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Guidance on consent for the processing and analysis of clinical samples following an initial consultation

Dear Editor

If we fully accept a patient's right to reject medical consultation, investigation, advice and treatment, does it follow that a pathologist may not order a test without approval from the patient? In *The Bulletin (RCPath Bulletin 2010;149:56-58)*, Menlowe, Croall and Bowles argued for something close to that, but their conclusions seem wrong-headed to such a degree that we should consider what may be wrong with their premises.

Assume first that when a patient seeks help it is to find out what is wrong, have it cured, or if that is not possible to be properly looked after: then consulting the first doctor in line might be considered equivalent to giving implicit consent for all. There is a contrary view and we shall return to the point but first there are other questions of professionalism and ethics bearing on the problem and contributing to the debate already opened by Furness in the same issue of *The Bulletin (RCPath Bulletin 2010;149:59)*.

There is an ethical obligation also on the doctor or clinic to undertake the basic tasks outlined above, well, quickly and at the lowest possible overall cost. So to fail in any part is either something imposed by external circumstances or a shortcoming in professional practice. Turning to the pathologist's dilemma; if an additional test is not ordered on the spot ('reflex testing'), what may follow?

First, it causes delay. Diagnosis or change in management may be deferred until the test is approved, a fresh sample obtained, a new request submitted, the test performed and the additional result has reached its destination; delays that can rarely have beneficial consequences.

Second, it gives rise to additional costs. The process just described may be already some hundreds of pounds worth and that is only the beginning. There are extra costs also for the patient, family, employer, insurance company (if any), DHSS, society generally and the national economy – costs of various forms and progressively more difficult to measure accurately as we go down the list but real costs all the same.

Third, it is poor medicine, substandard performance. It was possible perhaps to deliver a diagnosis by way of a single visit by the patient to the clinic: if we fail in that, it is a missed opportunity much like dropping a catch on the cricket field and we all know what that can lead to.

Thus, there is conflict between different aspects of professional ethics, which can only be resolved by recognition that there is a hierarchy in such matters. Upon the above assumptions

and in the ordinary practice of a pathologist, patient autonomy must take second place to doing a good job unless the patient's known preferences set limits to what the job may include. If the pathologist must seek the patient's consent to doing a reflex test, then that adds cost and time to the process, may be dangerous and is unethical. It follows that a patient's wishes in the matter, if negative, must be known in advance.

Of course, no analysis can be stronger than the assumptions on which it is based. For Menlowe *et al.* the patient is always right, which seems sound until another question is asked. Must a doctor always do what the patient asks? Clearly not, law and ethics both deny that. There are many situations where a doctor may refuse to treat a patient either in some particular fashion or altogether, others where a particular action is absolutely barred. Patient autonomy cannot be the only factor taken into account, else why hire a doctor? We are not permitted to act merely as a branch of the retail trade and a consultation or investigation is not only a commercial transaction.

The false premise was that patient autonomy is always paramount. In fact, it is so only conditionally.

An immediate, practical danger is that the guidelines advanced by Menlowe *et al.* may be treated as law, even though they are harmful to everyone's interests. A way through the impasse must be found and the following suggestions may be of interest. First, unless and until the legal position has been clarified, the results of a test not explicitly approved should be disclosed only to the patient. Second, there should be legislative or equivalent action to make clear that a patient is deemed to have agreed to additional tests at the discretion of the doctors unless that has been specifically disallowed in advance.

The first of these would have a pleasing side effect, in that NHS Trusts would be obliged to communicate direct with patients. Together with a proper assessment of the overall costs of a patient's engagement with the NHS, of the kind outlined above, the outcome might be a true national service, motivated to act in the interests of patients and country rather than its officers.

I am grateful to Mr Brian McEvoy for his contribution to the argument.

Professor T.R.C. Boyde MD FRCPath

Dear Editor

Professor Furness (*RCPath Bulletin 2010;149:59*), Dr Leeming (*RCPath Bulletin 2010;150:162*) and Professor Boyde (see above) all criticise my contribution on further or reflex testing (*RCPath Bulletin 2010;149: 56-58*) for similar reasons. I should make clear that I claim only the first part of the article as mine: the examples were added by others.

Professor Furness begins his comment on my contribution thus: 'The ethical analysis uncritically accepts the current fashion to place respect for individual autonomy as the highest good in medical ethics.' My analysis does not and I am mystified as to how anyone could have thought that it does. The Editor invited me to contribute an article that might generate some discussion within *The Bulletin* of an ethical issue and the relevant College policy. I chose to present for discussion two sides of an argument, both of which have merits, both of which had been debated in the College, without arguing for either. In order to present both sides, I asked the reader to 'Suppose that one thinks that autonomy...is paramount' for the sake of the argument. I did not assert in my contribution that autonomy is unquestionably the highest good in medical ethics, let alone the highest good *tout court*. In fact, nowhere in the contribution did I state my own view. Had I been asked to do, I would have written a different article entirely.

Professor Furness elaborates on my fashionable and uncritical use of the concept of autonomy. I accept that it is a difficult concept, often used uncritically and my contribution would have served a useful purpose if I had provoked readers into examining it. However, I nowhere made the philosophically illiterate mistake of which he accuses me, namely the mistake of treating autonomy as simply a matter of what the patient desires. I too have studied my Kant.

By way of finally dispatching a view which I did not assert, Professor Furness links it to two other views which he clearly believes are even more absurd. Not only is his argument irrelevant, it misfires even in its own terms. The view that the purpose of law is to increase autonomy is not an absurd view. It only appears so if you neglect all of civil law. Moreover, Kant and Kantians have defended it as a truth even about the criminal law.

Professor Furness suggests that the patient should be regarded as requesting or consenting to an investigation of his/her symptoms (rather than requesting a specific analysis), but he admits that this requires a 'shift of understanding'. If that were the way in which requests were viewed by both patients and pathologists, then I would not disagree with much of what Professor Furness describes as the implications. I was commenting on what, as a lay person, I took to the practice to be; not what it ought to be. However, there is a trap here into which Professor Boyde (see above) seems to fall.

Dr Leeming points out that respect for the rights of patients may have adverse consequences for others. Of course, he is correct. This is an example of the conflict between autonomy, beneficence and justice which Professor Furness chastises me for ignoring. That the conflict is real and difficult is one of the reasons why my contribution does not assume that autonomy always trumps other values.

Professor Boyde accuses me of even a cruder view than does Professor Furness. According to Professor Boyde, I assume that the patient is always right. I do not. My assumption is quite different. Respecting the patient's autonomy (properly understood) entails that the patient has a right to be wrong about what may be in his or her interest insofar as that interest is restricted to health. A patient may not want a particular further test carried out even if the patient could be persuaded that the test will assist in addressing his or her symptoms. The patient may be odd but, if not irrational, has

his or her reasons which must be respected (the real meaning of Kantian autonomy). There is a clear analogy with a patient who does not wish treatment without his or her explicit consent. These are patients for whom getting well may not be the only important thing. Such people may be eccentric but, as Kant would have said, they have a right to have their rationality respected. There are quite a lot interesting parallels to the dilemmas involved in treating patients who have legal capacity.

Professor Boyde also believes that I think that patient autonomy is 'the only factor taken into account', that I hold 'the false premise... that patient autonomy is always paramount.' I have already stated that I did not assert that, nor do I think that anything I wrote can be reasonably construed as asserting that. Professor Boyde writes: 'in the ordinary practice of a pathologist, patient autonomy must take second place to doing a good job *unless the patient's known preferences set limits to the what the job may include*...It follows that a patient's wishes in the matter, if negative, must be known in advance (Italics mine).' There is quite a lot in this which is contentious, but the reason for quoting it is that it grants an advocate of autonomy a crucial point; namely, that there is a boundary which should limit the job. I have space to offer only a brief explanation of why the point is crucial. Why does Professor Boyde think that patient's known preferences should limit the job? What's wrong with just ignoring or overriding those preferences? Professor Boyde supplies the answer: in allowing known preferences to have weight, we are allowing patient autonomy to take, as he puts it, first place. The advocate of autonomy, whilst not agreeing with the importance of known preferences *per se*, would argue that the fact that Professor Boyde gives any weight to preferences requires explanation. The explanation is in terms of the respect for the person's autonomy, the respect due to a person just because he or she is a rational person. But it does not respect the patient's autonomy at all to assume, as Professor Boyde does, 'consulting the first doctor in line might be considered equivalent to giving implicit consent to all.'

I should be pleased that my contribution has generated the discussion the Editor sought. I would have been even more pleased if the discussion had been about the article that I wrote.

Michael A. Menlowe
Formerly Head of the Philosophy Department, University of Edinburgh
Lay member of the College

Medical consultants: new appointments, offers and retirements

Dear Editor

The Bulletin has a regular item: "Medical consultants: new appointments, offers and retirements" which routinely includes inaccuracies, obfuscation and omission as follows.