Chapter One

Physician-Patient Relationships

1 General Features

The goal of this section is to reflect on the nature of the physician-patient relationship and to assist you in understanding the basic values that you can draw upon in discussions of specific issues and in your thinking about ethical dimensions of medicine. This relationship embodies certain important elements. We agree with Mark Siegler:

If moral certainty exists in medicine (that is, if it is possible to determine which actions in a medical context are moral and ethical, which are right and wrong), such moral certainty will be discovered not by recourse to formal laws, moral rules, or moral principles, but rather in the context of the particularities of the physician-patient relationship itself. (Siegler 1981a, 56)

What Siegler is speaking of is a moral counterpart to “clinical wisdom.” A proper understanding of and appreciation for these traditional medical values provide sound guidance in the face of influences (both societal and personal, some now on the scene and others on the horizon) that threaten to undermine them.

1.1 Fantasies: A Thought Experiment

Think back a few years to when you first envisioned going into medicine. Try to remember the answers to the questions below as a way of reconstructing your image of medicine at that time. [NOTE: Check the appropriate items on the page as you go through the exercise (or, if you have a psychological block instilled by elementary school teachers against writing in books, make notes on paper). You will be asked to reflect on your answers throughout this chapter.]
Instructions: For each question, indicate by some symbol as many items as apply; if one item on the list has been dominant in your fantasies, indicate it by a double symbol. Symbols to choose from include

\[ \sqrt{ } \quad \dagger \quad \_ \quad * \quad X \quad + \]

Several symbols are included to encourage you to return to this exercise periodically to measure changes in your image of medicine. Date the symbol you use now, and choose another the next time you work through this exercise.

1. What was the setting in which you imagined yourself practicing medicine?
   - an office
   - a hospital ward
   - an operating room
   - an emergency room
   - at the scene of an accident
   - a social setting (e.g., at someone’s home, at church) in which an emergency arises
   - a social setting in which someone asks for your advice and counsel
   - making a house call
   - practicing medicine in a research laboratory
   - other (specify): ________________________________

2. What was the nature of the interaction that represented your image of "practicing medicine"?
   - a procedure (e.g., sewing up a wound, CPR)
   - writing a prescription
   - giving an injection
   - giving advice
   - acting to comfort a patient
   - listening to a patient
   - other: ________________________________

3. What was the outcome of these interactions in your fantasies?
   - always favorable and dramatically so
   - usually favorable, but often not dramatically so
   - unfavorable as often as favorable, routine as often as dramatic
   - generally or always unfavorable
   - other: ________________________________
4. What was the patient’s reaction to this interaction and outcome?
   ___ dramatic relief and gratitude
   ___ quiet relief and gratitude
   ___ relief but not gratitude
   ___ indifference
   ___ quiet sadness
   ___ dramatic ingratitude and anger
   ___ other: ____________________________________________

5. Who were observers of the scene (besides yourself and the patient)?
   ___ an assorted throng
   ___ your family and/or friends
   ___ the patient’s family and/or friends
   ___ others: ___________________________________________
   ___ no one else

6. What was your personal reaction to the interaction and outcome?
   ___ relief
   ___ happiness
   ___ pride
   ___ sadness
   ___ guilt
   ___ anger
   ___ other: ____________________________________________

7. Which of the following were never included in your fantasies?
   ___ being called out in the middle of the night
   ___ resenting being called out in the middle of the night
   ___ informing a patient of a diagnosis of a terminal illness
   ___ sending a bill
   ___ a patient’s nonpayment of a bill
   ___ an angry patient
   ___ a patient you found yourself disliking
   ___ a personal feeling of uncertainty over what to do for a particular patient
   ___ uncertainty within medical science over what to do for a particular patient
   ___ a bad outcome
   ___ a personal feeling of failure at a bad outcome
   ___ certifying a psychiatric commitment
   ___ finding a patient’s problem uninteresting or boring
   ___ committee meetings
   ___ “pulling the plug” on a patient
dictating patient records
filling out forms
being sued by a patient
sexual attraction to a patient
subduing a combative patient
being chosen for a medical honorary society
informing the family about the death of a patient
winning the Nobel prize
other items:

1.2 Expectations

These fantasies have their basis in your process of growth and development. Examination of them is worthwhile, for this process gives clues to your view of medicine. Take some time to probe what lies behind these images, i.e., what particular events prompted you to think of medicine in this way, as well as what aspirations and life plans they reflect.

What elements of these fantasies remain with you? (Go back through questions 1–7 in Section 1.1 and use a different symbol to mark your present images of medical practice.)

Compare the two sets of answers and consider what images you are disappointed to have lost in your present, more realistic, understanding of medicine. Is your present understanding of medicine wholly realistic, or might your picture of it change as much in the next ten years as it has since you first entertained these fantasies? Most important, which of these thoughts about the medical enterprise represent fundamentals of being a physician, and which represent the "trimmings"? These are questions to tackle in depth in the next sections.

1.2.1 What Do You Expect from Yourself as a Physician? Reflection on the elements of your fantasies can reveal your expectations of medicine as a career and of yourself as a physician.

A. Motivations Examine these and try to determine whether your motivations are adequate to the tasks ahead.¹

1. If reflection reveals, for example, that your expectation is for medical practice to be an unbroken series of dramatic successes, then you are bound for frustration.

¹ Helpful reflection on motivations for and emotional reactions to medical training and practice is found in Knight (1981), especially Chapter 1: "The Decision to Become a Doctor."
2. If, on the other hand, your expectation is for an uninterrupted flow of dramatic failures accompanied by reactions of anger from patients and guilt on your part, then you should check yourself for masochistic tendencies.

3. If a dominant motivating force for you is the expectation of esteem and gratitude from patients as a prerequisite for a sense of accomplishment, you may have difficulty coping with reactions of anger or indifference from patients. The emotional reaction may hamper your capability to carry out adequate care of such patients. What motivating, moderating, or restraining resource is available within yourself that you can draw upon in such a situation?

   a. Resignation to self-sacrifice or martyrdom? If so, do you really undergo this to help patients, or are you acting for the sake of the good feeling you get from having practiced self-sacrifice?

   b. Unbounded love for humanity? Has this been tested and shown adequate to the task? If not, perhaps you had better not count on it.

   c. Dogged determination to “do a job right” once you have undertaken it? Has this been tested in prolonged and difficult tasks such as those facing you in a medical career?

   d. Curiosity about human nature, allowing you to create an emotional distance from certain situations by intellectualizing them? Could this not result in “bottling up” your negative reaction to this type of patient, perhaps allowing it to “spill over” into your private relationships?

   e. Self-discipline, by which you adhere to a code of professional behavior? How can you be sure what the code requires in every situation?

Some of these responses may sound cynical, but they are not meant to be. The point is to make you aware that not every motivation is adequate to the tasks you will face as a physician. However, physicians do manage to cope with situations like these, so it must not be impossible to find the motivating force to do so. It is likely that different motivations, and combinations of them, function in different people and in changing situations.

Considerations of motivation are relevant to judgments about a person’s character but in most systems of ethical theory, they are not directly relevant to judgments about the rightness or wrongness of a person’s actions. In other words, the fact remains that a person did the right (or wrong) thing, irrespective of the motivation that prompted the action. If Alberta and Alfred perform identical actions in identical circumstances, then their actions are subject to identical moral assessments—even if their motives were radically different. Differences in motive might lead to differences in assessments of the agents’ character, but this does not affect judgments regarding the rightness or wrongness of their actions. For example, suppose Alberta and Alfred each jump into a lake to rescue a small child who has fallen into the water. Examination of their motives reveals that Alberta
acted solely (or primarily) out of concern for the life of the infant, whereas Alfred's primary motivation for acting was the realization that television news cameras were rolling, recording the event, and that he is likely to receive a public acclaim as a hero. Both did the right thing in saving a life, but we regard Alberta with a moral respect (a character judgment) we would not confer on Alfred.

Even in the domain of character judgments there may be alternative motivations that are equally morally respectable. Immanuel Kant, an influential moral philosopher from eighteenth century Germany, denied this. He maintained that the only morally worthy motive was a "sense of duty," i.e., doing a thing because of acknowledgment that it is one's duty. However, most moral theorists would allow for a wider range of morally worthy motives. Consider Biffy and Buffy, who also rescue drowning infants in circumstances much like the pair in the previous paragraph. Biffy's primary motive for rescuing the infant was a sense of affection and helpfulness toward small children. (This motivation also prompts him to go out of his way to push children sitting alone in swings on public playgrounds, for example, or to rescue balls gone astray from children's games.) Buffy's primary motive was a sense of concern for the parents and a recognition of the blow they would experience if their child drowned. (The influence of this motivating force could also be detected in other actions. Buffy does not bother to push children in swings or to return balls that fly over the fence and land at her feet, but she has exerted a lot of energy to develop a "Parents' Day Out" program at the community center.)

Surely both Biffy and Buffy merit respect for their actions, in pretty much equal degrees. Both of these motivations are worthy and, indeed, laudable. Alfred "spoiled" his action, in character terms, by the unworthiness of his motive; but Alberta, Biffy, and Buffy would all be regarded as morally praiseworthy.

You may detect a variety of motives underlying the interest of your colleagues in medicine as a career (and there may even be a mixture of motives within yourself). However, many of these may be morally acceptable alternative forces prompting right action when the occasion calls for it. On-going self-examination can help determine the adequacy and soundness of your own motivating forces.

B. Specific Expectations To give some concreteness to these reflections about your expectations, allow us to offer a scenario of our own as a focus for discussion:

Lynn Languish sits in the waiting room. You sit in your office, dictating notes in the previous patient's record. As you finish your dictation and leaf quickly through the morning's mail, the nurse calls Lynn from the waiting room. They journey past the office scales; finally Lynn is installed in an examining room. You move down the hall to the room, remove the record from its rack on the door, and place your hand on the door handle. The clinical drama is about to begin.
What do you expect from this encounter and the many others like it, in which you will participate in your career in medicine? First, what is your primary focus in this sort of situation?

1. **Do you think of what is about to happen chiefly in terms of an intellectual puzzle of diagnosis and management of a disease process?**

If so, your focus is primarily on the disease rather than on the patient. You need to develop the habit of remembering that the patient is a person with a disease, and you must pay attention to the person's emotional reactions as well as to the pathophysiology of the disease.

2. **Does it occur to you that this interaction might be the source of a case report for a medical journal, or the start of a research project, or some other means to increase your professional laurels?**

This is an extension of the previous pattern, and the same warning applies.

3. **Do you think of this patient encounter in terms of the contribution it might make to the success of your department or university? Do you think in terms of how you will be evaluated by your resident or the supervising faculty, or perhaps of the impact it might have on your being chosen for advanced training or selected as chief resident, or the like?**

If so, you are reflecting patterns of socialization that have an important influence in medical training, but you must not lose sight of the needs of this particular patient in the process.

4. **Do you think of what is to come chiefly as an occasion for helpfulness to the patient?**

If so, what will be your reaction if you are unable to accomplish any helpful result? Will it be enough to have made an earnest attempt? What demands do you make on yourself in terms of intellectual preparation for this helping role?

Furthermore, you should examine the underlying basis of this attitude. Why do you seek to be helpful? Is it because of a sense of religious obligation, a felt professional standard, some past social experience, or some other source?

5. **Do you think of the encounter chiefly as an occasion for socialization and/or an opportunity to satisfy your intellectual curiosity about people?**

Here you must consider whether the questions you ask the patient are intended to give information essential to render care, or whether their only function is to satisfy your curiosity.
6. Do you think of the encounter chiefly as a chore? Is your only (or primary) motivation for acting to generate income, to fulfill a corporate contract, to satisfy the demands of a teaching program?

These sorts of external motivations are inevitable from time to time; but if they become recurrent, it may be difficult to maintain the motivation to provide an adequate level of care.

7. Do you think of the encounter predominantly as an occasion for exercise of technical prowess?

If so, be sure not to overreact to the clinical signs in a way that creates opportunities for the exercise of technical skill when intervention is not strictly necessary. Sometimes prospects for monetary gain can enter here as well, as can the role expectations of your specialty field. ("If I am a(n) _______ologist, I am supposed to be doing ________oscopies!!")

8. Do you think of the encounter predominantly as an "ego trip," i.e., an occasion to be lionized by grateful patients?

This expectation may have been created by the actions of patients in the past. But you need to guard against coming to expect this reaction. Doing so might cause you to neglect the needs of the ungrateful patient.

C. Self-Reflection on Other Categories of Expectations  In connection with each of the categories listed below, answer the following questions:

— What specific expectations do you have of yourself in this area?
— What barriers or difficulties do you foresee in your attempts to meet these expectations?
— What steps could you begin taking now to overcome these barriers and/or prepare yourself to meet these expectations?

1. Moral behavior
   a. honesty
   b. compassion
   c. desire to help
   d. courage^2

2. Hard work, self-discipline

3. Skill, current knowledge, relevance; recognition that patients may not follow your advice, even when it is soundly based

4. Resourcefulness

5. Priorities for time use

6. Economic achievement

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2. For an interesting interpretation of the role of courage in medical practice see Shelp (1983).
7. Having your own psychological needs fulfilled; social recognition
8. Peer group recognition
9. Other: _______________________________________

D. Professional Standards  Do you expect yourself to abide by professional
codes? What guidance do they provide in defining your expectations of yourself as
a physician?

1.2.2 What Do You Expect from Patients?  It might be ideal if you could look
forward to treating only patients with whom you can relate comfortably and easily.
This would involve their being like you in the following respects:

— similar moral values
— similar social position
— similar cultural history
— similar religious views
— willing to act on your recommendations
— other: _______________________________________

However, this ideal is not likely to be realized. You will probably encounter many
patients who are different from you in important ways; you must begin to develop
the ability to work with them effectively. What traits can you reasonably expect
from patients?

Think of specific patients with social, cultural, religious, and sexual values that
differ from yours. Answer the following questions about your relationship with
these patients in connection with each of the traits listed below:

— What specific expectations in the area mentioned do you have of patients?
— What barriers or difficulties might be created by differences in expectations
  between you and your patients?
— What steps could you take in your dealings with patients to overcome these
  barriers?

1. Honesty
2. A desire to be well
3. A need that can be met by your skills
4. Trust
   a. that you bring adequate knowledge and skill to your work with them
   b. that your credentials are acceptable, giving you credibility
   c. that you will preserve confidentiality, and thus they speak openly
   d. that you have their best interests as a primary value

3. Chapter 2 will examine professional codes in some detail: the Hippocratic Oath in Section 1.1, the
AMA Principles of Medical Ethics in Section 1.2, and the American College of Physicians Ethics
Manual in Section 1.3.
5. A recognition that you are fallible and that medical science is limited, and thus that a good result is not guaranteed

6. Gratitude
   a. for your hard work
   b. for your concern and compassion
   c. for your expertise

7. Cooperation in paying your bill

8. Other: ________________________________________

Even these more limited expectations will not always be met. You must prepare yourself for dealing with patients who fail to meet your expectations and who thereby frustrate your attempts to work with them. Significant categories here include patients who are

— belligerent
— noncompliant
— repugnant
— seductive
— ungrateful.

Remember when you encounter these sorts of patients that even the patients who do not meet your expectations may benefit from their encounter with you. The ungrateful patient may not acknowledge the value of your clinical contribution, but it may still have its effect, and thus that patient may get well as quickly as the grateful patient. This is one place to ask yourself what your fundamental goals are. Would you count the outcome of healing without gratitude as a success or a failure? Surely there is an important element of success here, even though there is also frustration.

1.2.3 What Do/Should Patients Expect from You? Just as your image of the “ideal patient” may be far removed from the type of patient you actually encounter, patients may have an image of the “ideal physician” that is unrealistic and cannot be satisfied by you or anybody else. In the following discussion, elements of many patients’ expectations will be examined critically to ascertain what patients have a right to expect from physicians.

Among the roles patients may expect physicians to fulfill (in addition to the obvious) are the following:

— parent
— magician
— actor
— confessor
— advocate
In connection with each of these, answer the following questions:

— How often have you encountered patients who expect you to fulfill this role? Think of specific examples.
— When is this expectation appropriate?
— What difficulties does this expectation present?
— What steps could you take in your dealings with patients to reduce unrealistic expectations?

1.2.4 The Experience of Illness In this section the typical progression of steps toward and within patienthood is described in detail. Consider concrete examples throughout this discussion. If you or someone close to you has had experience with illness, think about how the various steps were exemplified in that situation. Otherwise (or also), think of examples of these elements in connection with patients you have treated, or in literary or biographical accounts of illness you have read.* Excerpts from one biographical account are interspersed throughout the discussion to provide a concrete example. At each stage continue identifying specific expectations and difficulties, as well as means to resolve them.

A. The Preclinical (or Nonclinical) Phase It is important to keep in mind that "patienthood is a psychosocial, not a biologic state. A person becomes a patient by consulting a physician, or a surrogate for one, in the officially legitimated health care system" (Eisenberg 1980, 279). The psychosocial history of persons before they become patients can be a significant element in the course of clinical encounters.

A.1 "Dis-ease" The path toward patienthood begins with some "dis-ease," i.e., some experience of distress or "an experience of unexpected discomfort, decrease in previous functional capacities or a change in physical appearance" (Eisenberg 1980, 279). The following description offers a dramatic example of this stage:

4. Several such accounts are listed in the "Further Reading" section at the end of the chapter.
He woke at 7 A.M. with pain in his chest. The sort of pain that might cause panic if one were not a doctor, as he was, and did not know, as he knew, that it was heartburn. (Lear 1980, 11)

This state of "dis-ease" should not be identified with states of organic pathology (which may or may not underlie it). Eisenberg (1980, 278) makes the distinction in the following terms:

Modern physicians diagnose and treat diseases, that is, abnormalities in the structure and function of body organs and systems; whereas patients suffer illnesses, that is, experiences of disvalued changes in states of being and in social function. Disease and illness do not stand in a one-to-one relation. Similar degrees of organ pathology may generate quite different reports of pain and distress; illness may occur in the absence of disease, as witness the high proportion of visits to the physician for complaints without an ascertainable biologic basis. The course of disease is distinct from the trajectory of the accompanying illness.\(^6\)

However, the occurrence of "symptoms" does not, by itself, turn the person into a patient. There are several intermediate steps along the way, each involving decision making by the prospective patient, "almost always with the participation of important others" (Eisenberg 1980, 279).

A.2 Interpretation To quote Eisenberg again: "The first decision must be made: is the change a 'significant' deviation or is it a 'normal' part of living? Can it be dismissed as transient? Is it to be attributed to some recent event: the 'wrong' thing eaten, having 'strained' a muscle, 'that time of the month'?" (Eisenberg 1980, 279).

If the symptoms can be explained away in some such manner, the person may attempt to cope with them on his or her own (at least for the present) without seeking outside help. To illustrate, the story of Dr. Harold Lear continues.

He went into the kitchen to get some Coke, whose secret syrups often relieve heartburn. The refrigerator door seemed heavy, and he noted that he was having trouble unscrewing the bottle cap. Finally he wrenched it off, cursing the defective cap. He poured some liquid, took a sip. The pain did not go away. Another sip; still no relief.

Now he grew more attentive. He stood motionless, observing symptoms. His breath was coming hard. He felt faint. He was sweating, though the August morning was still cool. He put fingers to his pulse. It was rapid and weak. A powerful burning sensation was beginning to spread through his chest, radiating upward into his throat. Into his arm? No. But the pain was growing worse. Now it

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5. See Coulehan (1980) for a fascinating description of three patients with identical diagnoses but markedly different courses of illness.

6. For further explication of this distinction between "disease" and "illness," see Cassell (1976).
was crushing—"crushing," just as it is always described. And worse even than the pain was the sensation of losing all power, a terrifying seepage of strength. He could feel the entire degenerative process accelerating. He was growing fainter, faster. The pulse was growing weaker, faster. He was sweating much more profusely now—a heavy, clammy sweat. He felt that the life juices were draining from his body. He felt that he was about to die.

On some level he stood aside and observed all this with a certain clinical detachment. Here, the preposterous spectacle of this naked man holding a tumbler of Coke and waiting to die in an orange Formica kitchen on a sunny summer morning in the fifty-third year of his life.

I’ll be damned, he thought, I can’t believe it. (Lear 1980, 11–12)

A.3 Seeking and Choosing Help If no satisfactory explanation can be found, the person may decide to seek outside help. But the question is still open whether the help sought will be medical. "Once it has been decided that something must be done, one has to identify the appropriate type of help: a family remedy, a folk healer, the local druggist, a chiropractor, a doctor. The choice is not unconstrained; it will depend upon the resources, both financial and cognitive, available to the person and upon the culture in which that person is imbedded." (Eisenberg 1980, 279).

Terrence Ackerman (1982) describes some of these constraints, although he focuses primarily on the clinical phase. The four kinds of constraints he enumerates—physical, cognitive, psychological, and social—all come into play in the pre-clinical phase as well. The emotional impact of illness (psychological constraint) is felt from the first recognition of dis-ease and the attempt at its interpretation. The limits to the patient's understanding of the situation (cognitive constraints) have a strong influence on the decision about whether to seek help, and where to go for it. Social and physical constraints limit the possibilities for seeking help even when it is decided that medical institutions are the appropriate recourse.

Slowly he tugged on a robe, staggered back into the foyer and pressed for the elevator. At this hour it was on self-service. When it arrived, he entered, pushed 1 and CLOSE DOOR, and braced himself against the wall. Suddenly he knew that if he did not lie down he would fall. He lowered himself to the floor. When the elevator door opened, he rolled out into the lobby and said to the startled doorman, "Get a wheelchair. Get me to the emergency room. I am having a heart attack."

"An ambulance, Doctor? Shouldn't we get an ambulance?"

"No. No time. A wheelchair." [The hospital—his hospital, where he was on staff—was nearby, a few blocks from his home.] Then he lost clarity. (Lear 1980, 13)

Lear chose to seek medical help (wisely, given his condition). However, many who experience illness do not seek medical assistance. "Up to this point, a whole series of transactions have occurred outside the official health care network and may never be known to it, unless it extends its purview beyond the door of the doctor's office and the hospital. Community studies indicate that some 75 to 90 percent of episodes self-identified as illness are managed entirely without recourse to the medical system" (Eisenberg 1980, 279).

A.4 Reasons The remaining 10% to 25% do cross the threshold to patienthood. Ian McWhinney (1972) offers a useful set of categories that he claims are exhaustive and mutually exclusive, for classifying these episodes:

1. Limit of tolerance: "'The patient comes because his symptoms are causing pain, discomfort or disability that have become intolerable.'"
2. Limit of anxiety: "'The patient comes, not because his symptoms are causing distress, but because of their implications ... because he, or a relative, fears the consequences of his symptoms.'"
3. Problems of living presenting as symptoms (heterothetic): The decision to come is "'due to a problem of living that has disturbed the equilibrium that the patient has established with his environment.'"
4. Administrative: "'This category covers doctor-patient contacts whose sole purpose is administrative, even though the patient is ill,'" e.g., excuses from school, filling out an insurance form, or certifying a period of disability.
5. No illness: "'This category includes all attendances for preventive purposes, such as antenatal or well-baby care, or for general medical assessment when no symptoms are offered.'"

B. The Clinical Phase Just as the prospective patient must make a judgment, on the basis of a complex of factors, about the appropriateness of seeking medical help, "similarly the physician now embarks on the difficult task of disentangling these multiple factors to determine whether the patient has found his way to the proper institutional setting, i.e., a medical setting, and whether the patient's problem is properly 'medical' rather than being a social, religious, political, or economic problem" (Siegler 1981b, 635).

B.1 Clinical Method

What usually follows after the patient's initial presentation is a process which we have come to call the clinical method . . . [which] has two central components: 1) data-gathering, and 2) data-reduction and diagnosis. Both of these features of the clinical method, but especially the data-gathering phase, require a considerable amount of personal interaction and an exchange of information about both technical and value-laden concerns between the patient and the physician. (Siegler 1981b, 635)
Gathering and organizing data requires special sensitivity when (as frequently happens) the patient is unsure about the details of symptoms and/or interprets them in an unusual way. Furthermore, patients may not have made up their own minds about the value priorities involved in clinical choices. Thus, even here,

while the physician wears his persona of objective scientist, an enormous amount of human, personal, subjective interaction is occurring between patient and doctor. The eliciting of a medical history is not a job for machines and requires the profound subtlety that only trained, sensitive humans can bring to it. . . . Nor do I believe that the data-reduction phase which generates a diagnosis and a differential diagnosis is a mechanical process. The apparently scientific, mechanical [process] . . . is full of personal drama, and it leads inexorably to the individualization of the patient. . . . (Siegler 1981b, 636)

B.2 Recommendation and Negotiation  Ideally, the clinical method will yield a firm diagnosis for which some treatment regimen (or perhaps any one of several alternative approaches) is likely to be effective. Often, however, things are less clear-cut, and sometimes it will tragically become clear that no curative treatment is possible. In any case, the physician will be expected to offer recommendations. Pellegrino and Thomasma (1981, 211) speak especially of this clinical moment:

The end of medicine . . . is therefore a right and good healing action taken in the interest of a particular patient. All the science and art of the physician converge on the choice . . . a choice of what is right in the sense of what conforms scientifically, logically, and technically to the patient’s needs, and a choice of what is good, what is worthwhile for the patient.

Not only must the therapeutic course settled upon be worthwhile for this specific patient, but it must also be recognized as worthwhile by the patient. This is accomplished by the process of persuasion and negotiation that Siegler calls “the doctor-patient accommodation” (or DPA).

The careful physician will learn as much as possible about the expectations, values, and beliefs of the specific patient (insofar as these are settled in the patient’s own mind) and will take this information into account in formulating recommendations for this case. (This shows the merits of a complete psychosocial, religious, and sexual history.)

However, it is not enough to formulate a recommendation that is both right and good. If the patient cannot be made to see its appropriateness, he is unlikely to carry it out, and thus it will have as little effectiveness as a medically non-therapeutic regimen. Our legal and social structures leave the decision about cooperation with the physician’s recommendation to the patient.4

The physician and patient must come to agreement about the elements of their cooperative endeavor through a DPA.  

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8. See Section 3 of this chapter for further analysis of the legal and ethical requirements of informed consent, the primary social structure referred to here.
The process is one of communication and negotiation—sometimes short and to the point, sometimes extended—on what rights and responsibilities each of the participants wishes to retain and which will be relinquished in the context of their medical relationship. From the moment the patient originally presented to the physician’s attention, testing has been undertaken by both parties to decide whether this patient and this doctor wish to work together. (Siegler 1981b, 637–638)

This is the point at which you can communicate your expectations of patients (see Section 1.2.2) as well as your self-expectations (Section 1.2.1). If there are serious discrepancies between what the patient expects of you and what you are willing to provide, then perhaps no DPA can be reached between you and the patient, who should be advised to seek care elsewhere. If there are less serious discrepancies, compromise on both sides may be necessary to reach a DPA satisfactory to both parties. You need to define the points on which you are (and those on which you are not) willing to compromise your expectations in the interest of reaching accommodation with specific patients.

Often the patient remains unclear about what he wants, and he may abdicate his responsibility in the DPA. (‘‘Just do whatever you think is best, Doctor.’’) However, it is unwise for the physician to accept this invitation to paternalism at face value. The patient is the one who must live (or perhaps die) with the choices arrived at in the DPA, and he should be gently guided to work out a basis of values for participation in these choices. Otherwise, as the situation develops, the patient is unlikely to honor the choices through compliance, since he feels no ‘‘ownership’’ of them.

B.3 The Physician-Patient Relationship  Siegler describes the physician-patient relationship as ‘‘characterized by mature and enduring exchanges of trust between the patient and the physician, which establish an almost inseparable bond. If such an exchange of trust occurs, it serves as a stabilizer of the medical relationship even during periods of new and difficult stresses’’ (Siegler 1981b, 639).

The classic ‘‘chicken and egg’’ problem arises: Which comes first, the accommodation between physician and patient with regard to a specific treatment approach, or this deeper, more enduring relationship? Siegler insists that the former is prior:

In contrast to previous descriptions of the doctor-patient relationship [following Siegler, let us abbreviate this as DPR] which tend to regard it as an established, static arrangement between doctor and patient, the DPA provides a more dynamic and realistic model of the medical encounter. Perhaps DPRs as such rarely exist; rather, what we regard as a DPR may really be repeatedly negotiated DPAs. More likely, a DPR represents a specific, and increasingly uncommon variant of the DPA. It may be distinguished from the DPA by its duration, depth, and maturity. (Siegler 1981b, 639)
Certainly it is important to recognize that the relationship between patient and physician is dynamic and changing, but it is no less vital to recognize that many (though not all) such relationships contain from the start elements of a mutual bond of trust, depth of relationship, and expectation of an enduring continuation of the relationship. Without these, the physician cannot gain access to intimate information or cooperation for onerous treatment regimens.

It is true (as Siegler says elsewhere) that developments in technology, medical specialization, and institutional structures of health care create barriers to the early establishment of a “traditional” DPR. A full-scale DPR rarely occurs on the first encounter with a patient. Its development may be influenced by the setting of practice (Compare, for example, the clinic setting, an HMO structure, a group practice setting, and an individual practice: in which of these is a DPR likely to develop most quickly and naturally? Compare, also, a long-term relationship with a primary care provider to encounters with a specialist.) However, in spite of these difficulties, it is important to acknowledge that (1) the traditional relationship is still possible in many settings, and (2) it is still a goal to be vigorously pursued. Without the basis of trust and mutual regard, the DPA Siegler describes could not easily be achieved.

C. Extraclinical Elements Even during the clinical phase, there are elements of the patient’s life that are external to the immediate concerns of the health care system. These may have significant influence on the clinical course. Again, one important aspect of this is well illustrated in Dr. Harold Lear’s story:

Then, dimly, he felt himself being lifted onto a stretcher, sensed noise and light and a sudden commotion about him. They were giving him nasal oxygen, taking his pulse, taking his blood pressure, starting an intravenous, getting a cardiogram—the total force of modern emergency care suddenly mobilized; a team clicking away with the impersonality of an overwhelmingly efficient machine.

He understood that at this moment he was no more than a body with pathology. They were not treating a person; they were treating an acute coronary case in severe shock. They were racing, very quickly, against time. He himself had run this race so often, working in just this detached silent way on nameless, faceless bodies with pathologies. He did not resent the impersonality. He simply noted it. But one of the medical team, a young woman who was taking his blood pressure, seemed concerned about him. She patted him on the shoulder. She said, “How do you feel?” It was the only departure from this cool efficiency, and he felt achingly grateful for it. Ah, he thought in some fogged corner of the brain, she must be a medical student. She hasn’t yet learned to depersonalize. She will. We all do. What a pity.

(Later—he thought it was that same day, but it may have been the next—she came up to the coronary-care unit, and took his hand and said, “How are you doing, Dr. Lear?” and smiled at him. He never knew her name, and he never forgot her.) (Lear 1980, 14)
The patient will interpret events in terms of his cultural, educational, religious, and social categories of thought; and other people may contribute interpretive elements in communications with the patient. Furthermore, the patient may be preoccupied with events occurring outside the institution. It has been shown above that life stresses in the patient’s environment contribute to the step into patienthood. These events must not be forgotten by health professionals in the course of care, for they are a source of concern for the patient and may frustrate the best therapeutic efforts. The disruption the hospitalization produces in the patient’s social system may add new stresses, e.g., concerns about employment responsibilities or child care, financial worries, etc.

D. The Postclinical Phase  Except for those who remain in institutions permanently (whether for long-term custodial care, or in a short-term wait for death), patients have a life after the direct clinical interactions of patienthood. This can be divided into two sub-phases: recuperation and return to active life.

D.1 Recuperation  During the recuperation phase, the person is still partly a patient, for there are medical restrictions and/or treatment regimens to be carried out. However, the patient is no longer under the sort of total medical supervision that is possible during hospitalization, so the responsibility for carrying out these medical procedures is left to the patient and his or her social group.

This is an important part of the reason why cooperation, negotiation, or accommodation is to be preferred to an authoritarian or paternalistic approach. If you hope to influence patient cooperation after he or she has left direct medical supervision, it is important that the patient understand the issues and agree with the necessity for the procedures. (This may not, of course, be enough to guarantee cooperation, but without it noncooperation is virtually certain.)

D.2 “Back to Work”  The DPA and DPR are important even after the episode of illness, when the patient has returned to active life. Life-style changes that may prevent future illnesses can be a significant part of any DPA that has been reached. The trust characterizing the DPR (and the patient education stemming from this DPA) may be a significant influence in the patient’s decision to seek medical help the next time symptoms occur.

1.2.5 Expectations of/by Society  It is impossible to be a physician in isolation from others. This follows from the concept of a physician. If one of your colleagues jets to an uninhabited tropical isle immediately following graduation from medical school, before treating her first patient, to live a Robinson Crusoe existence, she would be “medically trained” but would not “be a physician.”

Medical practice depends upon society in more concrete ways as well. The government supports medical education through financial subsidies. The licensure system permits those appropriately trained to practice and enhances the prestige of the profession by providing legal barriers against practice by untrained, self-styled
healers (or even those whose training does not conform to the letter of United States standards).

Members of society make practice possible by submitting themselves for treatment, and special social and economic status is granted to members of the profession. Several authors have drawn ethical implications directly from this relationship of reciprocity, contract, or covenant between the profession and society (Ballantine, 1979; Chapman, 1979, 632; Veatch, 1981).

Even if one does not draw central ethical principles directly from the professional’s relationship with society, certain expectations of society must be acknowledged.

1. Society expects one who has accepted the training subsidized by its contributions to use these skills to promote the general welfare. A medical school graduate choosing not to employ those skills through practice, research, or teaching medicine tests this trust.

2. How much control over the location and form of one’s practice is society entitled to exert because of its contributions to medical training?
   a. Is it legitimate to provide scholarships conditional upon service obligations, while those who can afford to pay full tuition can avoid such obligations?
   b. Is it reasonable to require service obligations from all medical graduates, on grounds of national interest and/or some degree of governmental subsidy of virtually all medical education programs?

3. How important is the value of independence when balanced against society’s claims and needs?

These questions are considered at some length in Chapter 5.

Society also has specific expectations from physicians. It expects you to serve social institutions by certifying illness, disability, eligibility for various services, and the like. Society expects physicians to contribute to social decisions in matters relating to health. Consider other expectations by society you have encountered or expect to encounter in practice.

What specific things do you expect from society? What things do your patients expect? (Some answers to these questions will be discussed in Chapter 5).

1.3 Conclusion

Look back over this section to spot discrepancies between different elements you have examined. Do your expectations of yourself (Section 1.2.1) match likely patient expectations of you (Sections 1.2.3 and 1.2.4)? Do your expectations of patients (Section 1.2.2) match what patients are willing to offer as their part of the DPA (Section 1.2.4)? Are there serious discrepancies between what you and patients could agree on and expectations of society at large (Section 1.2.5)? If you
find significant discrepancies on any of these points, you need to begin to develop resources to deal with them.

You will examine specific elements of these expectations in the remainder of this and other chapters. Keep in mind the conclusions you have reached in this section, for you should bring them to the issues to which the discussion now turns.

# 2 Information Exchange

## 2.1 Relationships

As background for discussions of information exchange in the DPR, consider the expectations and obligations for providing information in the following relationships.

**2.1.1 Casual Encounters** You are flying home to visit your family. The person sitting next to you on the plane is a stranger, and is friendly. You chat casually from time to time, though you are both reading. When asked "what you do," you say only that you are "a student" and do not mention that you are in medical school. (Perhaps you are tired and not in the mood for the health history or the catalogue of gripes about doctors you know could follow your giving this information.) Then your neighbor calls your attention to a magazine advertisement for an acetaminophen tablet and asks, "I wonder if this stuff is really safer than aspirin? What do you think?"

How would you respond to this question? What is expected of you?

This stranger is clearly "making conversation." She may be genuinely interested in your opinion, which may influence her opinion on the matter. As a layperson herself (apparently), she has heard enough about this subject to have some concern about the relative safety of aspirin, and she assumes that you (whom she assumes to be a layperson) have been exposed to similar information. Her interest seems to be in hearing (1) something about what you have learned about this issue ("I have heard . . .") and/or (2) something about the impact this information has had on your own thinking about what pain reliever to take yourself ("I intend to keep taking my old reliable aspirin."). She would undoubtedly be shocked by either (3) an authoritative pronouncement from you without explanation (e.g., "Look, just ignore these 'scare pieces' in the popular press. Go ahead and take your aspirin and don't worry about a thing!") or (4) an elaborate explanation couched in scientific terminology.

If you give the sort of response she is expecting, your reply might have an influence on her thinking, but it will not be particularly great. She will consider what you say alongside what she has read and heard from others and, on that basis, she will make a decision.