

"I WOULD PREFER NOT TO". AUTONOMY AND THE BOUNDARIES OF MEDICAL INTERVENTION

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Mrs. G.O. is an 80-year-old retired high school teacher, a kind widow for the past decade. Her only son passed away in his youth, and she has no immediate family. At her first consultation, she stated, "Doctor, I'm alone, but I have friends and some distant nephews and nieces." The choice of the verb "to be" in "I'm alone" (*Yo soy sola*) as opposed to the more temporary "to be" (*estar*) in Spanish, underscores a sense of permanence in her condition, offering an insight into the nuances of the Spanish language that English speakers often find complex. Mrs. G.O. lives modestly in her home, accompanied by two cats and a rescued dog. Her medical history includes hypertension, managed with valsartan, bisoprolol, and furosemide; anticoagulation therapy with apixaban for atrial fibrillation; type II diabetes; overweight; and dyslipidemia treated with fenofibrate.

She was referred to the hematology department after her blood tests revealed *rouleaux* formation, an elevated erythrocyte sedimentation rate and a monoclonal band in the electrophoretic proteinogram. After several consultations, these findings led to the diagnosis of multiple myeloma. Bone marrow biopsy showed 30% infiltration of plasma cells without high-risk features. Renal function was normal, calcium levels were within range, she had no anemia or bone lesions, but the elevated plasma levels and ratio of free light chains indicated the need to begin treatment.

When informed that treatment was necessary and it would be tailored to her health conditions, Mrs. G.O. responded with a phrase that carried unexpected weight:

"Doctor, I prefer not to do it." Efforts were made to reassure her that treatment would be primarily oral, would not require hospitalization initially, and that consultations could be spaced out. Yet, she maintained her position: "I understand, Doctor. But I prefer not to do the treatment."

In the bright light of modern medical science, a determined patient with multiple myeloma refusing treatment with a phrase both unexpected and perplexing inevitably stands out. While Mrs. G.O. did not use the conditional tense of Melville's famous "I would prefer not to" from *Bartleby, the Scrivener*¹, her deliberate use of the present tense gave her statement an unshakable firmness. Nonetheless, her words conjured Melville's phrase as if she had uttered it precisely. Some have argued that Melville's formulation, while grammatically peculiar², possesses an extraordinary power, and in that moment within the confines of the office, the echoes of countless essays on those five words in their original English form, "I would prefer not to," filled the air.

Today, a patient refusing treatment for early-stage cancer presents a unique challenge to the attending physician. Embedded in the collective unconscious is the "war on cancer," declared by U.S. President Richard Nixon in 1971³, employing the kind of militaristic metaphors decried by Susan Sontag⁴. That war has never officially ended; no truce has been declared, and humanity remains entrenched in the battle. A person who voluntarily steps away from this war is seen as a deserter. The situation is so unusual that medical protocol dictates verifying the patient's mental state to rule out depression or other psycho-

logical factors that might explain their decision to reject life-prolonging treatment. Conversely, when patients accept treatment, no such verification is required, as it is assumed to be the "normal" course of action.

Mrs. G.O. clearly articulated her reasoning: *"Doctor, I've lived my life. I'm old. I already take too many medications. I don't have family, and it would be very hard to deal with side effects and such dependence on the hospital. As long as I can take care of myself, I don't want any more treatments—at least not for now. Let's talk in a few months, if I'm still here."*

This situation forces to pause and reflect on the essence of the doctor-patient relationship, the respect for autonomy, and the benefits of modern treatments. It raises the question of whether a refusal to follow medical advice constitutes a challenge to the authority of the physician, who more often prescribes than suggests a specific path forward. Medicine, guided by scientific knowledge, aims to prolong life, improve its quality, or alleviate suffering. However, the acceptance of treatment is ultimately a deeply personal decision. In this case, the patient, fully aware of her diagnosis and the available therapies, chose not to embark on a regimen that, while medically recommended, did not align with her life vision or values. Her decision was not rooted in ignorance or fear, nor in depression, but rather in a serene determination that, like Bartleby, rejects the expectations imposed upon her by the world.

Doctors often find it challenging to face these decisions, as they clash with the impulse to act, to intervene, to "do something." Experience shows that some patients who decline treatment, far from experiencing rapid deterioration or inevitable suffering, can lead acceptable, even fulfilling lives on their own terms for variable periods. They may express this preference even if their survival time might be shorter, valuing instead the notion of a better quality of life. Traditional academic medicine has sought to demonstrate that abstaining from treatment is associated with significant reductions in life expectancy⁵. How-

ever, studies applying this concept have, in some cases, misrepresented the meaning of refusing conventional treatments or using complementary therapies. These studies have been harshly criticized for drawing conclusions that may have been somewhat premature⁶. Such cases suggest that quality of life is not always defined by biomedical standards but rather by the meaning each person finds in their existence, even in the context of serious illness.

Accepting a refusal of medical recommendations does not mean abandoning the core principles of the profession; rather, it reflects a deeper understanding of medicine's essential role as a caretaker of others. It signifies respecting the patient's priorities and recognizing that medicine is not an exercise in control but a dialogue between science and humanity. As the principle of autonomy teaches, the task is not to impose treatments but to provide clear information, explore expectations, offer support, and, when the patient's decision diverges from medical advice, accompany them without judgment on the path they have chosen—so long as it is compatible with the physician's own ethical stance.

Studies have shown that patients' preferences to refuse treatment often persist even when they understand that conventional medical interventions could extend their lives. What they value instead is the absence of adverse effects and the possibility of maintaining a higher quality of life⁷.

Ultimately, confronting such dilemmas humanizes the physician. It forces them to grapple not only with the limitations of medicine but also with the profound complexity of life and death, which do not always follow predictable paths. Perhaps, like Bartleby, Mrs. G.O. teaches us something beyond her illness: the importance of preserving everyone's right to say, "I would prefer not to," and finding in that refusal a space for compassion and shared humanity. Bartleby chooses to end his story on his own terms, and the closing exclamation of Melville's tale still resonates: "Ah, Bartleby! Ah, humanity!"

References

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