Clinical Bioethics

The Good Patient: Responsibilities and Obligations of the Patient-Physician Relationship

By James Giordano, PhD

A Brief History: The Medical Relationship in Focus
The scope, nature and tenor of the interaction of physician and patient have been the source of considerable conjecture since antiquity. Prescriptions and proscriptions of the Hippocratic Oath and Corpus defined particular parameters of physicians and patients in relation,[1] and consideration of the medical relationship has been an element of almost all major accounts of medical practice from the middle ages through the twentieth century, as evidenced in the work of Galen, Percival, Holmes, Rush, and Osler.[2] In fact, one of the treatises for which William Osler was best known—"Aequanimitas, with Other Addresses"—was essentially a discourse on the responsibilities, obligations and conduct of physicians toward their patients.[3] Without doubt, the nature of the physician-patient relationship has been one of the more provocative issues of contemporary bioethics. A number of convergent factors have contributed to an increased awareness of the medical relationship over the past sixty years. To be sure, the elucidation of Nazi atrocities conducted under the aegis of "medicine" was catalytic, but so too were the ethical iniquities of Tuskegee and Willowbrook.[4] The progressive growth of the civil rights movement in the 1960s, coupled to reactions against an increasingly impersonal, third party-regulated medical system enthused a strongly libertarian posture that expressed wariness of, if not explicit challenge to paternalistic medical practice.[5]

It cannot be denied that the obligations and responsibilities of physicians to patients has become and remains a prominent focus of medical philosophy, ethics and law; and rightly so given that the physician-patient relationship is characterized by inherent asymmetries of knowledge, ability, and power. As Laurence McCullough has astutely noted, describing the clinical encounter in order of the physician-patient relationship is semantically important to articulate the burden of responsibility borne by the physician in light of 1) her intellectual and practical skills and abilities, 2) the public offering of these skills in the service of any and all who need them, and 3) the fact that patients are forced to seek these skills by their predicament of disease, injury, or illness, and must place their trust in the physician to act in their best interest.[6]

The Patient–Physician Relationship

Undeniably, this reflects the realities of the practice of medicine. But if we regard that practice as an exchange of good between agents in relationship,[7] then how can we assume that the patient does not have responsibilities? While the medical relationship is most assuredly asymmetrical, these imbalances are not wholly unilateral, and I argue that it is this relative distribution of inequalities that define the responsibilities—if not obligations—of the patient as well as the physician. Furthermore, I argue that like the physician, the patient has responsibility as both a moral person, and a participant in a relationship that is focused upon the patient's own benefit. It is this last point that I maintain to be particularly important; although sickness and suffering are usually not discretionary,[8] the act of becoming and/or remaining a patient can be. In other words, in most cases, rational and competent persons can, in fact, choose not to be treated[9] or, less conspicuously, can choose not to actively participate in (and thereby may passively reject) the care provided to them by physicians.

It is in this light that I believe we must examine the patient-physician relationship with regard to the potential roles that patients can, and perhaps should play in ensuring the authenticity of medicine as a practice. More simply put: for the good of the practice to be obtained, both physician and patient must uphold particular responsibilities and obligations; in many ways. These are reciprocal and mutually sustain the ends of right and good care. But what are these responsibilities and what realistic expectations can we maintain that patients will be able to uphold them?

While the knowledge, skills, and power of the physician are obvious; it is equally important to view these dimensions of the patient as I opine that much of the physician's power is enabled

by the responsible participation of the patient. While the physician possesses considerable expert knowledge of the objective facts of disease(s), treatments, and prognostic possibilities, these are little more than esoteric information unless and until they are focused upon the unique contexts of a given patient.[10] But the intersection of the physician's expert capabilities (and perhaps their beneficence) and the patient's needs relies upon the patient's permission.[11,12] Such permission is expressed in a number of ways.

First is that which arises from the patient truthfully representing their needs and condition. This "allows" the physician to engage in the first steps of the act of medicine, namely, the determination of what is wrong and how to help. A patient's failure of truthful representation "disallows" the physician's expert knowledge to be used appropriately, misleads the physician, and is subversive (to the ends of a right and good healing).

Second is permission representative of trust. In the most literal sense, this is the basis and provision of informed consent; but here too, such consent must be a truthful representation that 1) the patient has faith in the physician's (professed) abilities, 2) that the patient will participate and cooperate with the treatments provided, and/or 3) if such treatments become unacceptable, the patient will inform the physician of the decision to refuse or comply with such interventions. In this way, the patient empowers the physician to enact appropriate care.

Michael Meyer claims that it is the medical relationship itself– with it's centeredness upon the patient—that constructs these "rules" and obligations.[13] In this way, just as we have described how certain professional obligations are mandated by the rules (i.e. - the deontic frameworks) that establish the structure of medical practice,[14] according to Meyer, so too are the obligations of the patient. Howard Brody has taken a broader view of these duties that is more of a Kantian account.[15] Brody describes patients' relative duties not only to physicians and health care professionals, but to others in general, and to society, as well. These duties are grounded, at least in part, upon a responsibility to oneself as a moral person who must 1) justify her actions to herself, and 2) respect and regard others as equally worthy of moral consideration. While these extra-medical duties are important, a complete discussion of their merits, limitations, and implications is beyond the scope of this essay, and so I will restrict my discussion to only those responsibilities and obligations that are critical to the reciprocity of patient and physician in relationship.

Patienthood

If the basis of this relationship is the fact that one person has become a patient, then it is important to address and examine what patienthood is, the abilities, disabilities and constraints that it entails, and how these might compel, sustain, or impede particular responsibilities and moral obligations of the patient-physician relationship. Patienthood is an experience of vulnerability. Confronting and experiencing this vulnerability can be profound, as Carl Jung describes "… interpretation fails, for a turbulent life situation has arisen that refuses to fit any of the traditional meanings assigned to it. It is a moment of collapse. It is a surrender of our own powers… forced upon us by nature, not a voluntary submission… decked in moral garb, but an utter and unmistakable… fear of demoralization."[16] It is this state of unknowing and apprehension—literally patienthood as suffering—that brings the patient to the physician. But what the physician can offer, at least at first, is only an assignment to an objective category, and the proposition of potential treatment(s). Without a deeper and more contextual knowledge of the impact and effect of the disorder as rendered in the person who is the patient, such objective categorizations remain arbitrary, and prudent discernment of appropriate treatment remains lacking, if not practically impossible.

This is especially true for pain; the very nature and experience of which is wholly subjective. Thus, while the physician possesses expert objective knowledge, she must rely upon the patient's expert subjective knowledge (of self, and the effects of disease and illness upon the lived body and life world) in order to obtain the good of the medical relationship.[17] As Eric Cassell notes, disease and illness are expressed as a "collectivity of meanings" in each patient that are dependent upon the patient's life history, current situations, and future expectations.[18] This is the 'biographical self " that the phenomenological philosopher and psychiatrist Karl Jaspers insisted was critical to any meaningful interpretation of pathology that could be used to guide correct and responsible care.[19] According to S.K. Toombs, "… in attending to the patient's account of the lived experience of illness, the physician interprets this account in terms of his/her knowledge of physiology, anatomy , and so forth (i.e. the patient's lived experience is placed within the naturalistic attitude) in order to determine therapeutic interventions".[20]

"...while the physician possesses expert objective knowledge, she must rely upon the patient's expert subjective knowledge (of self, and the effects of disease and illness upon the lived body and life world) in order to obtain the good of the medical relationship."[17]

Situational Realities, Responsibility and the Possibility of Virtue

There are five critical elements involved in this process:

1) the patient's truthful representation of what is wrong,
2) the clinician's interpretation as diagnosis;
3) the formulation and explanation of a treatment plan;
4) the patient's acceptance of this diagnostic and therapeutic information, from which stems the fifth:
5) the patient's permission to initiate treatment and compliance with the prescribed care.

These elements are the basis for the patient's responsibilities and obligations as described by Martin Benjamin; namely, commitment, veracity, and compliance. Indeed, I think that it could be argued that commitment represents the single most overarching responsibility that any patient might be expected to maintain. Such commitment can be both to a particular medical relationship—between a specific patient and physician—and writ large(r) as a commitment to the concept of patient(s) and physician(s) in relation to achieve the good achieved through healing and/or care. In this way, the patient is not simply committed to a physician, but rather to physicians' agency in the therapeutic process, and to the therapeutic process itself.

In assuming this responsibility (and perhaps even this responsibility alone), patients are obligated to truthfully represent their

"The Least That Might Be Expected" from Patients as Conjoined Participants in the Therapeutic Process

Respect: For the physician as both a therapeutic and moral agent whose intent is focused upon providing safe, sound, and meaningful care (i.e., as being another moral person who is extending and providing help). It may be argued that politeness arises from this respect, but that is more representative of an individual demeanor than a frank responsibility or obligation.

Commitment: Enfranchisement to the notion of the medical relationship, healing encounter, and of being reciprocally involved in the process and its enactment within a specific patient-physician relationship (e.g., through provision of truthful information, genuine representation of the problem, its effects, and needs and values, and agreement to accept and comply with the care rendered, and/or explicitly refuse such care without subversion; vide infra)

Veracity: Truth telling; about the intent of seeking treatment. The description of symptoms, the use of various agents, the expectations for treatment, the understating of information about the scope and nature of treatment offered, and the compliance (or lack of compliance) with treatment offered or provided. In many ways this may also be considered to represent fidelity to the medical relationship.

TABLE 1. *Possible Responsibilities and Obligations of Patients in the Medical Relationship*

subjective experience of illness, and the symptoms that contribute to this experience. As well, such commitment entails some obligation for patients to define their needs and describe expectations (and apprehensions), so that the physician may construct a more accurate representation of the reality of the illness and be enabled to provide more meaningfully relevant and appropriate care. Together with Yuri Maricich, I have claimed that rules alone, while necessary, are insufficient to sustain the physician-patient relationship, and have argued, pro Pellegrino and Thomasma, that virtues are critical to enable the physician to intuit various ethical systems in effecting morally sound care.[21-25] This prompts the question of whether virtues are equally important to sustain the patient-physician relationship. More simply put, can we (or should we) expect the patient to be virtuous?

Karen Lebacqz argues that virtues—as incised traits of excellence of character—arise in response to situations, tasks, or the engagement in particular endeavors.[26] In this way, one can speak of the "virtues of medicine", etc. But what are the virtues of patienthood? If being a patient is viewed as a state of vulnerability, change, and loss, then what virtues could—or should—be expected to arise in response to (or because of) this existential predicament? Lebacqz describes the virtues of honesty and probity as being instrumental to working with clinicians toward restoring health, while other virtues such as serenity or simplicity, tolerance, fortitude, and honesty are more fundamental to restoring personal balance and holism, and are therefore not solely instrumental to maximizing clinical care. In contrast, my colleague Dan English has proposed that the circumstance(s) of being a patient may realistically limit the feasibility and/or expectation of any virtues and obligations beyond truth-telling and avoiding harm to others.[27] After all, what can be expected of a person whose personhood is being threatened?

Both Lebacqz and English have a point. If we consider the classical notion of virtue(s), we appreciate these not to be traits that one absolutely must have, but rather as traits that one ought to strive for if he/she is to approach the ideal. Lebacqz's (and others') consideration of patients' virtues have value when viewed in this light, namely as those traits of character that a patient should possess and exhibit so as to both regain a sense of self-unity, and bring this striving to work in partnership with the physician in the clinical encounter. But the ideal is not reality, and English's recognition that "the best we can hope for given the situation" is frequently the norm. Patients are often frightened, feel burdened by doubt and lack of knowledge, and may come to the medical relationship tainted by prior experience or false expectation(s). Moreover, if we consider the specific problem of pain, we must regard the potential for co-morbid psychological factors, problems with dose escalation, and denigration of social relationships as very real manifestations of the pain spectrum.[28] Yet, I believe that this does not rule out the possibility or need for any and all patients to assume some responsibility within the medical relationship.

Conclusion

To re-iterate, the relationship is initiated, based, and focused upon the patient's predicament. Given the impact of pain as symptom, disease, and/or illness, perhaps at best we can seek some "least common behavioral denominator" and expect patients to be respectful, truthful, be committed to the means and ends of the medical relationship, and be responsible for the consequences of their rational behaviors and actions (see Table 1). Patients and society can (and perhaps should) expect physicians to be bound by rule(s) and guided by virtue(s), because those persons who are physicians have actively chosen to enter the profession of medicine. On the other hand, disease and illness will unfortunately befall each and all of us,[29] irrespective of our career choices, and will deliver us to both patienthood and the care of those who profess to heal. Thus, while participation in the medical relationship might demand that patients uphold certain responsibilities such as veracity, commitment and compliance, we probably cannot expect much more, simply because they are patients. And just like the realities of life and the inevitability of sickness, the situational (and moral) reality remains that what we expect from those who are healers must and will always be greater than what is expected from those who suffer. ■

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