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Book Review

# Review of Robert M. Veatch, *Patient, Heal Thyself: How the New Medicine Puts the Patient in Charge*<sup>1</sup>

Reviewed by Ruth Levy Guyer

“How did we get ourselves in the absurd position that mature adults in a free country cannot possess beneficial drugs for their own use unless they can find some physician someplace who will write them a note?” asks Robert Veatch (111). “Patients of the world, take responsibility for your own healing. You have nothing to lose but your passivity” (257).

It is (long past) time to return to the drawing board for healthcare in the United States, examine how it works or mostly doesn’t, and then shift the paradigm. Veatch takes on this task in *Patient, Heal Thyself*, exposing fundamental flaws in healthcare’s foundational concepts and describing how and why the medical research and clinical care enterprises currently malfunction and must evolve. The problems start with the basic vocabulary of medicine and healthcare, which skews and influences our thinking.

No healthcare decision is solely medical. Each involves an amalgam of medical-science facts mixed with social, religious, cultural, financial, and other considerations. Forty years ago, Veatch began challenging students to bring him an example of a values-free, purely medical decision in exchange for a free gourmet meal. He has yet to take anyone to dinner, at least on those terms.

In an ideal, new, postmodern healthcare system power relations would differ significantly from those of today. The chief decision makers would be patients, not doctors, pharmacists, other health professionals, insurance agents, or policy makers. The critical new role filled by doctors would be an advisory one—making diagnoses and explaining treatment options; they would no longer be issuing “orders.” Medicine is not, in fact, the military.

We are unfortunately never likely to jettison the word “patient” from our vocabularies—with its connotations of passivity and long-suffering acceptance—but Veatch hopes at least that a re-conceptualized medicine would add to the word “a new dignity, a new authority, and a new activism” (17).

The patient, not the doctor, is the one who can best assess what is in his or her best interest and what will contribute most to total personal well being. Some of us are

optimists, some pessimists, some doers, others dreamers, writes Veatch. Some individuals willingly endure tremendous amounts of suffering, while others cannot; drug and treatment side effects, acceptable to one patient, may be entirely unacceptable to another. Some believe in natural, non-medical interventions, while others prefer pharmacological and other standard nostrums. Some think a long life is important no matter what its quality, whereas others weigh morbidity more intensively. Each person’s perspective is distinctive, and this Veatch illustrates with one of his felicitous metaphors: the auto mechanic and the artist describe the Maserati differently. A new construct for the healthcare enterprise will only truly serve patients when patients “recapture responsibility for their own health choices—including choosing therapies based on their own beliefs and values” (4).

The revamped system must accommodate competent patients who choose not to accept treatments, even those treatments offering likely strong benefits. No one can ever see into the future or know outcomes for sure. Furthermore, “the patient has the right to act foolishly” (49). Thus, no treatment or drug is ever literally “medically indicated” as long as an individual is willing to accept consequences, even a consequence as definitive as death.

And no single drug or treatment should ever be called a global “treatment of choice.” Something may be appropriate for a given condition, and it may have an excellent track record in situations similar to that of the patient considering the treatment. But decisions about healthcare choices are values decisions, and each of us has standing to make our own personal choices. Medicalizing values issues, though commonly encountered in medical parlance, is always inappropriate. “The ought judgment cannot come directly from the science,” writes Veatch. “It must be imported from some system of beliefs and values” (223).

Decades ago, the concept of informed consent, which acknowledged patient autonomy, began supplanting the old paternalism of medicine. But now, writes Veatch, the time has come to abandon consent. All researchers and clinicians

1. Oxford University Press, 2009, 287pp \$29.95 Hardback.

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know the truth about consent, how difficult or impossible it is to ever ensure that it is informed ... truly. Few researchers take the time to verify that volunteers in their clinical experiments have an authentic understanding of what they are signing onto. Patients often “consent” to treatments when in highly emotionally charged settings. Consent is such a twisted concept that advance directives include an individual’s consent to a non-treatment—the DNR—rather than specifying in a direct way that the signer is unwilling to consent to resuscitation. A healthcare system that genuinely buys into decision making for patients would not need consent, because the patient simply chooses the options s/he wants.

We live in what Veatch describes as a “crazy half-libertarian world in which patients are not considered capable of deciding on their own to take medications, but are considered capable of refusing to take medications prescribed by their physicians. ... Why the liberty to consume doesn’t match the liberty to refuse is a mystery” (128).

“Prescribing,” writes Veatch, “should, at best, be the act of a scribe, of one who records the patient’s choices” (114). Prescribing is currently an incredibly risky business. Today any doctor can prescribe for a patient any approved drug “off label” just based on a gut feeling that it might have salutary effects. Writes Veatch: “There is no requirement for the physician to get permission or approval. The naive patient may receive the prescription not knowing it to be a wild idea in the imagination of his or her physician” (130).

When Veatch was in pharmacy school, he and the other students were warned against explaining prescriptions to patients, because doctors often did not want their patients to know what the treatment plans were. Attempts to educate patients were considered unethical, and the pharmacist’s first loyalty was to the doctor’s therapeutic privilege. Veatch writes that such extraordinary security around treatment plans then and medicines even today “might be warranted for radioactive materials or top-secret, national-security data, but it is hard to defend for large classes of chemicals, most of which pose very little danger and have very little potential for abuse” (119–120). (The few classes of drugs that Veatch would classify as dangerous enough for such tight regulation are narcotic analgesics (morphine, codeine and synthetics), antihistamines, and methamphetamine).

Veatch’s plan for healthcare reform in the United States favors a single payer with multiple lists. Everyone would receive the same annual allotment, with age-appropriate adjustments, and individuals would then select the plan that covers the services they prize. (Those who can buy other

tiers of healthcare would also have that option.) Some 100–200 different lists would likely meet all needs. Universal entitlement ensures that everyone is covered. Choice ensures that no one is forced to purchase options that s/he finds morally offensive or socially off-base (birth control, cosmetic surgery, psychoanalysis, and others might be considered here). “Different lists are a moral necessity in order for a system to be equitable,” notes Veatch (116).

Every list would include a few basics, such as emergency care and immunizations, which are a public health necessity.

No list would include hospice care, which should be universally available for all who want it through another mechanism, probably Social Security. Dying is complex, and, although it obviously includes a medical component, equally significant are its social, spiritual, esthetic, financial and other dimensions. The very goal of hospice is, in fact, at odds with the goal of most medicine, which is to treat and cure ills and prolong lives.

Hospice provides a model of how the provider of care and the recipient of care can, at times, be ideally philosophically matched. Those receiving hospice care never worry that their explicit wishes for comfort care will be subverted by a provider who believes strongly in aggressive, intensive care. Veatch envisions a day when we might be able to effectively pair patients and their doctors for ongoing care on the basis of common world views (religion, social inclinations, political points of view, and so on). Such “deep values pairing” would greatly improve the quality of the partnerships of patients and their doctors (103).

The proposals and insights in this book run the gamut from the commonsensical to the visionary. The cases and examples are always interesting, and strategies for solving problems and moving to a new paradigm are specific. The reader feels optimistic that a workable and just healthcare system can be crafted for the United States. Veatch asks, though, whether our society is “sufficiently committed to the principles of liberty to give competent adults the freedom to make these choices for themselves ... in a matter that is literally life-and-death” and whether “the United States is sufficiently committed to human freedom to attempt this radical experiment” (126).

*Patient, Heal Thyself* is a fine guide for all—for current and future patients (namely, everyone), for healthcare practitioners, and for policy makers. I only hope that Oxford University Press has sent or will send a copy of *Patient, Heal Thyself* to each member of the foot-dragging U.S. Congress, or at least to the subset of them who know how to read.