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Should patients have obligations?

COMMENTARY

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The Act relating to Patient's Rights says little about patient's obligations. For example, it does not stipulate that truthful information must be provided to the health services. Invented medical histories may lead to large payments from public authorities and insurance companies. However, if the fraud is discovered, this may have serious consequences for the patient. Could the introduction of patient's obligations have improved this situation?

Treatment consists of cooperation between the patient and the treater(s). Mutual exchange of good information and confidence is essential. One of the functions of the Patient's Rights Act (1) is to help promote confidence between the patient and the health services, and to ensure that the human dignity of the individual is respected.

Immunity against unreliability?

The Patient's Rights Act clarifies the patient's rights in the present health care services, but says nothing about patient's obligations, apart from in the new Chapter 4A which states that individual patients may be obliged to receive treatment to which they object. The Act does not enjoin patients to make truthful presentations. When a person attains patient status, it seems as though unwritten immunity to unreliability comes into force. It is not possible to call into question the patient's account of pain and impaired function. An ill person must not be disbelieved. The task of the health services is to find out what causes the symptoms described and to start adequate treatment.

However, the presentation of symptoms and the clinical findings may sometimes be so distanced from known disease conditions that it is obvious that something is not quite right. But we cannot say this to a patient. We must take their symptoms seriously and try to help by providing some form of treatment. And if the patient asks for sick leave, this is usually given. The treater role is easily converted into a passive co-helper role in a continuing, but perhaps pointless treatment. This may be resource-demanding on the health services and expensive for the community, and is often experienced by specialists in musculoskeletal disorders to whom these patients are not infrequently referred.

Somatization or simulation?

Somatization is understood as meaning presentation of physical symptoms, primarily long-lasting pain, without it being possible to demonstrate definitely disturbed physiological processes or abnormal anatomical conditions, which could provide a rational explanation of the pain (2). In *simulation*, symptoms and functional impairment are «created», often copied from known medical conditions, but where the clinical picture does not correlate with objective findings, imaging diagnosis or haematological tests. On the other hand, in simulation, but not in somatisation, there may be positive results of clinical diversion tests, and irrelevant clinical tests with alleged symptoms in the musculoskeletal system (3, 4). These supplementary tests often differentiate conscious aggravation and simulation from somatoform conditions.

Is patient unreliability a problem?

Patient unreliability is not a problem in the great majority of patients who come for help with symptoms and functional impairment. However, with a constant influx of new insurance schemes that enable payments to «everyone» in connection with injuries sustained at work or during leisure, it is likely that attempts at false insurance claims based on «loss of health» may occur.

In a three year follow-up study on occupational injuries, health problems were most pronounced after non-specific soft tissue injuries (5). The majority of the injuries were assessed as modest, and insurance benefits were granted to more than half of these patients. The authors found that it was difficult to explain the lacking – and even inverse – connection between the injury and its clinical consequences.

Doctors have a demanding job acting as gatekeepers on behalf of the community. Disbelieving a patient and not offering treatment and social security benefits is very unpleasant and something to be avoided for as long as possible. But once a treatment has been started, perhaps with a rather doubtful clinical background, and the treatment does not work, this must be followed up with a new treatment and then further new treatments and extensions of sick leave, as long as the patient wants treatment. Call it misguided doctor kindness. Perhaps the patient has asked for treatment, not in order to recover, but to demonstrate that it is not possible to recover. The end result may be a troublesome «doctor therapy failure syndrome».

Does patient unreliability have consequences?

Patient unreliability may have consequences, even for the patient him/herself. During the past year, both the insurance companies and the Norwegian Labour and Welfare Administration (NAV) have taken on a far more active role if they suspect fraud, for example using video recordings in public areas and Google web search on individuals. This has resulted in several cases involving charges of fraud with subsequent court cases and demands for the reimbursement of paid benefits and insurance. The Health Services can help prevent these individuals from starting this process if long-lasting symptom-fixating treatment with accompanying periods of sick leave, which may make normal recovery and return to employment difficult, is only initiated after careful reflection. Early disclosure of patient unreliability in presentation of symptoms and clinical findings may prevent treatment being directed onto an unfortunate somatic treatment track, as a poor substitute for the psychosocial treatment that these patients may really need.

Should there be something called patient obligation?

Perhaps patient obligation should exist, particularly in long-lasting patient contacts. As long as the patient is consulting the public health services, which are responsible for paying for most of the evaluations and treatment, he/she should not only have rights, but also certain obligations: the obligation to give a true presentation and the obligation to cooperate to the extent possible. An announcement that certain demands will also be made on patients and not only on treaters may affect the treater-patient relationship.

But can the concept «patient obligation» be an ethically acceptable subject for discussion in political circles in today’s welfare Norway? Or internally by the different categories of treaters? Nevertheless, if the introduction of patient’s obligation could in any way contribute to reducing unnecessary use of health resources and the number of burnt-out health workers and patient tragedies, then perhaps it might be worth while looking at the problem in more detail? This evaluation would have to take place as a collaboration project between those employed by the health, social, and legal services, and politicians.

Reported conflicts of interest:

None.

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