What health providers know: a taxonomy of clinical disagreements essay examples

Experience, Belief

Having been involved in several cases, Daniel Groll's intention to provide a lasting solution to this problem intensified. His intentions are to develop a model for understanding disagreements in a clinical setting. Groll at providing insight into what doctors can and cannot plausibly be said to know regarding what's best for their patients. Groll deals with this by developing taxonomy of clinical disagreements. Groll's secondary aim is to show that Robert M. Veatch's theory on what on what clinicians can and cannot about their patients' well-being is overly skeptical and limits the role. In the article, Groll presents a case and a set of scenarios that he refers to throughout the article to support his model and beliefs and to disapprove Veatch's theory. What prompted him to come up with the theory was the misunderstanding between the doctor and his patient. Finally, it will be clear that Groll believes that in many cases, the health care provider knows what is best for his patient.

Groll presents a case and a set of scenarios regarding a patient, Mr. Johnson. The patient suffers from type 2 diabetes mellitus and has wet gangrene on his baby's toe. Mr. Johnson's physician, Dr. Garcia, is determined that the infection is so severe that the only treatment is amputation otherwise, the patient would die. Mr. Johnson has been declared competent in consultation with psychiatrist. Groll presents three different scenarios related to the case which he intends to develop his taxonomy around. In the first scenario, Mr. Johnson believes that the treatment would not help the patient's life and would get better without the treatment. In the second scenario, the patient believes that God will cure him without any medical any medical intervention. Lastly, the third scenario, Mr. Johnson is deeply attached to

having his body intact that he would rather die with ten than living with nine.

Groll develops taxonomy of clinical disagreement by comparing and analyzing the scenarios presented above. Take scenario one and two, the doctor and the patient have different goals; the doctor believes that amputation is the best option while the patient would that remain with his sickness and hopes for God’s intervention. However, both have one goal; to cure the patient. In these scenarios, believes that amputation is not the alternative. This is because he is so used to intact body and fears any attempt to take any part of his body in the name of curing him. Looking at scenario three, the patient agrees to the doctor’s suggestion, however, the patient does not want to live without his toes. Therefore, scenario three presents a disagreement in the goal in the goal of the doctor without that of the patient. Groll calls this type of disagreement an end disagreement. He supports his thesis by carefully bringing to board the doctor’s opinion and the patient’s belief.

In further developing his model, Groll breaks down the scenarios for easy analysis. Given the first scenario, Dr. Garcia, as Groll demonstrates, would simply use medically backed evidence that proves that shows that the treatment prescribed is effective and the patient’s belief is incorrect. By providing medical reasoning, empirical evidence, to support his view, Dr. Garcia will have what Groll refers to as a non-medical assessable disagreement. The reasons being, there is no such evidence as empirical evidence, to show that. It is within the doctor’s jurisdiction to decide what is best for the patient. Thus, he should employ his expertise to save the

situation. There is no medical reasoning to solve the disagreement in the third scenario. However, outside his role as a doctor, Dr. Garcia, as a sound and rational doctor can determine that the patient's decision is not logical and with strong grounds, she can guide the patient or have others influence the patient in making a logical decision. In all cases, Groll acknowledges that the patient's autonomy must be respected.

Groll splits scenario two into two sub scenarios; " God save" and " God saves me" to better illustrate between a medically assessable disagreement when versus a non-medical assessable disagreement. Given that God is not a part of medical science, medicine does not deny or support the power of God under any circumcise. Groll illustrates that the " God saves" scenario is a medically assessable disagreement via empirical testing by showing, through studies that patients with the same condition and opted not have amputation died. That means that they were not cured by any means including God. Looking at the" God saves" me scenario, the patient believes that God will specifically cure his condition. Given this scenario, the only way out is to let the patient die, which would be pointless. Using this scenario, Groll argues a non-medically assessable disagreement as the doctor. Outside his role as a medical expert, he can only try to show the patient that other patients with the same condition died after making bad decision, thus trying to persuade the patient to make the right decision.

With his expertise and taxonomy, Groll argues against Veatch's theory that in most cases, doctors do not know what is best for the patient's well-being, medical or otherwise. Both Veatch and Groll appear to agree that health providers' medical competence is not a dispute. Veatch, however, seems to

believe that clinicians ought to make logical judgment regardless of the patient's belief. Clinicians ought to combine their medical expertise and logical decision to make judgment. Groll, on his part believes that clinicians, as sound minded, rational and psychologically healthy persons can weigh and make logical decisions on what is logically best for the patient even in the case of nonmedically assessable disagreements. Groll differentiates between what is best as a psychologically healthy person outside the role of a physician and having special expertise as a physician to know the best. Both Groll and Veatch agree that a competent patient has the right to make their own decisions relating to his health. Based on his taxonomy presented, Groll believes that by carefully believes that by carefully separating means-end disagreement and disagreement, numerous decisions where the clinicians know what is best. Groll believes that the fact that Veatch fails to make is that between lacking expertise and knowledge, something that he feels he makes when comparing the different scenarios. Groll is convinced that clinicians have a special responsibility to patients to look out their well-being and that his taxonomy will help to guide the health providers when faced with disagreements. The taxonomy solves the disagreement whereby the patient has a different opinion from the doctor's point of view, which of course is the best option for patient.

Assignment 2- summary & Vulnerable Aspect

In the article, Daniel Groll's intentions are to develop a model for understanding disagreements in a clinical setting for the purpose of guiding health care providers in understanding their role when such disagreements arise. Groll aims at providing insight into what doctors can and cannot

plausibly be said to know regarding what's best for their patients. Groll goes about this by developing taxonomy of clinical disagreement. Groll's secondary aim is to show that Robert M. Veatch's theory on what clinicians can know and cannot know about their patients' well-being is overly skeptical and limits the clinician's role. In the article, Groll presents a case and set scenarios that he refers to throughout the article to help illustrate his model and beliefs and to disapprove Veatch theories. In the end, it will be clear that Groll believes that in many cases, the health care provider knows what is best for his patient. However, I intend to show that argument is most vulnerable in regards to physicians laying claim to know what is best for patients when faced with nonmedically assessable disagreements. He clearly develops the model to instill in doctors the fact that they ought to make more informed decisions regarding their patients' well-being.

Groll presents a case and a set of scenarios related to a case regarding a patient, Mr. Johnson. The patient from diabetes mellitus and has wet gangrene on his baby toe. Mr. Johnson's physician, Dr. Garcia, is determined that the infection is so severe that the treatment is amputation or else, the patient could die. Mr. Johnson has been declared competent following a consultation with a psychiatrist. Groll present three scenarios related to the case from which he intends to develop his taxonomy. In the first scenario, the patient the treatment will not save his life and he will get better without the treatment. In the second scenario, the patient believes that God will cure him without any medical intervention. Lastly, in the third scenario, Mr. Johnson is so attached to having an intact body that he would rather die with ten toes than to live with nine.

Groll develops taxonomy of clinical disagreement by comparing and analyzing the scenarios presented above. Focusing on scenarios one and two, the doctor and the patient aim at a gangrene free- patient. However, they disagree on the steps to be taken to achieve this common goal. In these scenarios, the patient believes that alternatives to the prescribed treatment will cure his condition and the doctor agrees to his opinion citing that the patient is competent. Groll calls this disagreement a means -end disagreement which he simply stated is a disagreement on how to achieve a common goal. In scenario three, the patient agrees to the doctor’s opinion regarding the necessary treatment to cure gangrene. However, the patient does not want to be without his baby toe. Therefore, scenario three presents a disagreement in the goal of the doctor and that of the patient. The purpose Groll intends this to serve is to help categorize different types of disagreements the health care providers may encounter in a clinical setting and to provide them with guidance on how to approach different categories of disagreements. He looks at the scenarios and advises the clinicians to analyze and understand the disagreements and make logical decision regarding the patient. In fact, he suggests that the clinician can persuade the patient to take the best option regarding his health.

In further developing his model, Groll breaks down the scenarios. Given the first scenario, Dr. Garcia, as Groll illustrates, would simply use medically backed evidence that shows that the treatment prescribed was effective and that the patient’s opinion regarding the treatment is incorrect. By providing medical reasoning, empirical evidence to support his view, Dr. Garcia will have what Groll calls a medically assessable disagreement. Given a

medically assessable disagreement, Groll argues that a doctor has special expertise in his role as a doctor which contains a high degree of certainty regarding knowledge of what is best for a patient. Looking at scenario three, Groll presents to us what he calls a nonmedically assessable disagreement. The reason being that there is lack of empirical evidence that the doctor can present which shows that, or else being equal it is better to live longer life without the baby toe. There is no medical reasoning to solve the disagreement in scenario three. However, outside his role as a doctor, Dr. Garcia as a sound minded and rational person can determine that the patient's decision is a bad one and on that ground, she can guide the patient or have other influence the patient in making a logically good decision. When encountered with a nonmedically assessable disagreement, Groll argues that although a doctor may not have special expertise within their role, they still, in many cases, have knowledge to help them determine what is best for their patients. Knowledge, however, does not suggest certainty as it lacks empirical evidence. The doctor's knowledge cannot be verified since there is no evidence to support his knowledge. In all cases, Groll acknowledges that the patient's autonomy must be respected and that the authority bestowed upon doctors by society must not be abused by ignoring a competent patient's decision. This is in spite of all the belief that the doctor has that the patient's decision is a bad decision.

Groll splits scenario two into two sub scenarios; " God saves" and " God saves me", to better illustrate between a medically assessable disagreement and a nonmedically assessable disagreement when faced with a case of means-end disagreement. Given that God is not part of medical science does

not deny or support the power of God in any circumstances. Groll illustrates that the “ God saves” scenario is a medically assessable disagreement via empirical testing by showing through studies that patients who opted not to have the amputation died. This proves that they were not cured by any means including God. Looking at the “ God saves me” sub-scenario, the patient believes that God will specifically cure his condition. Given this scenario, the only way to provide medical evidence would be to allow the patient to suffer and finally die which would be pointless. Using this scenario, Groll argues that a nonmedically assessable disagreement, as a doctor, outside his role as a doctor, can only try to show that other patients with the same condition died and that he is making a mistake, thus trying to persuade the patient to make the right decision. In both sub-scenarios, Groll argues that the doctor can lay claim to knowing what is best and again differentiates between having special expertise with a high degree of certainty within their role as doctors and having knowledge as normal, psychologically healthy people outside their role. The latter does not suggest certainty.

Using his taxonomy, Groll argues against Veatch’s theory that in most cases doctors do not know what is best for the well-being of the patient, medical or otherwise. Both Veatch and Groll appear to agree that the health care provider’s medical competence have not dispute. Veatch believes that all clinical decisions involves making logical judgments and that therefore the health care providers are not in a better position to determine what is best for their patients. Groll agrees with Veatch to a certain extent but argues that Veatch fails to make distinction between means-end disagreement and

end disagreement. Groll agrees that all decisions involve making value judgment but argues that, specifically in means-end disagreements, value judgments are not at dispute as the doctor and the patient agree on a common end and therefore as outlined in the taxonomy, provided doctors can lay claim to knowing what is best for their patients. As such they can guide treatment decisions both in medically assessable disagreement. Groll also agrees that Veatch's argument holds some merit in regard to end disagreements as in these disagreements, value judgment are at dispute. Even so, Groll argues that doctors can still lay claim to know what is best as normal, psychologically healthy people outside their role as doctors and can guide patients in making the right decision even in nonmedically assessable disagreement. Groll differentiates between laying claims to knowing what is best outside the role of physician and having special expertise as a physician to know what is best. Both Groll and Veatch agree that a competent patient has the right to make his own decision relating to their health. Based on the taxonomy presented, Groll believes that by carefully separating means-end disagreement from end disagreements, many decisions where the clinicians can lay claim to knowing what is best and only degree of certainty can be disputed. Groll's belief is that clinicians have a special responsibility to patients to look out of their well-being and that his taxonomy will help guide these health care provider when faced with disagreements. This is important because it gives a clear way forward to clinicians in solving different disagreements. Groll's argument is most vulnerable in regards to health care providers laying claim to knowing what is best a competent patient as a normal, psychologically healthy people when it comes to nonmedically

assessable disagreements. Groll himself suggests that the physicians' knowledge of what is best outside the medical sphere, nonmedically assessable disagreement. I do not dispute that physicians can lay claim to knowing what is best for his patient with a high degree of certainty when faced with medically assessable disagreements as they can claim to have special expertise. However, I intend to show that Groll's argument that a health provider can lay claim to knowing what is best is false. I believe that health care providers, as all other professionals, are biased in their opinion of what is best for a patient. Each patient has unique values and beliefs. I believe that the health care provider is in no position to judge a patient's values and as a matter of fact is less qualified to lay claim as to knowing what is in the best interest of a patient than is an ordinary citizen when faced with a nonmedically assessable disagreement. Groll argues that health care providers have a special responsibility to their patients to look out for their well-being. I believe that health care providers have a biased impression of what accounts for total well-being by places a huge emphasis on medical well-being while ignoring other spheres of life that account for total well-being. The patients' formula and the health care providers' formula for calculating total well-being each assign different weights to each element. It is more than likely that the health care provider will assign more importance to medical well-being than would the patient, to what extent relies on the patients value judgments and sacrifices they would be required to make. My health care provider wants me to attain optimal health and will suggest that I allocate the bulk of my resources in pursuit of this while in the mean time I just want to be healthy enough to enjoy the things in life that are fulfilling to

me. Therefore, I believe that a health care provider can only get lucky and guess what is best for a patient when it comes to nonmedically assessable disagreements as they truly cannot valuate the importance of the patient's interest and beliefs. The patient's healing is psychologically attached to his beliefs and any attempt to go against them can turn out to be dangerous on his health. As such, Groll's idea may not help much when the patient stands his ground.

Basing my argument on Groll's taxonomy, I believe the clinicians have all the responsibility to advise the patient appropriately to make informed decision. However, it is within the patient's mandate to make the last decision. Let's take an example of a patient's total refusal to undergo

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the treatment as prescribed by the doctor, and the doctor insists on treating the patient. The patient's beliefs and interest will have been tampered with. Moreover, any failure in the treatment will be blamed entirely on the clinician. This may put the expertise and knowledge of the clinician at a stake. Again, the success of a treatment is attached to the psychological preparedness of the patient. In such case, the patient's psychological set up may reject the treatment hence failure of the treatment. Take the case of Mr. Johnson who is so much attached to living with all his body parts intact, any attempt to amputate his baby toe without his acceptance would definitely result into a failed treatment. This would finally turn to be blame on the part

of the clinicians, their knowledge of what is best notwithstanding.

In fact, is the legal right of the patient to be heard and to be respected in spite of the dangers the patient is exposing himself to. To an extent, the clinician’s role ends at persuading the patient to make informed decisions. Even as such, it is still the responsibility of the clinicians to support the claims with facts to change the way of thinking of the patient. The most viable facts could be by giving example of people who made the same decision died. Therefore Groll’s taxonomy is only helpful if it can change the patient’s decision in respect to the doctor’s advice.

Works Cited

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