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The Distressed Patient Seeking Self-Harm: Autonomy versus Beneficence

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Introduction

The moral endpoints of beneficence, non-maleficence, and autonomy are well established among the action-based theories of normative ethics (Bober-Moken, Apr 16, 2007). In practice, however, these values often compete for priority. When two values cannot be maximized simultaneously, clinicians face the challenging task of assigning priority to one value over another (Ozar & Sokol, 2002, p. 67). On a third-year oral surgery rotation a few months ago, I confronted just such a task, one that challenged me to critically think about the way I assign priority to competing, but important values.

Case Description

Mr. Bentley (names changed throughout), a 26 year-old white male, presented to the State Hospital Oral and Maxillofacial Surgery Department on Mar 31, 2008. Citing spontaneous, throbbing, 10/10 pain associated with tooth #14 as his chief dental concern, Mr. Bentley related that he had originally visited his family dentist with the same concern about two weeks ago. Mr. Bentley's dentist had performed an appropriate work-up, and, upon finding no overt pathology to account for Mr. Bentley's symptoms, recommended that his patient be referred to an endodontist for further evaluation. But Mr. Bentley, unable to afford an endodontic examination and anxious to resolve his symptoms immediately, asked his dentist instead to extract the tooth right then or else refer him to an oral surgeon for immediate treatment. Even though Mr. Bentley's dentist hesitated to refer him for surgery in the absence of a diagnosis, he did so anyway on the insistence of his patient.

By the time Mr. Bentley presented to attending faculty Dr. Sunner and me at State Hospital two weeks later, his pain had only grown more constant, preventing him from working or even functioning at home. He entered the clinic practically begging us to extract his tooth. I performed an examination only to find, as did the general dentist before me, no obvious lesion to suggest a mode of infection or other etiology accounting for Mr. Bentley's symptoms. I presented my findings to Dr. Sunner, who agreed with

my assessment, and we explained to Mr. Bentley that despite the pain he felt in his tooth, the source of pain had no apparent dental origin, and therefore extraction was neither recommended nor indicated. Rather, our differential diagnosis would include maxillary sinusitis as well as cystic and neoplastic disease. Dr. Sunner and I recommended an antibiotic regimen to rule out sinusitis and asked Mr. Bentley to return in three days for follow-up care. If symptoms had not resolved by then, we would refer to a radiologist for further diagnostic imaging of the quadrant.

Mr. Bentley was stunned. He had come to the clinic expecting the extraction to be performed that day. After all, his general dentist had referred him for the surgery, and it was something he had requested and consented to. He felt, furthermore, that he was the one who understood the problem the most, since it was his tooth and he could *feel* it, and so felt that he should be the one to decide what to do about it. He couldn't understand how an oral surgeon, who had the technical competence to perform the surgery he wanted, would still refuse to do it, even when he—Mr. Bentley—was the one requesting it. Mr. Bentley acknowledged the risk that extracting tooth #14 might not resolve his symptoms, and further acknowledged the inferiority of replacing the newly edentulous space with a prosthesis versus maintaining a natural, healthy tooth. To him, it was worth the risk. The pain was too urgent. It was his body, he thought—why, then, was it not his decision to make over ours?

The primary ethical issue at hand here is whether or not the autonomy of a patient supersedes that of his or her providers. Mr. Bentley's position, in ethical terms, was that his autonomy should ultimately prioritize over the surgeon's. The surgeon, on the other hand, would contend that his autonomy to practice how he chooses and his commitment to do no harm to his patients should receive equal, if not greater, value. On reflection, I realized that what in the classroom would have seemed like a simple, open-and-shut case—that is, you never treat without a diagnosis—became much less clear to me upon actually facing a desperate patient begging me to perform a treatment, diagnosis or not. How could I refuse to perform a surgery I was certainly competent to do when I had a consenting patient in my chair, urging me to do it?

After a short discussion in the hallway, Dr. Sunner and I held to our treatment decision. We sent Mr. Bentley home with a sinusitis regimen and analgesic, explaining to him that it was in his own best,

long-term interest, despite his immediate pain, to seek the underlying cause of his symptoms and receive a corresponding, appropriate treatment. My rotation at State Hospital ended before I had the chance to follow-up with Mr. Bentley to see how our decision had affected him.

Case Analysis

Dr. Sunner and I faced several alternatives in handling the ethical problem that Mr. Bentley's case presented to us. They are detailed below, with pros and cons of each enumerated:

1) Dr. Sunner and I could have delayed treatment until a definitive diagnosis could be made, offering palliative care in the interim. By sending the patient home with a sinusitis regimen and analgesic, this is, as described above, what we decided to do.

   Pros: Beneficence maximized (patient treated)
   Non-maleficence maximized (tooth not treated unnecessarily)
   Provider autonomy maximized

   Cons: Patient autonomy compromised

2) Dr. Sunner and I could have extracted the tooth, honoring the patient's request to be treated immediately.

   Pros: Patient autonomy maximized

   Cons: Beneficence compromised (patient not treated)
   Non-maleficence compromised (tooth treated unnecessarily)
   Provider autonomy compromised

3) Dr. Sunner and I could have referred the patient to another oral surgeon who might have been more willing to perform the extraction in the absence of a diagnosis.

   Pros: Achieves autonomy of both patient and provider

   Cons: Beneficence compromised (patient not treated immediately)
   Non-maleficence compromised (tooth treated unnecessarily)

4) Dr. Sunner and I could have referred the patient to an endodontist for non-surgical root canal therapy, urging the patient to find the money for the procedure so that he could save the tooth while still treating it.

   Pros: Patient autonomy accommodated (tooth is treated)
   Less maleficence done to patient (tooth treated unnecessarily but not lost)

Provider autonomy accommodated (provider not forced to harm patient as much)

Cons: Beneficence compromised (patient still not treated immediately)
Non-maleficence compromised (tooth still treated unnecessarily)
Patient and provider autonomy compromised (neither acting in full autonomy)

5) Dr. Sunner and I could have refused treatment by referring the patient back to his general dentist.

Pros: Non-maleficence maximized (tooth not treated unnecessarily)
Provider autonomy maximized

Cons: Beneficence compromised (patient not treated)
Patient autonomy compromised

Ultimately, Dr. Sunner and I selected alternative one as the best alternative because it was the only one that provided beneficence to the patient. It was also the only one that allowed us, as providers, to ultimately resolve Mr. Bentley's symptoms, which was in his own, long-term best interest, even if he *wanted* something else right now. Admittedly, alternative one favors beneficence, or good for the patient, over patient autonomy, in this case being employed toward self-harm. So, by choosing alternative one, Dr. Sunner and I admittedly were robbing our patient of self-determination in an effort to produce a greater good. Our actions were thus paternal in nature, assuming an authority role over another independently autonomous individual (Ozar & Sokol, 2002, p. 55). We were making the decision about what Mr. Bentley wanted, *for* Mr. Bentley.

In ethics theory, this is the classic example of the "harm principle," an important exception to the rule, proposed by so many of the shapers of Western philosophy, that respect for autonomy must be upheld above all other moral ends (Ozar & Sokol, 2002, p. 55). Immanuel Kant, the influential German philosopher of the 18th century, was a leader in autonomy-first philosophical thought. He articulated the absolute idea this way: "No right is held more sacred. . . than the right of every individual to the possession and control of his own person, free from all restraint or interference. . ." (Bober-Moken, Apr 23, 2007) With the phrase, "no right is held more sacred," Kant argued that under no circumstances could another end be granted more value than individual autonomy.

But philosophers like Kant had to acknowledge that occasions arise in which the autonomy of two parties directly clash, wherein the autonomy of one party threatens to harm a second party against its own autonomy (Ozar & Sokol, 2002, p. 54). By defending itself against the aggressor party, the victim party would be likewise violating the autonomy of the aggressor party, thereby breaking Kant's rule, asserting that an end more valuable than autonomy *does* exist, in such a case. Kant and others explain this exception by pointing out that the aggressor party, in threatening to harm the victim party, is violating the autonomy of the victim party and thus setting up an internal contradiction, since the aggressor party itself apparently values its own autonomy but not the autonomy of an independent party (Ozar & Sokol, 2002, p. 55). This contradiction makes the actions of the aggressor party irrational, and therefore the aggressor party is not acting autonomously at all, the very definition of which makes rational decision-making a prerequisite. Thus, by interfering with the aggressor party's actions, the victim party is not, after all, violating the aggressor party's autonomy. And so, Kant and others argue, autonomy is still upheld above all other moral ends.

The situation becomes more difficult, however, when one party threatens to harm itself, as in the present case. In such a case, a second, interventional party cannot rationalize interfering with the aggressor party on grounds that the aggressor party is acting irrationally, because the aggressor party is not threatening to irrationally violate any other party's autonomy (Ozar & Sokol, 2002, p. 55). But could the pain experience—or other strong emotional experience—threaten to compromise one's rationality, thereby justifying an interventional party's interference with that individual's autonomy? In other words, could pain itself be acting as an "external" agent, holding the self-harm seeking party hostage and preventing the party from fully rational, autonomous decision-making? Or, could it be that even if the self-harming party is argued to be acting in full, rational autonomy, that in some cases an interventional party *may* justify prioritizing beneficence—to the end of preventing the intended self-harm—over Kant's ever-sacred value of autonomy?

Some argue yes, and arguments like these, which *do* place a value—in this case, beneficence—over autonomy, offer a distinctly more utilitarian flavor than the autonomy-first arguments of the Kantian philosophers. If the greater good were served by interfering with a party's autonomy, the utilitarian

argument would contend, then the interference is justifiable, or the end justifies the means (Ozar & Sokol, 2002, p. 54). The "harm principle," then, is a decidedly utilitarian concept that describes those important exceptions to the autonomy-first rule, cases in which beneficence or non-maleficence reasonably trump the otherwise sacred moral end of autonomy.

In not treating Mr. Bentley, Dr. Sunner and I were using the "harm principle" to rationalize a beneficent aim over respect for Mr. Bentley's autonomy when the two could not both be maximized simultaneously. A Kantian purist would have argued that nothing could rationalize our interference with Mr. Bentley's will to have the tooth extracted (Ozar & Sokol, 2002, p. 55). We would have been obligated to perform the surgery. But we favored a more utilitarian approach, denying the principle of self-determination in an effort to achieve a greater good, in this case seeking a definitive diagnosis that would allow us to treat the underlying cause and ultimately relieve Mr. Bentley's symptoms.

Dental ethics authors David Ozar and David Sokol take just such an approach when they argue that among the first three "central values" of dental practice—that is, "1) the patient's life and general health," "2) the patient's oral health," and "3) the patient's autonomy"—the first two take priority over the latter (Ozar & Sokol, 2002, p. 73). They write:

> If a patient asked a dentist to perform a procedure that, in the dentist's professional judgment, would significantly harm the patient's oral health or harm the patient's life or general health, and if the dentist acted on the patient's request out of respect for the patient's autonomy and did the procedure, the dentist would be acting unprofessionally. . . . It seems obvious, then, that the patient's autonomy ranks lower in the hierarchy of central values than both the oral health of the patient and the patient's life and general health (Ozar & Sokol, 2002, p. 74).

The American Dental Association Principles of Ethics and Code of Professional Conduct articulates a similar priority. Under "Section 1 — Principle: Patient Autonomy," the widely accepted document affirms,

> The dentist has a duty to respect the patient's [right] to self-determination. . . This principle expresses the concept that professionals have a duty to treat the patient according to the patient's desires, *within the bounds of accepted treatment*. . . (American Dental Association, 2005, p. 3, emphasis added).

That last phrase is the critical one. It connotes that professionals cannot ethically stray outside the bounds of accepted treatment, even if their patients desire it. Thus, accepted treatment—"accepted" because it treats, or is beneficent—cannot be compromised in favor of a patient's autonomy.

This very issue of patient versus provider autonomy took center stage as a hot-button political issue during the most recent election cycle in Washington state. Up for voter enactment was The Washington Death with Dignity Act, an initiative that proposed allowing physicians to prescribe lethal, self-administered medications to terminally-ill, competent patients whose illness was reasonably judged by a licensed physician to produce death within six months (Initiative, 2008, p. 3). With 57.8% voter approval, the people enacted the initiative into law on Nov 4, 2008 (Secretary of State, 2008). In granting this expanded autonomy for terminally-ill patients, initiative authors were careful to include a provision exempting unwilling physicians from any form of forced participation. In doing so, the act worked to honor the autonomy of physicians who felt that prescribing such medications violated their Hippocratic oath of "primum, non nocere" ("first, do no harm"), or ethical principle of non-maleficence.

The act specifies that "Only *willing* health care providers shall participate in the provision to a qualified patient of medication to end his or her life in a humane and dignified manner" (Initiative, 2008, p. 10, emphasis added). Also, that

> A professional organization or association, or health care provider, may not subject a person to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for. . . refusing to participate in good faith compliance with this chapter. . . (Initiative, 2008, p. 10)

And further,

> A health care provider may prohibit another health care provider from participating under this act on the premises of the prohibiting provider if the prohibiting provider has given notice to all health care providers with privileges to practice on the premises and to the general public of the prohibiting provider's policy regarding participating under this act. (Initiative, 2008, p. 10)

Thus, not only are unwilling physicians exempt from participating, but they are protected from any form of coercion to participate from employers or professional organizations. They are further afforded the

latitude to prohibit other, willing physicians working under them from participating in the practice at the facilities over which they preside.

Another provision of the act establishes yet another layer of participant autonomy, this time on the patient's side. The act provides that patients requesting the lethal medication must be deemed "competent", that is, considered by the court or by the patient's physician to have "the ability to make and communicate an informed decision to health care providers" (Initiative, 2008, p. 1) The provision continues,

> If, in the opinion of the attending physician or the consulting physician, a patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment, either physician shall refer the patient for counseling. Medication to end a patient's life in a humane and dignified manner shall not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment (Initiative, 2008, p. 5).

Thus, this section mandates that terminally-ill patients be free from any condition that would impair their rational decision-making, thereby precluding their full autonomy, before they may choose to participate. Provider and patient alike, then, must be acting in full autonomy for lawful participation in the practice. Without such provisions for provider and patient autonomy, The Washington Death with Dignity Act may very well have had a much more difficult time attaining the approval of Washington state voters. This example within contemporary politics demonstrates the continued relevance of an ongoing dialogue between patients and providers regarding how we, as providers, should assign priority to the competing values of autonomy, beneficence, and non-maleficence in our daily practice and in our daily effort to achieve the greater good through the care we provide.

Conclusion

In light of these arguments, a strong case can be made for what Dr. Sunner and I ultimately chose to do in treating Mr. Bentley. The greater good was served, and Mr. Bentley likely found a more appropriate treatment than the one on which he originally insisted, under distress. This case highlights an important exception to honoring patient autonomy, regularly regarded as one of the highest moral ends in

medical and dental ethics. It further highlights the careful, reasoned decision-making we must demonstrate as dental providers who, ultimately, wish to do the best for our patients and our profession.

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