SOUNDING BOARD

Legislative Interference with the Patient–Physician Relationship

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Increasingly in recent years, legislators in the United States have been overstepping the proper limits of their role in the health care of Americans to dictate the nature and content of patients' interactions with their physicians. Some recent laws and proposed legislation inappropriately infringe on clinical practice and patient–physician relationships, crossing traditional boundaries and intruding into the realm of medical professionalism. We, the executive staff leadership of five professional societies that represent the majority of U.S. physicians providing clinical care — the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American College of Physicians, and the American College of Surgeons — find this trend alarming and believe that legislators should abide by principles that put patients' best interests first. Critical to achieving this goal is respect for the importance of scientific evidence, patient autonomy, and the patient–physician relationship.

Examples of inappropriate legislative interference with this relationship are proliferating, as lawmakers increasingly intrude into the realm of medical practice, often to satisfy political agendas without regard to established, evidence-based guidelines for care. Of particular concern are four specific types of laws or legislative proposals.

The first type of law prohibits physicians from discussing with or asking their patients about risk factors that may affect their health or the health of their families, as recommended by evidence-based guidelines of care. In 2011, for example, Florida enacted the Firearm Owners' Privacy Act, which substantially impaired physicians' ability to deliver gun-safety messages to patients.[1] The law also prohibited practitioners from routinely inquiring about whether patients own firearms and recording this information in a patient's medical record. Practitioners who violated the law were potentially subject to severe disciplinary action, including fines and loss of licensure. The concerns we have about this law were well explained by U.S. District Judge Marcia G. Cooke, who issued a permanent injunction on June 29, 2012, barring the law's enforcement. As Cooke noted in the opinion, "The State, through this law, inserts itself in the doctor–patient relationship, prohibiting and burdening speech necessary to the proper practice of preventive medicine, thereby preventing patients from receiving truthful, non-misleading information. This it cannot do. . . . This law chills practitioners' speech in a way that impairs the provision of medical care and may ultimately harm the patient."[2] Yet the state of Florida is continuing to push this issue: Governor Rick Scott recently announced the state's submission of an appeal of Judge Cooke's ruling.[3]

Second, some new laws require physicians to discuss specific practices that may not be necessary or appropriate at the time of a specific encounter with a patient, according to the physician's best clinical judgment. New York legislation that was enacted in 2010 and became effective in early 2011 requires physicians and other health care practitioners to offer terminally ill patients "information and counseling regarding palliative care and end-of-life options appropriate to the patient, including . . . prognosis, risks and benefits of the various options; and the patient's legal rights to comprehensive pain and symptom management."[4] Although the law requires only that the clinician offer to provide information, the Medical Society of the State of New York and others have criticized it for failing to recognize the complexity and uncertainty involved in end-of-life discussions among patients and their families and physicians.[5,6] This is an area in which one size does not fit all and in

which physicians are best able to determine what discussions with patients and families are necessary or appropriate at a given time. Yet failure to comply with the law can result in fines of up to $5,000 for repeat offenses and a jail term of up to 1 year for willful violations.

Third, still other laws would require physicians to provide — and patients to receive — diagnostic tests or medical interventions whose use is not supported by evidence, including tests or interventions that are invasive and required to be performed even without the patient's consent. In Virginia, a bill requiring women to undergo ultrasonography before having an abortion would have mandated the use of transvaginal ultrasonography for a woman in the very early stages of pregnancy.[7] As the Virginia chapter of the American College of Physicians stressed in a letter urging Governor Bob McDonnell to veto the bill, "opposition to the legislation does not reflect our opinions individually or collectively on the practice of abortion itself," but rather the conviction that "this legislation represents a dangerous and unprecedented intrusion by the Commonwealth of Virginia into patient privacy and that it encroaches on the doctor–patient relationship."[8] A modified bill requiring women to undergo transabdominal rather than transvaginal ultrasonography, which still represents inappropriate legislative intrusion into the patient–physician relationship, was signed by McDonnell in March 2012.[9]

Finally, there are laws limiting the information that physicians can disclose to patients, to consultants in patient care, or both. Four states (Pennsylvania, Ohio, Colorado, and Texas) have passed legislation relating to disclosure of information about exposure to chemicals used in the process of hydraulic fracturing ("fracking").[10] Fracking involves injecting into the ground toxic chemicals such as benzene, toluene, ethylbenzene, and xylene to extract oil and natural gas.[11] Low levels of exposure to those chemicals can trigger headaches, dizziness, and drowsiness; higher levels of exposure can cause cancer. In Pennsylvania, physicians can obtain information about chemicals used in the fracking process that may be relevant to a patient's care, but only after requesting the information in writing and executing a nonstandardized confidentiality and nondisclosure agreement drafted by the drilling companies.[12]

Unfortunately, laws and regulations are blunt instruments. By reducing health care decisions to a series of mandates, lawmakers devalue the patient–physician relationship. Legislators, regrettably, often propose new laws or regulations for political or other reasons unrelated to the scientific evidence and counter to the health care needs of patients. Legislative mandates regarding the practice of medicine do not allow for the infinite array of exceptions — cases in which the mandate may be unnecessary, inappropriate, or even harmful to an individual patient. For example, a patient may already have undergone the test in question or may have specific contraindications to it. Lawmakers would also do well to remember that patient autonomy and individual needs, values, and preferences must be respected.

Laws that specifically dictate or limit what physicians discuss during health care encounters also undermine the patient–physician relationship. Physicians must have the ability and freedom to speak to their patients freely and confidentially, to provide patients with factual information relevant to their health, to fully answer their patients' questions, and to advise them on the course of best care without the fear of penalty.

Federal, state, and local governments have long played valued and important roles in our nation's health care. Various levels of government are appropriately involved in providing essential health care services, licensing health care professionals, protecting public health, determining the safety of drugs and medical devices, and investing in medical education and research. Government plays a particularly important role in ensuring health care access for vulnerable and special-needs populations, including the elderly and disabled (Medicare), the poor (Medicaid), children (the Children's Health Insurance Program), and veterans (the Veterans Health Administration). We are fortunate to have a broad-based and extensive health care system, whose improvement and future excellence depend on a continued partnership between health care professionals and government.

None of the concerns raised above imply that we object to these governmental roles. But we believe that health legislation should focus on public health measures that extend beyond the individual patient and are outside the capacity of individual physicians or patients to control.

In contrast, government must avoid regulating the content of the individual clinical encounter without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

Our objection to legislatively mandated health care decisions does not translate into an argument that physicians can do whatever they want. Physicians are still bound by broadly accepted ethical and professional values.[13] The fundamental principles of respect for autonomy, beneficence, nonmaleficence, and justice dictate physicians' actions and behavior and shape the interactions between patients and their physicians. When physicians adhere to these principles, when patients are empowered to make informed decisions about their care, and when legislators avoid inappropriate interference with the patient–physician relationship, we can best balance and serve the health care needs of individual patients and the broader society.

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