999). The idea is quite simple: if you want to know what is good care, ask the patients. As regards technical aspects, the most important for patients are: the feeling that the GP is competent, that the GP has good professional knowledge, that the GP diagnoses and treats illness well. The interpersonal aspects of general practice, considered most important for patients, were: the GP guarantees confidentiality of information about patients, takes enough time to listen, talk and explain things, understands what the patients wants from him or her, and tells patients everything they want to know about their illness (Jung, 1999).

The assumption of these studies is that quality of care can be identified by asking the preferences of patients. By presenting their preferences, patients can make an indispensable contribution to defining the quality of general practice care and setting the standards by which to judge it.

In general, the aspects of care evaluated most positively by patients are primarily interpersonal. These aspects can be summarized under three headings: humaneness, informativeness, and competency. These studies also show that the views of patients and GPs in regard to quality of care do not differ substantially. Considerable similarity was found to occur between the preferences of patients and GPs. However, patients tend to give more emphasis on communication, while GPs emphasize

the organisational aspects of care. Nonetheless, for both parties, aspects of the doctor-patient relation are mostly perceived as important and evaluated positively, much more than other aspects of care, such as coordination, management, organisation, accessibility or efficiency. So, the doctor must be competent, of course, but above all he or she should address you as a person.

### **Emphasis On Rights**

In the 30 years history of modern bioethics, much attention has been focused on formulating, differentiating and implementing patient rights. The reasons for these efforts are known. In short, they relate to the criticism of medical power and the need to strengthen the position of patients within a context of paternalism (Ten Have, ter Meulen and van Leeuwen, 1998). At the same time, it has led to a situation where in many countries, the doctor-patient relationship is now strongly regulated within a legal framework. The moral concerns with the fragile position of patients have been translated into a juridical approach. Perhaps this development towards a juridification of medical interactions was unavoidable. But we should also be aware of the price that is paid: the focus now is on the doctor-patient relationship as a contract.

In our country, since 1995, we have a new law on the doctor-patient relationship, regulating the obligations and rights in the contract between doctors and patients. A range of issues is regulated: the right to information, the right not to know, the requirement to consent (oral or written consent; the special case of incompetent patients; the question of patient representatives), the duty to make a record, the period of record storage, the right to destroy the record, the right to consult the record, the duty of confidentiality, the protection of data, the right to privacy. There seems to be an ever growing list of rights and duties in modern health care that are in need of regulation.

The most important legal measure directing contemporary medical practice, is the attribution of an enforceable right of patients to refuse any medical interventions offered, or even stronger, a right not to have to undergo any medical treatment without first having been provided the opportunity to grant consent. A care provider is not only obligated to obtain consent and to respect any refusal, but also to provide all information that may be relevant to the patient in order to make such decisions.

### **Trust Vs Mistrust, Protection Vs Care**

The legal approach to patient rights usually proceeds from the idea of reciprocity of rights and duties of patients and physicians. The general view is that most rights of individuals and duties to individuals are correlative. Every assertion of patients' rights could be translated into statements concerning the obligations of health professionals to patients. For example, if the patient has a right to information concerning his or her condition, it is the duty of the health professionals to provide such information. Philosophers have argued that this focus on patients' rights assumes a parity between health professionals and patients that seldom exists. There is significant difference in knowledge between physicians and patients. Sometimes ill or depressed patients have little choice but to enter a physician-patient relationship. The language of rights is in this perspective necessary to provide protection and safeguards to patients in vulnerable circumstances. But rights language presupposes that there are conscientious and virtuous health care professionals who regard it their duty to care for patients even if the rights are not explicitly formulated and enacted yet.

The idea of patients rights is also closely connected with the notion of doctor-patient interaction as a contract. The notion of a contract has played a prominent role in discussions of the rights and duties of patients and health professionals. A contract is considered as a formal statement of mutually agreed-upon rights and duties.

When doctors and patients enter into a relationship they, at least implicitly accept a contract.

But the professional-patient relationship is more complex than any one-to-one contractual model might suggest. For example, for the sake of community's interest, obligations may be imposed on physicians that conflict with their obligations to their patients, e.g. in the mandatory reporting of communicable diseases.

However, there is also a more fundamental reason why the interpretation of the medical relation as a contract is one-sided.

### **A Care Relationship**

Physicians do not simply provide care because they are contracted to do so. They are engaged in a relationship because they care about the patient. In their professional activity they represent another human being who cares, who is willing to share in the patient's adversity, who goes about seeking an answer, who provides hope, who can be trusted. Patients need to be empowered in the face of medical power. But also the care providers need to be empowered in the face of suffering human beings. They have a right to guide patients. Prudent guidance is never a limitation of a patient's freedom, but opens up new horizons, new options, new possibilities. This is an essential element of care. In the profession of medicine, physicians continuously are trying to promote the patient's good, and therefore in their activities they attempt to balance beneficence and autonomy.

Considering the relationship between doctor and patients primarily as a care relation rather than a contract, also brings the focus on responsibilities rather than rights. Patients' rights are recently developed in legal and moral statements. Professional responsibilities have long been recognized in medical codes. In the context of a care relationship, the physician has the

responsibility to act in accordance with the patient's interests, while he or she is interpreting those interests. In order to have the best perspective on the patient's good, the views of the patient are indispensable. Interpretation of the patient's interests without input from the patient is a contradiction. But acting on the basis of a common interpretation of the patient's good is different from acting in response to the rights-claims advanced by the patient.

### **The Patients' Charter Of The Malta College Of Family Doctors**

At first reading, the Patients' Charter of the Malta College of Family Doctors, provokes the question concerning the status of the document. It has the external characteristics of a quasi-legal statement. But as all self-legislative documents developed by the medical profession, this charter has only the force that the profession chooses to attribute to it. The document therefore is more a promise or pledge than a legal statement.

Secondly, the focus of the document is not on patient rights as well as on professional responsibilities. Of course, I do not know precisely the genesis of the charter, but as I read it, it seems to me to present the ideal self-perception of Maltese family doctors. Nothing is wrong with that. This is how doctors prefer to be viewed within a community. However, it would be overestimating to assume that in this charter doctors would also formulate the rights of patients. They identify the obligations they voluntarily adopt because they regard themselves as members of a profession.

Third, the document also raises the question concerning the relation to general ethical principles. Usually professional statements present themselves as applications of ethical principles. Very often the principles are not very clear. Quite often the statements present rules of conduct, sometimes moral rules, that implicitly appeal to general ethical principles. Interpreting the charter primarily as a statement of professional responsibilities, present a stronger commitment as simply referring to patient rights.

Every right that is postulated and endorsed, needs virtuous and conscientious physicians in order to be enforced in daily practice. This commitment to apply the rights is actually proclaimed in the charter under discussion.

*References:*

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