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# The centrality of patient-physician relationship to medical professionalism: an ethical evaluation of some contemporary models

## The dynamic nature of the PPR

Because a physician's primary professional obligation is to promote the welfare of the patients directly under his or her care, the patient-physician relationship (PPR) is the irreplaceable cornerstone of medical practice.[1] A PPR 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 PPR 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 PPR 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 PPR models are ethically evaluated and justified by normative standards, the ideal PPR model preferred by a community also reflects that community's moral values. As such, PPR models are dynamic, culturally sensitive, and not easily universalised.

## Ethical models of the PPR

Robert Veatch, an American pioneer bioethicist, proposed four models of the PPR in 1972[2]: "engineering", "priestly", "collegial", and "contractual". In the "engineering" model, physicians are scientists, providing objective information and delivering technical solutions to patients with little or no consideration for patients' preferences or the choices that reflect their values and beliefs. In the "priestly" model, physicians are competent both in scientific medicine and with the personal values and beliefs that inform patients' treatment choices. In the "collegial" model, physicians and patients are friends, treating each other with equality, mutuality, trust, and loyalty. In the "contractual" model, physicians and patients are businessmen seeking to benefit from each other through the relationship. Twenty years later, Emanuel[3] proposed another four PPR models: "paternalistic", "deliberative", "interpretive", and "informative". These are essentially nothing more than a sophisticated exposition of Veatch's earlier models. In the "paternalistic" model (equivalent to Veatch's "priestly"), physicians are authoritative parents, and patients are passive and submissive recipients of medical benefits. In the "deliberative" model, physicians act as mentors guiding patients to identify and focus on "values that affect or are affected by the patient's disease or treatment"[3] as they make medical decisions. The "interpretive" model (equivalent to "collegial") assumes that in a given medical situation, patients' values are neither fixed nor self-evident, and physicians act as counsellors assisting patients in the interpretation and articulation of their values, and in making medical decisions that best realise these personal values. In the "informative" model (equivalent to "engineering"), physicians provide medical information, and patients make medical decisions independently based on their personal values. Rich metaphors such as engineer, priest, businessman, friend, etc, powerfully describe many common PPRs in the local medical community, and expose the tension found in the PPR stemming from the false belief that physicians alone possess medical facts and patients have exclusive access to personal values. We need to further examine this "fact-value" dichotomy in order to understand the dynamics of different PPR models.

### *Physicians as parents or priests*

In the "priestly"/"paternalistic" model, physicians are presumed to be capable of mastering the complexities of both the scientific/objective world of medicine, and the subjective world of the patient's personal values. Hence, physicians are in the best position to judge what is best for their patients. In a mild form of this model, physicians make treatment decisions and recommend that patients consent; in its strong form, physicians authoritatively order patients to assent (with coercion if necessary). In either form, physicians control the fact-value dichotomy, and as long as physicians can always act faithfully in patients' best interests, and patients do not object to being treated from a parental perspective, the fact-value tension in the PPR is minimal and patient interests can be well served.

### *Physicians as mentors*

Since most physicians cannot sustain parental fidelity towards their patients, and most patients resent being treated as children, the "paternalistic"/"priestly" model has been replaced by other models in the West. One such alternative is the "deliberative" model that continues to assume the physician's ability to objectively know and prioritise a patient's medical and personal values. This helps physicians persuade patients that some health-related values are weightier than some of their personal values. As such, the model enables physicians to normatively assess their patients' personal values and exert enormous influence over not only what patients can do but also what they should do. The physician-

mentor's grip on decision-making is more relaxed than the physician-parent/priest, but the "fact-value" dichotomy remains with the physician, and many autonomy-conscious patients find it unsatisfactory.

***Physicians as technicians or contractors***

Conceding further to demands of autonomy, the "informative"/"engineering" model radically separates the fact-value dichotomy and reduces physicians to moral-neutral technicians/engineers providing patients with presumably value-neutral medical information and leaving patients to make decisions independently based on personal values. In this PPR, physicians are technicians treating diseases rather than patients, and sick persons are "consumers" shopping for medical services they need. Such a contractual client-provider relationship does not constitute a healthy PPR and predictably leads to poor therapeutic outcomes.

***Physicians as friends or counsellors***

In a healthy PPR, physicians' medical facts and patients' personal values contribute to balanced medical decision-making. The "interpretive"/"collegial" model acknowledges that physicians have full access to medical facts and limited access to patient values. Physicians provide medical expertise, and are capable of counselling patients as friends to make decisions that best realise the patient's own personal values. This approach upholds patient autonomy without undermining the physician's duty of beneficence. The fact-value dichotomy is neither completely separated nor collapsed to one side, but is held in creative tension between physicians and patients, achieving shared decision-making between the two parties in a balanced PPR.[4]

## Ethical evaluation of patient-physician models

Patient-physician models are evaluated by a community's social values and moral norms, and in the West, patient autonomy is the favoured yardstick. On the ethic-scale of autonomy, the "informative"/"engineering" models rank on top and 'paternalistic"/"priestly" models at the bottom, with the others falling somewhere in between. The ranking reverses when the models are assessed on the ethic-scale of physician autonomy and beneficence. This implies that when physicians assume greater autonomy than patients in medical decision-making, especially when autonomy is exercised for a patient's benefit (paternalism), physician beneficence and responsibility increase. This inverse relationship between patient autonomy and physician responsibility/beneficence is clearly present in the "paternalistic" and "informative" models and is very troubling for medical ethics as it implies that patient autonomy can only be purchased with physician beneficence and vice versa. The goals of medicine can best be served by "interpretive"/"collegial" models of the PPR, where the fact-value dichotomy is maintained in a delicate yet constructive balance.

## The patient-physician models in the Chinese cultural context

One prominent feature of Chinese culture is its exhaustively comprehensive and rigidly hierarchical relational structure, which ensures everyone abides by the social roles one is born into or acquires and performs all the specific duties that come with these roles. In this tradition, physicians have social roles equivalent to that of parents and they are expected to treat patients with the benevolence of parental "hearts". But since fathers (before the modern era, all physicians were male) also assume authoritative roles in the Chinese tradition, physicians are also expected to behave authoritatively.[5] A combination of benevolence and authority provides the perfect soil for the development of paternalism. A Chinese PPR most closely resembles a parent-child relationship and fits well in the "priestly"/"paternalistic" models that are incompatible with modern medical moral codes of patient autonomy, informed consent, shared decision-making, and so on. It is not only physicians who find it difficult to adjust to the autonomy-based and patient-centred models of the PPR, many patients expect to be treated from a paternalistic or parental posture. In extreme cases, patients may misunderstand the physician's respect of patient autonomy as a form of physician indifference. Chinese physicians practising in the local context are faced with the difficult cultural tasks of not only foregoing their own instinctive parental authoritarianism, but also educating and enabling their patients to properly exercise their right of autonomy so that shared decision-making and optimal therapeutic outcomes can be achieved through the ideal "interpretive"/"collegial" PPR model. This will be the Chinese physician's main challenge for the foreseeable future.

EC Hui, MD, PhD (e-mail: edwinhui@hku.hk)
Medical Ethics Unit, Faculty of Medicine
University of Hong Kong, Hong Kong

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