



Title	The contractual model of the patient-physician relationship and the demise of medical professionalism
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The contractual model of the patient-physician relationship and the demise of medical professionalism

The contractual model of the patient-physician relationship

In the previous discussion of the patient-physician relationship (PPR),¹ the 'informative'/'engineering' model was said to assume that doctors have exclusive access to medical 'facts', and patients to personal values and preferences, thus justifying unfettered patient autonomy in medical decision-making. This complete separation of the fact-value dichotomy has had the unfortunate consequence of contributing to the commercialisation of modern medicine, in which doctors are seen as service providers/contractors (or salesmen/saleswomen of medical expertise), patients as consumers shopping for medical goods, and the PPR as nothing more than a business or contractual relationship.²

In a modern libertarian society, contractual relationships cover a wide range of human transactions and interactions in which equal parties agree freely and voluntarily as autonomous agents on particular undertakings with specific interests, purposes, and goals in mind. In private medical practice where doctors retain more control over the type, scope, location, and conditions of practice, the contractual nature of the PPR is readily visible. However, even in a non-private setting where there is no specific agreement in place, by convention, whenever a doctor undertakes to treat or care for a patient, he or she is held in law to have implicitly contracted with the patient, and the physician's subsequent conduct is governed by the 'implied contract' to render care according to certain pre-established standards.^{3,4} Hence, common law often assumes the contractual model as the starting point for analysis of tort duties in a PPR,⁵ and such an approach is not without advantages. Firstly, by infusing a strong sense of equality, symmetry, and mutuality into the PPR, the contractual model undermines the traditionally more authoritarian (eg priestly or parental) models. Secondly, since a contract is driven by the interests and goals of the contracting parties, and each party 'uses' the contract to his or her own ends and advantages, it removes the overbearing element of philanthropy or 'condescension of charity' often displayed by doctors in a PPR. Finally, by providing or referring to explicit contractual terms that are legally enforceable, the

model affords formal protection for parties in a PPR. But a contractual PPR has far more vices than virtues, and it is to some of the key limitations we now turn.

The contractual model is inadequate to describe the complexities of the patient-physician relationship

In ordinary commercial applications, contractual relationships are relatively simple, eg a property lease. In contrast, PPRs are complex, both externally and internally. Unlike simple commercial contracts, PPRs are subject to many social and institutional forces external to and uncontrolled by parties constituting a PPR. These may come from government health care policies, professional codes of ethics, legal statutes, institutional/peer pressure, insurance/co-payment schemes, family/cultural traditions, personal values, religious allegiances, etc, and they all impinge on the PPR by adding complexities and constraints. The PPR is also intrinsically complex because patients and doctors are not 'contracted' as conventional buyers and sellers. Firstly, patients hardly 'voluntarily consent' to 'purchase' health care in the same way customers agree to buy a car. The need to 'purchase' medical care is unwelcome and it often arises in acute or emergency situations that do not allow enough time to conduct a careful market analysis of available medical services, even if this were possible. Secondly, doctors have an almost complete monopoly on the 'merchandise' patients need, and the bargaining power of patients is more like that between an individual and a public utility rather than that of a potential car buyer in a car dealership.⁶ Thirdly, the PPR is a personal and intimate relationship in which one party, the patient, is a sick, vulnerable, dependent, and helpless person whose "illness is inherently degrading and dehumanizing, and... exposes and threatens the sick person's body, soul, and intimate relationships."⁷ In contrast, the other party, the doctor, is confident, independent, equipped with superior knowledge and skills, and socially superior. In short, there is a significant asymmetry in power, knowledge, and status in a PPR. Finally, in order for doctors to provide treatment, patients often have to expose the body, and reluctantly divulge personal/family information to their doctors that is otherwise held

with the strictest confidentiality. In other words, a PPR is a project much more involved than the purchase of merchandise or services to cure a disease. With all its imbalances and asymmetries, the PPR exists to 're-humanise' sick persons who are not only threatened bodily, but for whom all of the values that the person stands for are being endangered. This complex and intimately personal 'medical transaction' far exceeds what the contractual model can describe or accommodate.

The contractual model is inadequate to regulate the patient-physician relationship

Contracts may be very efficient in regulating the arms-length commercial dealings that occur in conventional buyer/seller relationships, but they are particularly deficient when it comes to the complexities of the PPR. Parties in a commercial contract are ultimately motivated by self-interest, and each is expected to protect oneself from the other's self-interested behaviour. This means that the interests of contracting parties are potentially in conflict, and the relationship is potentially adversarial in nature. This is alarmingly unfair for a PPR, where one party is a vulnerable patient and the other a powerful, if not seemingly omnipotent doctor. In recent times, under the influence of the contractual model, patients have been called 'clients' and physicians 'providers'—terms not only empty of all the connotations of the terms 'patient' and 'doctor', respectively, but also suggesting that providers/physicians and clients/patients only need to oblige each other with a minimal marketplace morality, eg prohibition of fraud and coercion, in much the same way automobile mechanics are obliged to their customers. Such a contractual/commercial PPR is too ill-equipped and impoverished to ensure that patients receive fair treatment. Furthermore, within the PPR, doctors must deal with patients in the midst of sickness, crises, or tragedies, and their conditions are by nature unpredictable. There is no way to precisely and exhaustively specify patients' medical needs in advance, and doctors must be willing to cope with contingencies. They may be called upon to perform services that exceed those that could be specified in a contract or for which they may not be compensated. As well, doctors cannot unilaterally withdraw from their contracted responsibilities (explicit or implied) unless they are prepared to be charged with patient abandonment. But the contractual model of the PPR encourages a minimalism that "reduces everything to tit-for-tat: do no more for your patients than what the contract calls for; perform specified services for certain fees and no more" and

produces doctors "too grudging, too calculating, too lacking in spontaneity, too quickly exhausted to go the second mile with [their] patients along the road of their distress..."⁸ In sum, the nature of the PPR and society's expectations of the medical profession far exceed the regulatory function of a commercial contract, and law courts, rightly, do not always judge doctors' obligations solely based on contract law analysis.⁹

The contractual model does not nurture or sustain medical professionalism and ethics

The most devastating effect of a commercial view of medicine and a contractual model of the PPR is to cause doctors to become amnesic of the 'professional promise' they have collectively made to society. This professional promise of service and commitment is in reciprocity to society's generous gifts of support, financial or otherwise, to train people to become doctors, to build hospitals for doctors to practise their profession in, to permit them to practice and perfect their skills on patients, and to establish the medical profession as an exclusive body of experts with a monopoly of practice and an elevated social status. In return, a 'professional promise' is made that doctors will be obligated to preserve and protect the health and well-being of all members of the society. To breach this promise indicates that doctors have unconscionably removed from their collective memory their enormous indebtedness to society and the patients who have enabled them to become and to remain doctors. Commercial/marketplace medicine and contractual PPRs are morally unprofessional and unacceptable because they assume that doctors do not owe any duties to society and patients. Doctors, in turn, are encouraged to believe that they become doctors solely because of their superior intellectual qualities, and their professional commitment to patients as practising doctors is due to their personal virtues of philanthropy or altruism. They mistakenly assume that their acts of healing and caring are entirely gratuitous and charitable, when in reality all of their professional activities should be seen as discharging their prior indebtedness to society and its citizens for having provided them with their professional education, practice, and status. Professional membership is both a gift from society and a promise by doctors, and the moral foundation of medical professionalism is based on society's generosity and doctors' gratitude, marked by elements of gift, exchange, indebtedness, and reciprocity. This mandates an ethical model of the PPR

that is considerably more sensitive and responsive to the social definition of the medical profession than a commercial contract. The understanding of the PPR in purely commercial/contractual terms is a flashing amber light that warns of the impending moral bankruptcy of the medical profession in our times.

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**Answers to CME Programme
 Hong Kong Medical Journal
 August 2005 issue**

Hong Kong Med J 2005;11:243-50

I. Chromosomal abnormalities and *FMRI* gene premutation in Chinese women with premature menopause

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|---|----------|----------|---------|----------|---------|
| A | 1. False | 2. True | 3. True | 4. False | 5. True |
| B | 1. False | 2. False | 3. True | 4. True | 5. True |

Hong Kong Med J 2005;11:251-8

II. Medullary thyroid carcinoma in Hong Kong Chinese patients

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|---|---------|----------|----------|---------|----------|
| A | 1. True | 2. False | 3. True | 4. True | 5. False |
| B | 1. True | 2. True | 3. False | 4. True | 5. True |