On Choosing One's Patients

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The Principles of Medical Ethics, Section 6 states:

> *"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 services."*

Private practitioners often turn down referrals for practical reasons such as no room in their schedules, lack of expertise in the disorder in question or the need to limit the number of low pay patients that can be assimilated into their practices. Other reasons for turning down a patient have to do with conflicts of interest such as social or professional ties or having treated a close relative of the referred patient. In addition, high maintenance patients may call for more than a solo practitioner can deliver and interfere with care of existing patients.

An entirely new rationale for turning down patients was raised at the American Medical Association (AMA) meeting last June. A South Carolina surgeon, Dr. Hawk, proposed a resolution requesting that the AMA tell its members that it was not unethical to refuse to care for plaintiffs' attorneys and their families other than in emergency situations. Dr. Hawk's intent in introducing the resolution was to call attention to rising medical malpractice costs and, as he put it, "a broken system." He pointed to the growing number of physicians leaving his state because of high liability premiums. In Mississippi, Dr. Kanosky, a plastic surgeon, referred the daughter of a state legislator who opposed caps on lawsuits against doctors to a colleague rather than treat her. He opined that to perform surgery on her would have posed a conflict of interest in as much as he had lobbied on the other side of the issue.

"Physicians cannot refuse to care for patients based on race, gender, sexual orientation, or any other criteria that would constitute invidious discrimination... They also have an obligation to share in providing charity care but not to the degree that would seriously compromise the care provided to existing patients." *(AMA Code of Medical Ethics)*

While many would object to Dr. Hawk's proposal, it does raise the question as to what extent we may discriminate on ideological grounds regarding whom we chose to treat. Are prejudices regarding political and religious views and race or sexual identity legitimate grounds for turning down a potential patient? Treating someone with views we fear might actually be a good way to understand what lies beneath the surface and to develop tolerance for divergent points of view. In my own career, I never imagined I'd be evaluating or treating persons who committed homicide. Yet, through my work in prisons and forensics, I have learned to be less judgmental, to see the human side of persons who have committed heinous crimes and to learn more about the cycle of shame and violence in their lives. However, if one chooses to treat the Tony Sopranos of the world, one should be very aware of counter-transference issues, as well as possible voyeurism regarding forays into worlds unknown to most of us.

There are cases where strong countertransference might preclude taking a case for psychotherapy or evaluation. If one is in the midst of one's own custody battle, it might be difficult to objectively assess the best interests of a child in a custody case. If a psychiatrist has recently experienced a traumatic loss or not yet worked through prior traumas it might be difficult to work with someone with Post-Traumatic Stress Disorder. These reasons for turning down a referral focus on what is in the prospective patient's interest in the long run, as the psychiatrist's unresolved issues may interfere with objectivity and rendering optimal evaluations or care. Of note, the patient's interests remain primary and the physician's interests are secondary. In contrast, Dr. Hawk's proposal had to do more with using patients as pawns in a political statement. The question begs that we also weigh short versus long term gains in such a strategy and consider the interim harm that might come to rejected patients, particularly in states where physicians are in short supply.

It is difficult to believe that Dr. Kanosky's feelings towards the uncle of the woman referred to him would affect his ability to perform plastic surgery on her. On the other hand, countertransference is probably not in the vocabulary of most surgeons and may not get explored. If we were to screen all patients for their political, moral and religious views before accepting them into our practice it could make for a very long screening process. The conflict of interest Dr. Kanosky cited for turning her down appears spurious.

Dr. Hawk's resolution was denounced by "passionate speeches" from physicians attending the annual meeting of the AMA and he chose to withdraw his resolution. In earlier opinions, the AMA has cited three grounds on which it is ethically permissible to decline a potential patient. These include: a) a request for treatment which is beyond the competence of the physician (Opinion 9.12), b) a treatment request which lacks scientific validity or has no possible benefit to the patient (Opinion 8.20), and c) "a specific treatment sought by an individual is incompatible with the physician's personal, religious, or moral beliefs (AMA, p. 289)." The AMA states, "Physicians cannot refuse to care for patients based on race, gender, sexual orientation, or any other criteria that would constitute invidious discrimination (Opinion 8.11)." It further opines, "They also have an obligation to share in providing charity care (Opinion 9.065) but not to the degree that would seriously compromise the care provided to existing patients." ■

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References

AMA: Council on Ethical and Judicial Affairs: Code of Medical Ethics. Current Opinions with Annotations. Chicago: AMA Press, 2002–2003.

Doctors Denounce Idea to Allow Denial of Care to Some Lawyers. The New York Times, A 14, June 14, 2004.