PHYSICIAN- PATIENT RELATIONSHIP – AN ETHICAL PARADIGM

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Abstract

As far as the physician- patient relationship is concerned, the physician's primary responsibility is to promote the health and well -being of the patient directly under his/her care. At the same time, the patient's role in medical decision making is also debatable. There occurs a conflict of ideas when the values of the patient coincide with the value of the physician. This patient's autonomy and physician's dominance makes physician- patient relationship as unique, depending on the context, purpose and function of each physician- patient encounter and the specific expectations of all parties involved. These aspects vary from one culture to another and change over time. Hence, the different models of physician-patient relationship reflect the wide spectrum of the clinical encounter that are established in dissimilar situation and at different times. Therefore, out of the four different models, one single model cannot be labeled as perfect but time to time, these models are ethically evaluated and justified by normative standards. The model which fulfills the community's moral values is considered to be the preferred model. Therefore, it is right to say that the physician-patient models are culturally sensitive and dynamic.

Keywords: patient's autonomy, physician's dominance, decision making, four models of physician-patient relationship

Introduction

There has been a debate over the physician- patient role in medical decision-making that is often characterized as a conflict between autonomy and health, between the values of the patient and the values of the physician. Seeking to overcome physician's dominance, many have advocated an ideal of greater patient control.[1] Others have questioned the greater patient control because it fails to acknowledge the potentially imbalanced nature of this interaction when one party is sick and searching for

security, and when judgments entail the interpretation of technical information.[2] So others are trying to balance the more mutual relationship.[3] This discussion shapes the expectations of physicians and patients as well as the ethical and legal standards for the physician's duties, informed consent, and medical malpractice and it emphasizes that What should be the ideal physician-patient relationship?[4]

Hence in western society lot of work had been done on these issues but in our society these issues has not been well addressed. So we conduct a study regarding importance of ethics in which we included few questions regarding physician-patient relationship.

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Hypothesis

Hypothesis 1: Paternalistic model is preferable to other models in Pakistani society.

Hypothesis 2: Informative model is preferable to paternalistic model in Pakistani society

Hypothesis 3: Deliberative model is preferable to paternalistic model in Pakistani society.

Hypothesis 4: Interpretative model is preferable to paternalistic model in Pakistani society.

Methodology

This research article is from the original research done on importance of ethics in health service management. The research was done on 200 doctors and 200 patients as a questionnaire based survey. Many aspects of ethics have been included. Out of these major aspects one important aspect was physician-patient relationship. Two questionnaires were framed; one for the doctors and one for the patients. In these questionnaires few questions were related to physician –patient relationship. Of these questions, the following questions were asked and the responses were close-ended. What is the role of physician in Pakistani hospital? Do you believe in patient's autonomy in decision making of treatment plan? Is dominance of physician healthy in the treatment of patient? Has the physician ever discussed the treatment plan with you? Which model is preferable for the physician-patient relationship?

Place and duration of study: Different hospitals of Karachi including government and private sector hospitals. Duration of study was from 2009-2012.

Study Design: Questionnaire based observational and cross sectional survey.

Results

The results which are shown in table number 1-4 were asked from two hundred doctors and result of table number 5 were asked from patients of different hospitals. 64% of doctors mentioned the role of physician in Pakistan is that of the guardian and 75.5% favored physician's dominance in treatment plan and 62% favored patient autonomy in decision making of treatment plan. 46.5% of doctors answered paternalistic model as a preferable model for physician patient relationship. As for as the patients are concerned, only 27.5% mentioned that they ever get a chance to discuss their treatment with the patient.

Table 1

What is the role of physician in Pakistani hospital?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Guardian	128	64.0	64.0	64.0
	Interpreter	31	15.5	15.5	36.0
	Don't know	41	20.5	20.5	100
	Total	200	100.0	100.0	

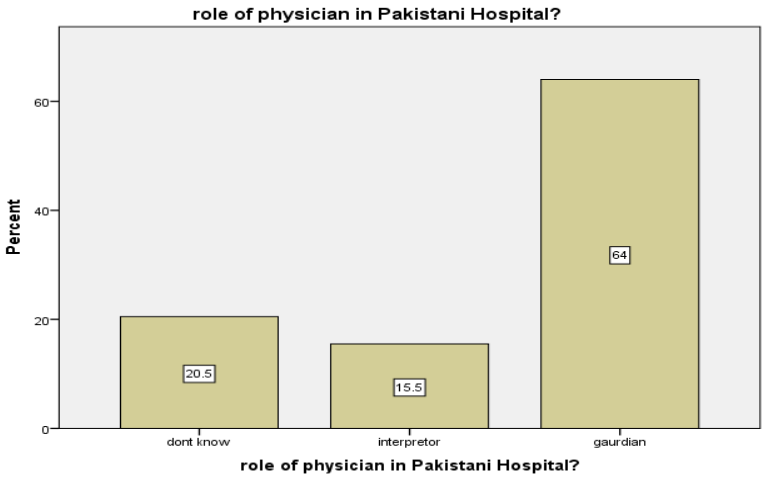


Table 2

Do you believe in patient's autonomy in decision making of treatment plan?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	124	62.0	62.0	62.0
	No	37	18.5	18.5	80.5
	Don't know	39	19.5	19.5	100.0
	Total	200	100.0	100.0	

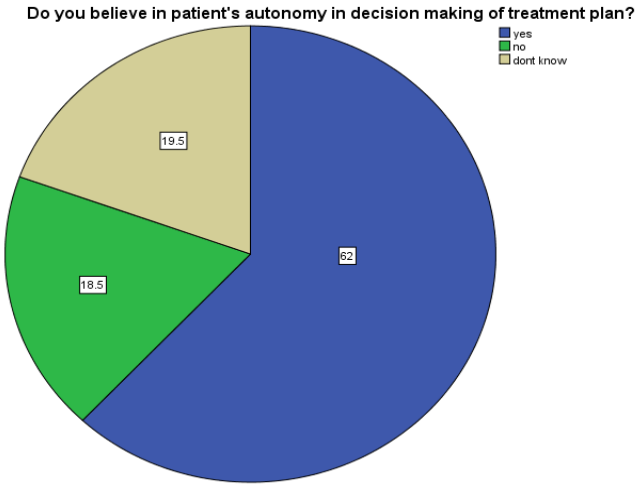


Table 3

Is dominance of physicians healthy in the treatment of patient?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	151	75.5	75.5	75.5
	No	23	11.5	11.5	87.0
	Don't know	26	13.0	13.0	100.0
	Total	200	100.0	100.0	

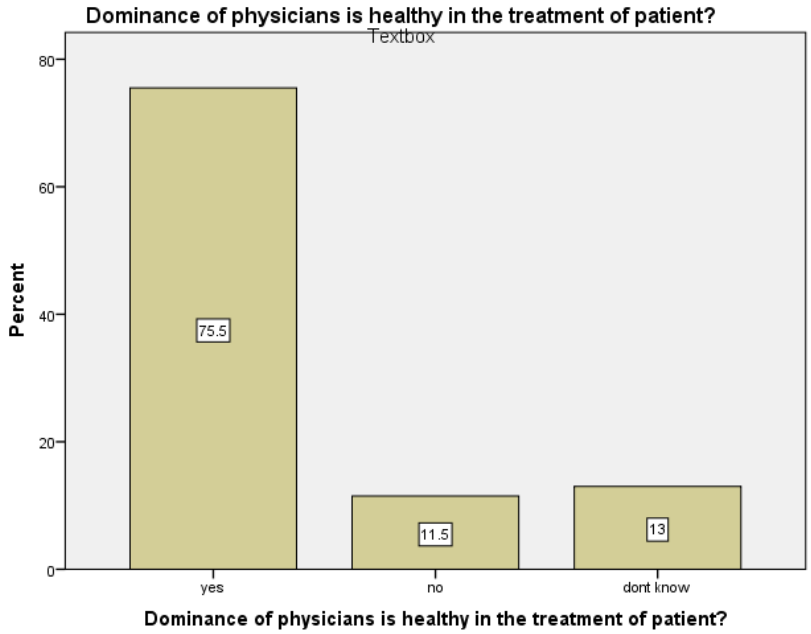


Table 4

Which model is preferable for physician-patient relationship?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Paternalistic Model	93	46.5	46.5	46.5
	Informative Model	56	28.0	28.0	74.5
	Interpretive Model	23	11.5	11.5	86.0
	Deliberative Model	28	14.0	14.0	100.0
	Total	200	100.0	100.0	

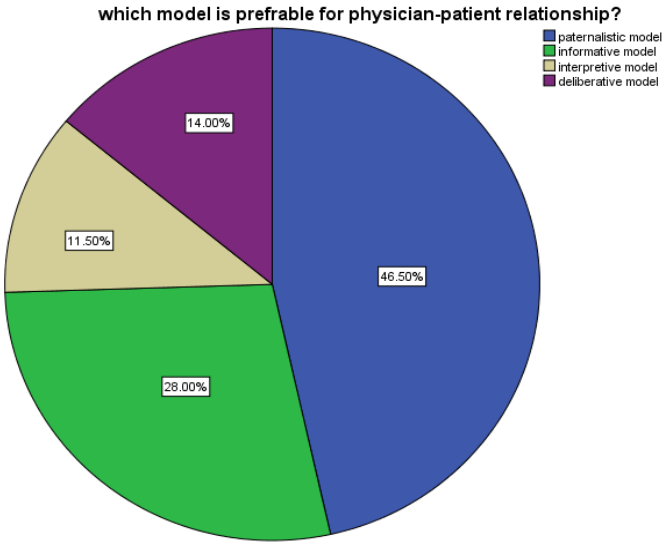
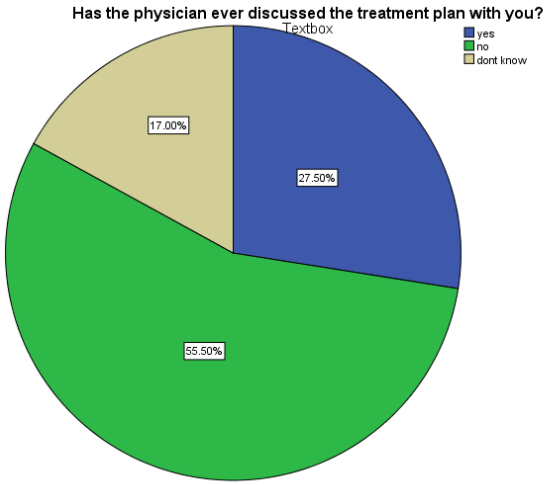


Table 5

Has the physician ever discussed the treatment plan with you?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	55	27.5	27.5	27.5
	No	111	55.5	55.5	83.0
	Don't know	34	17.0	17.0	100.0
	Total	200	100.0	100.0	



Discussion

The study showed that in our Pakistani society, the role of physician is just like a guardian, who really acquires dominance without including patient's participation in the treatment plan. This paternalistic role of the physician deprives the patient of his or her right in decision making which is against the moral norms and values or against the ethical virtues as a whole. The paternalistic physician-patient relationship in our society is due to the lack of awareness of the ethics in the doctors. They are unaware of the moral significance and implementation of ethical values in its true meaning in practical sense and secondly, the social and cultural norms of our society are such that the patients lack the empowerment to participate in their treatment plan due to lack of

education and lack of awareness of their rights on ethical grounds. And even worst deprived segment of our society are female patients whose decisions are in the hands of parents or husbands or mother in laws which is totally against the ethics.

Physician's primary professional obligation is to promote the welfare of the patients directly under his or her care, the patient-physician relationship is the irreplaceable cornerstone of medical practice.[5]

A patient-physician relationship is formed when a patient seeks medical help and a physician responds by providing medical service, including giving an opinion, making a diagnosis, or treating the patient. Each patient-physician relationship is unique, depending on the context, purpose, and function of each patient-physician encounter and the specific expectations of all parties involved. These aspects vary from one culture to another, and change over time. Hence, different models of the patient-physician relationship reflect the wide spectrum of clinical encounters that are established in dissimilar situations and at different times. No one model is always appropriate, but for daily medical practice, one model that works better than others can usually be identified. Since patient-physician relationship models are ethically evaluated and justified by normative standards, the ideal patient-physician relationship model preferred by a community also reflects that community's moral values. As such, patient-physician relationship models are dynamic, culturally sensitive, and not easily universalized.

The relationship between patient and physician has three basic roots.

1. A root of social contract relying upon a mutual perception of interpersonal obligations as well as upon profession.
2. A root developing out of the historical tradition of society and profession.
3. A personal root that gains its strength from the unique relationship produced by an interaction of the various personalities.

The above three basic roots were first described by Szasz and Hollander. These essentially behavioral models assume that physicians or other health care workers are primarily responsible to individual patients.[6]

Robert Veatch, an American pioneer bioethicist, proposed four models of the physician-patient relationship in 1972 which are as follows: [7]

i. Engineering model
ii. Priestly model
iii. Collegial model
iv. Contractual model

1. The engineering model

The physician is an applied scientist who presents the facts to the lay person but leaves all the decision to the latter. The scientist must be pure, factual, divorcing himself from all considerations of value. Even the physician logically could eliminate all ethical and value consideration from his decision making, it would be morally outrageous for him to do so. It would make him an engineer,

a plumber making repairs, connecting tubes and flushing out clogged systems, with no questions asked.

2. The priestly model

The Physician guided by the principle "benefit and do no harm" plays a paternalistic role in relation to the patient. In this model following norms are included:

a) Producing good and not harm
b) Protecting individual freedom
c) Preserving individual dignity
d) Truth telling and promise keeping
e) Maintain and restoring justice

3. The collegial model

With the engineering model the physician becomes a plumber and in the priestly model physician's moral authority is so dominating that the patient's freedom and dignity are extinguished. In effort to balance this, some have suggested that the physician and the patient should see themselves as colleagues pursuing the common goal of eliminating the illness and preserving the health of patient.

4. The contractual model

The physician and lay person are not perceived as equals but as having some mutual interests and sharing ethical authority and responsibility. Both parties are interacting in a way where there are obligations and expected benefits for both parties. This model strengthens the autonomy of the both patient and physician and it acknowledges shared aspects of decision making. The weakness of this model is that no contracts are signed in real physician patient relationships.[8]

In the year 1992, Emanuel proposed another four Physician patient relationship models which are as follows: [9]

i. Informative model
ii. Paternalistic
iii. Interpretive model
iv. Deliberative.

These are basically sophisticated exposition of Veatch's earlier models.

1. Informative model

In this model, physician who act like a scientist and discloses all the information associated with the patient diagnosis hence also called as scientific model.[10]

Factual risks, benefits, and treatment options are presented and the patient is given complete control of determining which intervention they would like to pursue

however physician does not provide their own recommendation on the best treatment. An objection to this model is that the patients do not have sufficient medical knowledge to interpret the information and to select an appropriate action plan. Furthermore it undermines the role of the physician by impeding on their duty to suggest what is in the best interest for the client. The informative model provides complete autonomy; however the complexity of extensive and often irrelevant information can simply cause more anxiety for the patient and does not create a balanced physician-patient relationship. This model has also been called as consumer or engineering model.[11]

2. Paternalistic model

The patient comes for treatment, counsel, and comfort. The decision making is placed in the physician's hands and the patient who does not follow the physician's orders is adding an even greater "sin" on top of his illness.[12]

This model empowers the doctor as a professional who gives order and the patient obeys, it strengthens and emphasizes the expertise and knowledge of the doctor. However it ignores the autonomy of the patient and ignores non-health related but morally legitimate values of the patient.

Treatments that conflict with patient values are of no concern to the physician because his/her number one concern is the patient's health despite differing ethics. Patients are not provided complete information making it impossible for them to make a completely autonomous decision.

In the paternalistic model, the physician acts as the patient's guardian, articulating and implementing what is best for the patient. The conception of patient autonomy is patient assent, either at the time or later, to the physician's determinations of what is best.[13]

3. Interpretive model

It is equivalent to collegial model. The interpretive physician provides the patient with information on the nature of the condition and the risks and benefits of possible interventions. The interpretive model enables physicians to suggest interventions that will work best with the patient and the patient ultimately decides which course of action to pursue. The physician does not dictate to the patient; it is the patient who ultimately decides about interventions.

The main objection to the interpretive model is that physicians may unintentionally push their own values on to their patients who are uncertain of their own personal values and can be easily persuaded and patient's personal values may not be good for their overall health and treatment. The interpretive model consequently threatens patient autonomy as physicians concern themselves with more than just health-related values.[14]

4. The deliberative model

This model is similar to the interpretative model however instead of considering all values of the patient, the deliberative model confines the physician's focus to only health-related principles. "The physician discusses only values that affect or affected by the patient's disease and treatments and indicates what the patient could do, and then recommends what the patient should do".[15] By focusing only on principles related to medical values, the physician does not extend the range of his/her training. Also intervention remains focused on health risks and benefits rather than values irrelevant to the patient's medical circumstances.[16]

Further, the physician aims at no more than moral persuasion; ultimately, coercion is avoided, and the patient must define the ordering of values to be followed.

In the deliberative model, the physician acts as a teacher or friend, engaging the patient in dialogue on what course of action would be best. The conception of patient autonomy is moral self-development; the patient is empowered not simply to follow unexamined preferences or examined values, but to consider, through dialogue, alternative health-related values, their worthiness, and their implications for treatment.

Objections to the deliberative model pertain around the idea that physician encouragement of certain health-related values does not entirely support patient autonomy. Emphasis on certain medical values can differ between physicians and their moral persuasions can easily lead to inadvertent paternalism. Also the deliberative model ignores values that are not necessarily health-related yet are important to the decision making process.

Which model is preferable?

Ezekiel and Linda Emanuel claim that the deliberative model is the preferred model for the physician-patient relationship. The Emanuel's first support to defend this claim is that the deliberative model preserves autonomy most efficiently. The patient receives all relevant information concerning their diagnosis and treatment while receiving health-related guidance from the physician. In the informative model, complete disclosure without advice could lead to patient uncertainty and an inability to interpret information: this causes a non-autonomous decision.

On the other hand, the paternalistic model does not provide the patient with enough information or control to construct an autonomous choice. The deliberative model maintains patient autonomy by allowing the physician to disclose information and suggest a recommendation that takes in to consideration important health-related values. After discussing the significance of each health value, and considering the doctor's suggestion, the patient is prepared to make an entirely autonomous decision.

The second argument the Emanuel's' present that defends the deliberative model as the best model for the physician-patient relationship is that the society's ideal physician is knowledgeable about health values and communicates these values, not

only factual information, to their client. It is important to allow physicians to discuss health-related values with their clients because by providing only facts, as done in the informative model, the physician comes across as impersonal and cold towards the client.

A strong objection against the deliberative model is that incorporating values into the decision making process converts the physician-patient relationship into a paternalistic model. The Emanuel's argue that the deliberative model is not in fact a form of paternalism because physicians use persuasion rather than authority when discussing health-related values. A deliberative physician-patient relationship is not paternalistic because the physician shares relevant medical values in a non-authoritative manner and enables the patient to make the ultimate decision concerning treatment.

The final defense Ezekiel and Linda Emanuel have to support the deliberative model as the preferred physician-patient model is that doctors should advocate health values and are qualified to do so. One of the largest criticisms against the deliberative model is that physicians lack the ability to articulate and convey health-related values to their patients due to extensive specialization.

Roter and Hall described four basic forms of the doctor–patient relationship: default, paternalistic, consumerist, and mutualistic. Default relationships are characterized by a lack of control on either side and are far from ideal. Paternalism is characterized by dominant doctors and passive patients, whereas consumerism is associated with the reverse and a focus on patients' rights and doctors' obligations.[17] Consumerism in health care is an extension of the value of individual autonomy, independence, control, and rationality seen in western societies today.[18]Mutuality is characterized by a sharing of decision-making and often advocated as the best type of relationship.

Shared decision-making

Evidence-based patient choice emphasizes patient autonomy, informed consent, and empowerment. However, there is recognition that mutuality or shared decision-making may not suit all types of patients.[19]

In our study when we asked about four models of physician-patient relationships; most of the doctors supported paternalistic model in our society because of lack of education, cultural and financial factors.

According to hypothesis 1 paternalistic model is preferable to other model and our study proved hypothesis number one due to certain reasons.

Conclusion

On behalf of comparison of the four different model of physician- patient relationship, it is concluded that what so ever be the model but the important thing is the balance between the patient's autonomy and physician's dominance. The patient autonomy is displayed by the participation and in decision making and

physicians dominance is depicted by virtue of his technical information and knowledge of the subject he possesses. Every model of physician patient relationship has its weak and strong areas. The patient's values are defined, fixed and known to the patient in the informative model but conflicting and requiring elucidation in the interpretative model. They are open to development and revision through moral discussion in the deliberative model and truly objective in the paternalistic model. And if the physician obligations are compared in these four models then according to the informative model, relevant, factual information is provided to the patient but in the interpretive model the physician's role is interpretative and informative. In the deliberative model the physician articulates and persuades the patient of the most admirable values and in the paternalistic model, the patients well -being is independent of the patient's current preferences. Hence, the role of physician is that of a competent technical, expert in informative model, counselor or advisor in the interpretive model, friend or a teacher in the deliberative model and guardian in the paternalistic model. In our society paternalistic model may be considered preferable due to certain reasons.

References

Emanuel E.J. Emanuel L.L. "The Physician-Patient Relationship." *JAMA* 1992; 267: pp. 2221-2226

Marzuk PM. "The Right Kind of Paternalism" .*N Engl J Med*. 1985; 313: pp.1474-1476.

Siegler M. "The Progression of Medicine: From Physician Paternalism To Patient Autonomy To Bureaucratic Parsimony." *Arch Intern Med*. 1985; 145: pp.713-715.

Szasz T.S. Hollander M.H. "The Basic Models of The Doctor-Patient Relationship." *Arch Intern Med*. 1956; 97: pp.585-592.

Hui EC. The Physician As A Professional And The Moral Implications Of Medical Professionalism. Hong Kong Med J 2005; 11: pp.67-9.

Veatch RM.(1972) Models For Ethical Medicine In A Revolutionary Age. What Physician-Patient Roles Foster The Most Ethical Relationship?" *Hastings Cent Rep* 1972; 2: pp.5-7.

Burke G. "Ethics and Medical Decision-Making." *Prime Care*. 1980; 7: pp. 615-624.

Brody H. *Ethical Decisions In Medicine* (New York: Little Brown& Company 1981), pp.37-57

Roter D. Hall J. (1992) "Doctors talking with patients/patients talking with doctors." West port**:** Connecticut auburn house pp.220-224.

Bishop, F. and Yardley, L. (2004) "Constructing Agency in Treatment Decisions: Negotiating Responsibility In Cancer." *Health: An Interdisciplinary Journal For The Social Study Of Health, Illness And Medicine*; 8: pp.465–482.