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Autonomy and Coercion: Moral Values in Medical Practice

Richard A. McCormick, S.J.

In his article, Fr. McCormick underscores the dangers of isolating a "right" from the environment in which it is exercised and from other, possibly superseding, "rights." He then goes on to a discussion of the physician's right to autonomy in its full context.

The prospect of some form of National Health Insurance Plan (NHIP) raises any number of issues with moral implications. One is the matter of coercion on the medical profession. Many physicians fear that a NHIP may be a form of economic coercion forcing the physician to come under its aegis in a

way that violates his right to dispose freely of his services. He may also be unable to collect remuneration commensurate with his training. Coercion, then, suggests a possible double loss of autonomy: in the disposal of services and in remuneration.

This brief essay will not discuss whether a NHIP is necessary, nor whether it would involve some measure of coercion. Important as these questions are, they are far too broad and complicated to be discussed in a brief space. Rather, I will discuss professional and economic coercion on the physician within an hypo-

thesis: if NHIP is called for, and if it brings some coercion, is loss of full autonomy of the physician sufficient reason in itself to say that a NHIP is unwarranted? Or, in other terms, where on the ladder of human and moral values does professional medical autonomy rate? Professional autonomy (as described) is certainly a value. The question is: how important a value? Coercion is certainly a disvalue. The question is: how important a disvalue?

Some medical opinion on the value of autonomy ranks it so high that it calls it a *right*. Thus Dr. Paul W. Leithart referred to a doctor's "right to choose whom he would serve." (*Linacre Quarterly*, May, 1970) The reasons behind this high evaluation are familiar. Loss of full autonomy tends to introduce a third party into the doctor-patient relationship with all the dangers associated with such an intrusion. Secondly, there is the time-consuming multiplication of paper work. Thirdly, autonomy promotes specialization with the consequent advance of medicine (because specialists can charge commensurately for their services). Fourthly, government involvement could lead to growing apathy on the part of health providers, and to eventual carelessness and routine in medical practice. And so on. Considerations such as these have led many physicians to regard their full economic and professional autonomy as a strict right. And if it is a right, then obviously any system which infringes on it is no longer a legitimate option.

But should we speak of the physician's ability to dispose freely of his services as a right? Especially, should we view this as an *absolute* right? Here a caution seems to be in order. Any conversation about rights takes place in a definite culture, a culture with particular qualities and characteristic perspectives, and these perspectives influence the direction of the conversation. American culture is stamped with the following characteristics: the market economy; a strong tradition of private enterprise; a strong tradition of individual freedom (especially in the face of governmental bureaucracy and collectivistic tendencies); a near idolatry of affluence as the symbol of success; a highly sophisticated technology which leads Americans to canonize and reward special technical expertise. These factors combine to constitute a climate or value-structure within which we delineate rights and interpret their meaning. It can be persuasively argued, I believe, that this climate favors an individualistic reading of rights—both as to their existence and their meaning. By "individualistic" I mean a reading which views the right apart from the value which generates it and which it serves.

A Right As Moral Claim

In the present context, it can be said that a right is a moral claim one has on others in view of a certain goal. It is this goal or value which generates the right and controls its interpretation and application. For instance, in an industrial society, the

need for just wages and decent working conditions generate the right of workers to organize in pursuit of these values. At the point where organization would no longer serve these ends, it would be senseless to speak of the "right to organize." Similarly, since good medical practice often demands disclosure of confidential information, the doctor-patient relationship is surrounded by the protections of professional secrecy. The patient has the right to have certain of his self-disclosures remain confidential. But this right exists precisely because sound medical care demands it. It is this good or value which generates the right. If confidentiality (almost *per impossibile*) were no longer necessary for good medical care, it would be senseless to speak of it as a right.

Now what are we to say of the "right of a physician to dispose freely of his services" and his "right to determine his fee?" If we are to speak of these as rights—and if properly nuanced, it seems that we should—it is precisely because they are demanded by good medical care, its availability and quality. To say anything else would be to ascribe a right to a service-oriented profession which had nothing to do with the services rendered.

As soon, however, as one speaks of "good medical care, its availability and quality," one encounters a serious problem. For a judgment about the *adequacy* of medical care

depends heavily on whether one views such care as a right or a privilege. If it is a privilege, then the fact that millions are without it might not affect one's judgment of the adequacy of a given health care system. If it is a right, a quite different assessment might be made. Professor Louis F. Buckley (*Linacre Quarterly*, May, 1970) has argued very persuasively that there is a right to health care. I believe that this conclusion, when it is properly understood, is absolutely correct. However, since its entry into contemporary consciousness is quite recent, it is a conclusion not likely to be endorsed by all physicians and therefore one likely to split the medical profession right down the middle. Nonetheless, one's position on the right to health care is determinative of his position on the scope of physicians' rights.

The 'Delivery System' and the Right to Health

If all individuals have a right to health care, (as an outgrowth of their right to life and health), then obviously the duty to provide this care falls heavily on those who have the competence: physicians and para-medical personnel. This does *not* mean—as Dr. Leithart argued—that any individual has a claim on a specific doctor's services. It does mean that the profession as a whole, since it is service-oriented *in support of a fundamental right*, must organize its delivery system in such a way that it brings the exercise of this right within the reach of as many as is

humanly possible. The prerogatives of the medical profession (its rights) cannot be viewed as privileges grounded in the convenience of the physician; they are rooted in the good of the patient(s). If an open, fee-for-service delivery system without any governmental partnership does not provide for this good adequately, and if a health care system involving federal partnership would do so, then it is not clear that the moral rights of the physician are infringed, even if his autonomy is somewhat reduced.

These brief reflections are both abstract and very possibly misleading. By saying that they are abstract I mean that they provide only the most general framework within which to think about autonomy and the physician's rights. This framework yields the conclusion that full autonomy, even though a very important value, is a subordinate one. It is subordinate to the delivery of adequate health care to those who have a right to expect such care. This conclusion is not very sensational, but at least it frees us from the rhetorical absolutisms so often encountered in discussions of national health insurance plans. These discussions often overlook the fact that physicians have already sacrificed some autonomy in the many insurance plans now available, and in the growing phenomenon of group practice. The reflections presented here are abstract also in the sense that it is not factually clear how much autonomy would be sacrificed in a NHIP.

More importantly, these general reflections could very easily be misleading. They tend to suggest two desperate and competing alternatives as the only live options in facing the health care problem of the nation: an open, fee-for-service, voluntary delivery system vs. a federal delivery system. Actually, since government partnership and voluntary, private provision of health care both represent genuine values in contemporary American society, we should strive to maintain the advantages of both, in thought as well as in action. Sister Mary Maurita, RSM, executive director of the Catholic Hospital Association, put this very well in her testimony before the House Ways and Means Committee: "Systems and programs which restrict a person's right to choice, and which stifle the initiative of providers of health services to seek out and help these people, will, in the long run, lead to total reliance on a federal system which could be inflexible, unimaginative and insensitive to needs, and these could hinder the common good. Great care must be taken to strike the proper balance between those matters in which government has a role and those which are developed privately."

Relationship and Balance

On the basis of this complementary relationship and balance, Sister Maurita concluded: "We urge the continuing viability of our voluntary or private sector of health providers in a balanced partnership with government as we restructure a com-

prehensive health delivery system for the future. This viability and balance requires involvement of the private sector with government in setting standards for quality services, as well as reasonable controls and regulations." (*Hospital Progress*, Dec. 1971)

This is the approach to bring to a discussion of government partnership in health care. Any other attitude, besides being unrealistic, would either underestimate or overestimate the physician's autonomy. By underestimating autonomy we could get trapped in a stifling collectivism which would eventually undermine the provision of sound health care. But by overestimating it, the medical profession could be its own worst enemy by failing to face the nation's health problems in a creative, service-minded way. Such failure would all but constitute a mandate to the government to intervene in bungling and inefficient ways, since the intervention would not enjoy the cooperation and consultation of the medical profession. If a NHIP is to support the rights of all—physician as well as patient—the medical profession must be a partner in the planning. And if it is wise, it will bring to this planning an attitude toward its rights which interprets them within a service-minded structure. This means that while the autonomy in question is a genuine value, it may not be approached as an independent and absolute value.

Editorial Comment:

Father McCormick here raises a new and important distinction, viz, the distinction between the autonomy of the individual physician and the autonomy of the profession as a whole in relation to the provision of health care service especially of those who through no fault of their own are incapable of providing this service for themselves.

Given an established fact that there exist two distinctive rights (the individual physician's right to dispose autonomously of his service and the patient's right to health care) then it further seems to me that Father McCormick has demonstrated again great balance by grasping the apparent dilemma by both horns and going through the middle. Both values (rights) are to be preserved wherein possible but where this is not possible then the right to life (health care) of the patient is a more fundamental and urgent right than the right of the profession as a whole to its autonomy. Therefore, the profession as a whole should and must surrender through its members a part of its autonomy in order to guarantee the more fundamental right of the patient. It is granted that the profession can surrender autonomy only through the person of the individual physician. It must therefore be held as equally fundamental that never is it allowed that this personal loss of autonomy can become total or absolute or in any way dehumanizing for the individual physician.

I trust that Father McCormick's thought will stimulate a lively commentary from our readers. (VHP)