ARTICLE PRESENTATION EXAMPLE:
PHI 213: MEDICAL AND BIO-ETHICS
DR. DAVE YOUNT

1. **BEARINGS**: (1-3 minutes, depending on what information you can find about your author(s) online) Give the Title, Author, and page number of the article you’re presenting. Also, make sure you give the year that the article was written. Then, pass around a picture of the author(s) if available, and give us an idea if the author is a doctor, a philosopher, where they practice or teach, books they’ve written, etc.

   “Why Doctors Should Intervene,” Terrence F. Ackerman (pp. 127-131) (1982). (Other information will be given in class.)

2. **OVERVIEW**: (8-10 minutes) Briefly describe what the author’s main thesis or point is, in the assigned material. What is the argument? What is the issue? Why is this issue important? How does the author support his or her position? Does the author make any assumptions in order to make his or her argument (if so, mention them)? Is the author making any objections against his or her opponents’ position(s) (if so, mention them)?

   [**What is the issue?**] Ackerman wants to argue against the view that autonomy is best construed as non-interference. This argument is too simplified, however, because it doesn’t take into account the transforming effects of illness.

   [**Why is this issue important?**] This is important because whatever view of autonomy you have will actually influence how you treat patients, and can even lead to misunderstandings and lawsuits.

   [**What is the argument?**]

   **A. Introduction**: Opponent’s view: In 1980, the AMA claimed that it was no longer permissible for a doctor to withhold information from a patient, even on the grounds that it may be harmful (127c1). The physician is expected to “deal honestly with patients” at all times; respect confidentiality (only disclose to a third party when required by law). Patients have the right to refuse treatment, give informed consent, to privacy, to competent medical care provided with “respect for human dignity.” However, the underlying moral vision that places exclusive emphasis upon these factors is more troublesome, because the profession’s notion of respect for autonomy makes non-interference its essential feature (127c1). EX: “To respect autonomous agents is to recognize with due appreciation of their own considered value judgments and outlooks even when it is believed that their judgments are mistaken” (Beauchamp and Childress). That is, people “are entitled to autonomous determination without limitation on their liberty being imposed by others” (127c2). OBJ: If respect for personal autonomy is non–interference, the physician’s role is dramatically simplified. The doctor need only be an honest and good technician, providing relevant info and dispensing professionally competent care. Non–interference does not respect patient autonomy because it fails to take account of the transforming effects of illness (127c2).

   **B. Autonomy (according to Ackerman) = self-governance**: An autonomous person’s behavior: (1) is governed by plans of action formulated through deliberation or reflection (which requires information) and (2) issues intentionally and voluntarily from choices based on life plans or values (127c2).

   **C. There are four constraints impeding autonomous behavior**:

   1. **Physical**: Being a prisoner (127c2).
   2. **Cognitive**: Due to a lack of information or ignorance (128c1).
   3. **Psychological**: Denial, anxiety, fear, guilt, or depression inhibits adequate deliberation (see 4 cases below).
   4. **Social**: Institutionalized roles and expectations (“doctors know best”). [**DY OBJ**: But the patient doesn’t know best, right?]

   **D. The effect of illness**. [Pellegrino quotation] Illness obstructs (temporarily or permanently) our attempts to act upon cherished life plans (128c1). E.g., alteration in diet and physical activity, rehabilitation, etc. “Illness renders sick persons ‘qualitatively different’ than when they were healthy. ‘Without medical understanding, the patient cannot assess his or her condition accurately.’” So the notion of autonomy is
really hampered – the patient’s deliberative ability isn’t fully functional. Ackerman seems to imply that if someone merely defers to the doctor’s suggestions for treatment, then they aren’t really being autonomous. We need to understand the psychological constraints (128c1) (denial, depression, guilt and fear) on an illness. EX1: Denial: An 18-year-old cancer patient in denial that he was going to die soon so he couldn’t competently choose treatment options. EX2: Depression: Middle-aged woman with ovarian cancer in remission and also depression had a possible pulmonary metastasis, is put on a respirator for a few days and then refuses further treatment. The medical staff stalled and she improved. EX3: Fear: A patient with a probably malignant cerebral tumor refused life-saving surgery because he feared the cosmetic effects of neurosurgery and the possibility of neurological damage. He went to a coma and his family agreed to surgery and a benign tumor was removed. He died of complications related to the unfortunate delay and surgery (128c2). EX4: Social constraints: A 12-year-old boy (128c2) with a disease that required him to enter phase 1 of an experimental drug trial (101c1). He wanted to stop further therapy but his parents remained steadfast in their belief that God would save their child; he respected their wishes and died soon thereafter (the drug failed to work). Social/cultural expectations: the patient is supposed to seek technically competent help and cooperate with a physician. Many patients relinquish their opportunity to deliberate and make choices regarding treatment in deference to the physician’s superior educational achievement and social status (“Whatever you think, Dr.!”) (129c1). Paternalistic behavior may be one way to assist persons whose autonomous behavior has been impaired by illness (129c1). Only by coming to grips with psychological and social (129c1) dimensions of illness can we discuss how physicians can best respect persons who were patients (129c2). [DY OBJ]: Does autonomy occur when the patient merely says, “Whatever you think, doctor!”? What if you have deliberated that they know most about what is going on and that one should trust the experts? Aren’t you making a choice?

**E. RETURNING CONTROL TO PATIENTS, and the four constraints** (129c2-130c2). When the patient’s choices will be seriously limited, real respect for autonomy entails a more inclusive understanding of the relationship between patients and physicians: physicians should actively seek to neutralize the impediments that interfere with patients’ choices (129c2). EX1: Cassell, in The Healer’s Art, says that the most destructive aspect of illness is the loss of control, so control must be returned to the patient. Loss of control and illness is precipitated by a physical or mental defect (e.g., lack of knowledge) (129c2). EX2: Pellegrino says that the preeminent duties of the physician are to provide technically competent care and to fully inform the patient (130c1). Ackerman: These factors might be thought to restore control in the patient, but only if we assume that the only constraints are physical and cognitive. This approach will not help psychological or social constraints (e.g., denial, fear of ugliness after surgery, influence attitudes of the patient’s family). Crucial information may have to be repeatedly shared with patients; the physician may also need to influence the beliefs or attitudes of other people, such as family members, that limit their awareness of the patient’s perspective. Assuming psychological and social constraints impaire patient autonomy, physicians must carefully assess the psychological and social profiles and needs of the patients (130c1). Knowledge of the “patient’s psychological and social situation is also necessary to help the patient to act as a fully autonomous person” (130c2).

**BEYOND LEGALISM: The insufficiency of the legal model of physician-patient relationship** (130c2-131c2). The legal model of physician-patient interaction sees the relationship as a typical commodity exchange – technically competent medical care in return for financial compensation. [The compromising effects of illness, superior knowledge of physicians, and various institutional arrangements give the physician an unfair power advantage.] The legal model is insufficient (though maybe it’s necessary) because (1) it fails to recognize the impact of illness upon autonomous behavior. The goal of the therapeutic physician-patient relationship is “the development” of the patient – helping to resolve the underlying physical or mental defect, and to deal with the cognitive, psychological, and social constraints in order to restore autonomous functioning. The legal model is also insufficient (though maybe it’s necessary) because (2) the therapeutic relationship is not a typical commodity exchange where the parties use each other to mutually achieve goals (131c1). So the physician needs to gain a curse on knowledge about an interest in the patient; and we need to emphasize freeing patients of constraints upon autonomy (as opposed to noninterference). The physician (according to the AMA’s “Principles of Medical Ethics”) needs to tell the truth “in a way, at a time,
and in whatever increments are necessary to allow patients to effectively use the information in adjusting their life plans” (131c1). Moreover, respecting the patient’s refusal of treatment maximizes autonomy only if a balanced and thorough deliberation precedes the decision (131c2). At its root, illness is an evil primarily because it compromises our efforts to control our lives; so we must preserve an understanding of the physicians art that transcends non–interference and addresses this fundamental reality (131c2).

3. **CLARIFICATION**: (5-15 minutes, depending on your and the other students’ questions) Is there anything about this material that you did not understand (after looking up unclear or unknown words, etc.)? What are you confused about? What did not make sense in the reading? What questions would you ask if you could talk to this philosopher right here and now?

I didn’t really have any questions, since I’ve presented it twice before and it’s pretty straightforward. But do YOU have any questions about something that may have been unclear? [NOTE: This is where I want you students even if you are the presenter to be really honest and tell me if you are confused about ANYTHING!]

4. **CRITICISM/ANALYSIS**: (2-5 minutes – NOT merely a one sentence summary of what you thought) What do you think about the author’s argument or point? Do you agree and why or why not? Do you have any objection(s) to the author’s argument? Do you have a better idea, and if so, what is it? How does this author’s position or argument compare with other authors’ positions or arguments already presented?

I thought this article was well-argued. I agree that a patient’s autonomy can be dramatically affected by illness and the internal and external constraints he mentioned, as well as that the legal model of the physician-patient relationship is woefully inadequate. However, I had a few objections:

1. Ackerman says that an external constraint is “Social: Institutionalized roles and expectations (“doctors know best”),” on 128c1. Can the patient never know best? NOTE: This can merely be a poor example, and there are certainly still social constraints, but this one can be one we don’t approve of, and are increasingly questioning, right?

2. Does autonomy occur when the patient merely says, “Whatever you think, doctor!”? What if you have deliberated that they know most about what is going on and, after that deliberation, they think one should trust the experts? Isn’t that patient making a choice too, and can’t (and even shouldn’t, in most cases) that patient make that choice?

**[DAVE’S QUESTIONS FOR THE CLASS – (Note to Students: You don’t need discussion questions for the class for your presentations – I will handle those):**

1. Do you think my objections are good objections?
2. Do you agree that the legal model of physician-patient relationship is insufficient?
3. Reactions: “The physician needs to tell the truth “in a way, at a time, and in whatever increments are necessary to allow patients to effectively use the information in adjusting their life plans”? (131c)