If Mr. Younis is not mentally competent, the doctrine of informed consent does not apply directly. Consent is related to the rights derived from the principle of autonomy. As such it only applies to substantially autonomous persons. If Mr. Younis is incompetent, his wife is his presumed surrogate. She would retain the right to determine how much he should be told based on her assessment of his best interest. This is the same approach used in informing young children, who are also mentally not competent to consent to medical treatment.

Not all mentally compromised patients are sufficiently lacking in autonomy that they should be treated as incompetent. Thus the first problem for Dr. Caldarone is a determination of Mr. Younis's competence. This could involve a psychiatric consultation and, especially if the matter is in dispute, potentially a judicial determination of whether the patient is competent, and, if not, who should be his surrogate or guardian.

If Mr. Younis is found to be incompetent, his wife would plausibly become the moral and legal surrogate. The obligation to benefit the patient clinically would prevail unless she knows his wishes about how he would want to be treated. A good utilitarian argument could be made that the greatest good is preservation of life, which calls for proper clinical diagnosis and treatment of a potential life-threatening illness as well as avoiding the threatened suicide. This could lead to a biopsy diagnosis and then truth-telling in careful but honest terms, with promise of and support/care of the patient afterward. The attending physician will require virtues of interpersonal skills, professional skills of evaluation and decision-making, and great sensitivity in truly caring for this patient.

The abrupt canceling of the biopsy raises additional moral issues. While it is true that that physician cannot legally operate without a valid consent, either consent from the next-of-kin under the presumption that the patient was not competent or a further discussion with the wife if the patient is determined to be competent would seem to be in order.

THE RIGHT OF ACCESS TO MEDICAL RECORDS

Closely related to the ethics of truth-telling is the question of the right of access of a patient to his or her medical records. This is a problem for medical records administrators and also for all other health care professionals, especially those in a hospital setting. If the patient has the right to be told all that is potentially meaningful about his or her medical condition and treatment, does that also imply a right to see his or her medical records or at least to know what they contain?

Traditional medical ethics and law presumed that patients had no right of access to their medical records. They were presumed to be the property of the treating health professional. Concern was expressed based on Hippocratic concern for patient well-being that if patients saw their records, they could learn things that would be upsetting. Moreover, they might misunderstand the content of the record causing psychological distress and confusion.

More recently as medical ethics has shifted from more paternalistic consequentialism to a more rights-oriented ethic, patients are seen as having a right of access as part of their more general right to be truthfully informed of their medical condition.[16]

CASE 7–8

A Psychiatric Patient's Right to See Her Medical Record

Claire Mowry was a 38-year-old, never-married woman who had worked intermittently over the past ten years as a secretary. She had had difficulty keeping jobs because she would regularly engage in disputes with fellow employees accusing them of not carrying their load of the office work, criticizing her work, and in one case reporting her to the supervisor for consistently showing up late for work.

Currently out of work, she was seeing Martin Gaskell, a psychiatrist working with the mental health clinic of the HMO of her previous employer. Ms. Mowry was currently paying out-of-pocket so her HMO coverage could continue.

Dr. Gaskell had now had four appointments with Ms. Mowry. He had identified patterns of what appeared to be paranoid thinking and had generally come to find her an unpleasant, difficult patient. She clearly did not have a major psychiatric disorder. She was not psychotic—a paranoid schizophrenic—but she had personality traits that were causing her problems.

By the end of her fourth visit with Dr. Gaskell, Ms. Mowry had become convinced that Dr. Gaskell did not like her. She thought he seemed to be implying that her employment problems were her own fault and that she needed further therapy to address these issues. Ms. Mowry suspected that Dr. Gaskell was keeping notes on her that would reflect his poor opinion of her. She asked to see her medical record.

When Dr. Gaskell hesitated, she indicated she would report him to the management of the HMO. The law is currently in flux regarding the right of patients to see their medical records. Moral uncertainty also exists. In particular, many physicians, especially psychiatrists, are concerned that granting patients the right to see their records may harm patients as well as violate the privacy rights of the provider. Regardless of the law in the jurisdiction of this case, what is an ethically appropriate decision by Dr. Gaskell?

COMMENTARY

In the era of Hippocratic medicine, it was assumed that medical records were not for the patient to see. They were the property of the physician. A patient would not be able to understand the physician's documentation and could be harmed by any misunderstanding. Psychiatric records were particularly subject to the claim that disclosing of contents could do more harm than good. If the patient were mentally incompetent—a child, an adult adjudicated to be incompetent, or perhaps even an adult who has not formally been found incompetent but is deemed to lack sufficient mental capacity for autonomous medical decision-making, there is good reason why records might not be disclosed, but cases of mentally competent adults, including those who have some psychiatric problems, pose the question of whether they ought to be given access to their records, whether the information in some sense belongs to them.

In more recent times, the assumption that patient access to medical records will cause harm to the patient has been called into question. Some claim that seeing the record will actually help the patient understand his or her condition and clarify matters not adequately presented by the physician. Seeing the record of the physician or the hospital is considered an additional source of information to help the patient understand the diagnosis and treatment as well as clarify any miscommunication from the provider. In addition, the patient is sometimes believed to have a right to information about the physician's views of the patient's problem.

Those concerned that the record could be misunderstood have suggested that the patient who asks to see his or her record should have access with the professional present to clarify any issues that are not clear. Others have suggested that the patient should be given an oral summary rather than the printed text.

Ms. Mowry has revealed sufficient signs of paranoid thought that she probably would not be satisfied with an oral summary. She might well believe that the psychiatrist was not presenting his written notes accurately.

A traditional consequentialist would ask whether the information would, on balance, be beneficial to the patient. The answer in this case is not obvious. There is information at stake that is potentially important to her current health care and peace of mind. On the other hand, the physician or other members of the health care team may have entered notes about the patient's mental state or other potentially embarrassing information they did not expect the patient to see. Basing an assessment just on the consequences, it may not be clear whether the patient will, on balance, be helped or hurt by seeing her record.

Now look at the case from the point of view of the rights of the patient. Assuming she has the right to information that is potentially meaningful in making medical decisions, from this point of view she would have a right to the information even if it is, on balance, likely to harm her.

Increasingly, courts are granting the right of patients to see medical records[17] and many state legislatures now have passed laws granting patients the right to see their records.[18] Patient advocacy groups are pressing for a right of access.[19] Physicians and others examining the psychological and medical effects of granting a right of access are increasingly more positive about such access.[20] Most laws require a written request to the physician and the physician has a certain amount of time to comply. In California, for example, the physician does not have to give the actual copy of the record; he or she can provide a written summary of the information in the record. Would that be an acceptable policy in this case?

This completes the exploration of the cases dealing with the ethical principle of veracity. Autonomy and veracity, the issues of the previous chapter and this one, were the first two principles related to respect for persons. We now turn to the third such principle: fidelity.

NOTES

[1] American Medical Association. *Current Opinion of the Judicial Council of the American Medical Association*. Chicago, IL: American Medical Association, 1981, p. ix.

[2] American Medical Association. Council on Ethical and Judicial Affairs. *Code of Medical Ethics: Current Opinions with Annotations*, 2004–2005. Chicago, IL: AMA Press, 2004, p. 229.

[3] American Pharmaceutical Association. *Code of Ethics*. Washington, DC: American Pharmaceutical Association, 1969. This provision was not changed in the amendments of 1975 or the revision of 1981.

[4] It continues, however, with a possible opening to the more traditional Hippocratic paternalism when it adds that, "A pharmacist avoids…actions that compromise dedication to the best interests of patients." See American Pharmaceutical Association. *Code of Ethics for Pharmacists*. Washington, DC: American Pharmaceutical Association, 1995.

[5] American Nurses Association. *Code of Ethics for Nurses with Interpretive Statements*. Washington, DC: American Nurses Association, 2001, p. 8.

[6] Sidgwick, Henry. *The Methods of Ethics*. New York: Dover Publications, Inc., 1966, [1874].

[7] Meyer, Bernard. "Truth and the Physician." In *Ethical Issues in Medicine*. E. Fuller Torrey, editor. Boston, MA: Little Brown, 1968, pp. 159–177.

[8] Kant, Immanuel. "On the Supposed Right to Tell Lies from Benevolent Motives." Translated by Thomas Kingsmill Abbott and reprinted in Kant's *Critique of Practical Reason and Other Works on the Theory of Ethics*. London: Longmans, 1909 [1797], pp. 361–365.

[9] Ross, W. D. *The Right and the Good*. Oxford: Oxford University Press, 1939.

[10] Oken, Donald. "What to Tell Cancer Patients: A Study of Medical Attitudes." *Journal of the American Medical Association* 175 (April 1, 1961):1120–1128.

[11] Hooker, Worthington. *Physician and Patient: Or, a Practical View of the Mutual Duties, Relations and Interests of the Medical Profession and the Community*. New York: Baker & Scribner, 1849; Cabot, Richard Clarke. *Honesty*. New York: The Macmillan Company, 1938.

[12] Novack, Dennis H., Robin Plumer, Raymond L. Smith, Herbert Ochitill, Gary R. Morrow, and John M. Bennett. "Changes in Physicians' Attitudes Toward Telling the Cancer Patient." *Journal of the American Medical Association* 241 (March 2, 1979):897–900.

[13] Good discussions of the problems of uncertainty faced by health professionals are Fox, Renée C. "Training for Uncertainty." In *The Student-Physician*. Robert