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Patient's Autonomy: The Right to Choose Who Patients Consult in a Public Teaching Hospital

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Abstract
Medical teaching is based on the apprentice model; students learn from their teachers by acquiring the necessary knowledge, attitude and skills that prepare them to become doctors. In this process, students assess patients and present their findings to their teachers. Patients exercising their autonomy can object to being assessed by students. Their refusal can, on the other hand, create challenges for medical teachers and students. Practising medicine whilst experiencing emotional reactions can pose challenges in adhering to the principles of beneficence and non-maleficence. These issues are explored in the context of a real incident in which a patient refused to be examined by a medical student. From these experiences, I aim to provide some clinical context, explore assumptions of parties involved and discuss future ways to handle these complex issues. These are likely to relate to medical students globally, who may experience similar situations. Pinning this argument against the pillars of medical ethics allows objective and rational exploration of such underlying ethical challenges.

Key Words
Medical Students; Medical Education; Autonomy; Beneficence and Non-maleficence.

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Introduction

I am a fifth-year medical student. Recently I was allowed to see patients on my own, on my general surgical run. I was taught to first explain my role as a medical student to the patients and ask whether they would be happy to see me before the consultant came in. I would take a history, perform an examination and provide some brief advice. Then, I would explain my findings and management plan to my consultant. He would see the patient, modifying my plan when appropriate. One particular day, I was asked to see an elderly patient presenting with problematic PR bleeding. The patient, however, said he preferred not to *"see a student, as I am here for an actual problem and want to see someone who can actually help me."*

I explained the situation to the consultant. He appeared indignant at the patient's response, telling me *"this is a teaching hospital, you are a student and you will only become a doctor if you are able to practice what doctors do."* If the patient wanted *"to dictate his own healthcare, then he should visit a private hospital."* The consultant said, "*let the patient wait in the room for 30-40 minutes, let's go see the others before him."* This *"served him right" for "disrespecting the traditions of medical education."*

Discussion

My consultant's response pleased me initially. I felt happy to know I had the top man on my side. On further reflection, however, this interaction provided ethical challenges. The patients' rights to appropriate healthcare and their autonomy in decision-making challenged traditions of medical education based on the apprenticeship model of learning. I reflected on the four pillars of medical ethics (autonomy, non-maleficence, beneficence, and justice) and tried to examine how they applied to this encounter. There was a direct conflict between what the patient desired and the mindset of the consultant. I felt the consultant doctor, acting on his beliefs, chose to delay his consultation with the patient- almost punishing the patient for his behaviour. In my view, the patient received delayed, arguably poorer, healthcare than what he would have expected.

I wanted to first examine the patient's point of view. His presentation with PR bleeding was potentially sensitive and worrying. Health concerns may provoke feelings of uncertainty and discomfort amongst the general population. Doctors, being experts in this field, are entrusted with the sacred responsibility of managing individuals' health and

alleviating such fears. They use a range of communicative behaviours that during consultation including instrumental (cure oriented) vs affective (care oriented) behaviour, verbal vs non-verbal behaviour, privacy behaviour, high vs low controlling behaviour, and medical vs everyday language vocabularies. Not paying attention to the most appropriate communication behaviour specific to a situation may have far reaching consequences including poor patient satisfaction, inadequate treatment adherence and difficulties with recall and understanding of information. In the context of my patient, who clearly wished to see a senior doctor to address his concerns acknowledging his concern could have enabled him to experience care orientated intervention and not just cure. In his eyes, only a doctor, not a mere medical student, was capable of providing this service. Putting myself in his shoes, I could see his choice was understandable.

Furthermore, the Code of Health and Disability Service Consumers' Rights (HDC) offers protection of rights to the users of health or disability service in New Zealand (Code of Health and Disability Service Consumers' Rights, 2020). Section 4(1) of the code states, "Every consumer has the right to have services provided with reasonable care and skill" and 4(3) "Every consumer has the right to have services provided in a manner consistent with his or her needs." I realised the patient had the right to be autonomous in his decision making about who he wanted to see. By exercising his autonomy, the patient had decided that only a doctor, and not a student, was able to provide reasonable care. It is difficult to argue against this logic, given how explicitly it aligns with the Rights that patients are clearly entitled to.

Despite *understanding* these actions and even agreeing with them, I still felt slightly bitter towards the patient. It felt as if he had undermined my ability. I felt devalued. I found myself agreeing with my consultant's position that the patient was willing to 'take' from the public healthcare system, without 'giving back' by disallowing me the chance to learn and practice my practical skills. These thoughts were then followed by doubts like, "Am I allowed to even think like that?" "Are there written guidelines, as there was for the patient and the HDC, that medical students *are meant* to see patients?"

Some of these questions were answered by reflecting on the advice I had received from my consultant. My consultant clearly appreciated the significance of clinical exposure and that of developing a personal skillset for medical students. I learned there is a strong tradition of learning and teaching in Medicine, tracing back to Hippocratic times. This system ensures medical students acquire the knowledge, attitude and skills required to practice medicine safely and independently. If they were unable to learn by practicing, they will not be able to treat patients one day. He was also sensitive to the functioning of a healthcare system- realising our limited experience level. Instead of letting us run rampant with decision-making, he made an effort to oversee management plans and ensure the patient received appropriate care, ultimately from a consultant's level of experience. As a result, I felt, his model of teaching satisfied both student-learning *and* patientcare.

I am acutely aware my consultant was not unique in his stance. This culture of bedside teaching and learning is widespread across the globe and indeed is reported to be preferred by most patients (Ghimire, et al., 2019). Simply put, this is how we learn! The patient, when refusing to see a student and wishing only for a senior doctor, challenged both the consultant's beliefs *and* the structure of the hospital system. The doctor, perhaps, perceived the patient to be ungrateful and insensitive to traditions in clinical environments. This aggravation could possibly explain the consultant's decision to delay the consultation in an attempt 'to teach the patient a lesson.' I can understand the indignant reaction, again on a psychological level. I myself felt annoyed and liked the fact that the doctor was somehow 'stepping up for me.'

Since then I have also learned the significance of not acting while feeling angry. Arguably, the consultant did the right thing by not attending to the patient while he was upset. We have a responsibility to care for our patients. Being free from emotional influences ensures that we make objective decisions and act on principles of beneficence and non-maleficence. I would argue that by delaying the consultation, my consultant made a rational decision which avoided compromise of these core pillars of medical ethics.

The misuse of responsibility and power always exists in any doctor-patient interaction. In this instance the patient placed his trust and confidence in the consultant, who in my initial opinion, used this power to 'punish' the same very patient. This misuse of power amongst vulnerable individuals contradicted core beliefs that I have surrounding our role as doctors. If a doctor is to treat a patient while harbouring negative feelings against them, they are at higher risk of breaching the duty of "*Primum non nocere*" or *"first, do no harm"* (Lloyd, 1983). Active acknowledgement of the dually occurring tensions between the experience of negative emotions and the requirement for rationality is

perhaps crucial in ensuring we deliver objective, appropriate care. These values were the same very ones that attracted us to a career in medicine in the first place (Robinson, 1985).

Conclusion

These events prompted me to think about how I would handle this particular situation and other similar ones, should I encounter them in the future. When I become a consultant, I will need to take time to understand my patient's background and their reasons behind their decisions or actions. Understanding the patient's autonomy to decision-making is crucial. I must also realise that I am not impervious to emotional fluctuations. I will need to learn to act in a manner which sits true to what I believe in. This was a strength that I saw from the consultant; he was able to stick to his core beliefs about the apprentice model of medical teaching and the spirit of the public health system.

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