THE PHYSICIAN-PATIENT RELATIONSHIP: SHOULD PHYSICIANS CONTROL HEALTHCARE?

BY MARC ALIOTTA[1]

Introduction: The Nature Of The Physician-Patient Relationship

Healthcare is complicated. The delivery of it is complicated. The finance of it is complicated. The politics and philosophies of it are complicated. With all of its moving parts, the healthcare system has shown time and time again that it is difficult to design a system that is fair, efficient, and accepted by an overwhelming majority of the populace.

At the heart of the healthcare system is the physician-patient relationship—a relationship that has been recognized for millennia. As with many social relationships, the natural order tends to create hierarchies of power. In the case of the physician-patient relationship, the physician's role tends to be superior in the relationship. The American Jurisprudence Proof of Facts—a document used to determine whether a physician-patient relationship exists in a given legal case—discusses the nature of the relationship: "[I]ts foundation [is] in the theory that the physician is learned, skilled, and experienced in those subjects about which the patient ordinarily knows little or nothing" but those subjects "are of the most vital interest to [*the patient*] since they determine the health and well-being of the patient and his family."[2]

But this authority is not merely granted *legally* to physicians by society; it comes with the natural interaction between physicians and patients. Fundamentally, the physician delivers a service to the patient to help with a health problem. But whether *information* demonstrates that this service contains standard quality and effectiveness is typically left for the physician's judgment – and this is definitely not a bad thing when physicians are following medical conclusion based on objective scientific research.

Issues With The Patient/Physician Relationship

Physicians have special knowledge from both education and experience. They are learned and can make informed decision of quality and effectiveness. Patients, on the other hand, lack this special knowledge of physicians to make informed judgments of the quality and effectiveness of a given service. Generally, patients perceive the value of medical procedures based on a limited understanding of the medical information involved with the healthcare they are receiving. This information asymmetry complicates the way we value healthcare as a society, because the value essentially stems from physicians who are more aware of the effectiveness of a procedure and willing to provide it to the general public.

Patients all agree with the ends/goals of sound medical judgment; patients ultimately want their health issues fixed. But the majority of patients may not understand the means—the services—that the physicians render to reach those ends. The patient puts her/his trust and faith in the physician's decisions. The information asymmetry creates an environment where physicians are the only ones able to make a medical decision. However, just because physicians are the only ones who can make a medical decision does not mean that patients will submissively surrender their trust over to them.

In current affairs, organized public movements opposing physician judgment are common. The anti-vaccination front is an example of how physician superiority can be disregarded because of patient hubris. Such movements weaken the support for a shared-decision-making process, an integrative system between physician and patient, because patients may trust pseudo-scientific theories on links between autism and vaccination.

Another example is the Chronic Lyme Disease movement. Patients in this movement disagree with the physician consensus of the non-existence of such a disease.[3] This

disagreement may lead to patients seeking advice from a small minority of dissenting physicians who cater to their unjustified belief and potentially harm patients and others with unnecessary medical procedures.

These examples push us to consider what we mean by physician authority and superiority in healthcare. It is crucial to consider that this technocratic approach to physician power over patients is not solely tied to individual physician-patient relationships. The authority of physicians to deliver medical opinions is not without merit; to ensure reliable information throughout the medical community, physicians must rely on empirical research to make sound, objective medial judgments.

A well-respected opposition to *strong* physician superiority in healthcare does exist, however. Similar to the idea that "you don't have to be a weatherman to know which way the wind blows,"[4] the healthcare system's strict technocratic approach flies in the face of decisions related to more value based judgments (rather than scientific). The philosopher Gerald Dworkin expresses this opposition:

> "Decisions about what form of treatment to undergo, the probabilities of cure and of side effects, judgments about how the body will look to others after various forms of surgery, whether to spend one's last days in a hospital or at home-these are not technical, medical judgments. To suppose that these are matters of expertise, decisions to be taken by experts, represents a denial of autonomy."[5]

Support of a personal/patient autonomy in healthcare decisions is reasonable, but one should still suppose limits on it. Posing limits on patient autonomy *should* be based on two factors: (1) whether the decision is the technical part of healthcare, and (2) whether the patient's autonomous decision creates a burden on others.

PHYSICIANS CONTROL THE TECHNICAL PART OF HEALTHCARE. BUT WHAT'S TECHNICAL?

A justifiable approach to physician superiority in healthcare limits the power to the technical side of things. This begs the question: What is meant by *technical*? It would be safe to say that physicians are superior on which medical services are more effective than others – the technical side. However, situations concerning life and death of patients tend to be less related to technical medical services and more linked to deep philosophical issues in bioethics (value-based judgments).

In 1928, in his dissenting opinion in *Olmstead v. United States*, Justice Brandeis eloquently articulated the problem of government oversight in a case involving government wiretapping of phone conversations: "Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. The greatest dangers to liberty lurk in the insidious encroachment by men of zeal, well-meaning but without understanding."[6] Transferring this insight to the physician-patient relationship, we can see that foundational disagreements with moral intuitions may leave physician authority less superior. More objective areas, such as determining which medical services are more likely to increase the physical well-being of the patient (a more scientific component), are where physician authority and superiority naturally reside. On the other hand, areas of less objectivity include medical decisions that rely on a "*value* dimension often requiring that medical benefits (such as continued life and health) be weighed against not only medical risks but non-medical values as well."[7]

Patient Autonomy Is Important, Unless It Burdens Others

Patient autonomy in healthcare has its roots in modern philosophy. John Stuart Mill championed the idea that individuals should have the freedom to act on their own opinions, as

long as it is only at their risk or peril.[8] When patients have autonomy to choose in the healthcare context of medical services it should be typically a choice between a set of options. Whether the patient can choose between various medical service options supplied by the physician is an example of justified share-decision-making—of an integrative approach—in healthcare. Of course, these medical service options should ideally be tied to objective, scientifically based judgment that is not rooted in irrational and non-empirical beliefs that can potentially hurt the patient and society.

Nevertheless, the 20th century "bioethics movement" of medicine in the United States led to a shift from a physician superiority model to a model that grants more power for patients,[9] regardless of whether the patient made a value judgment based on religious/cultural beliefs divorced from a scientific model of reasoning.[10] In the past, for instance, physicians would be reluctant to disclose cancer diagnoses to patients, whereas the vast majority of physicians today "feel obliged to disclose" such information.[11]

However, the idea that patients should have full freedom in healthcare is dangerous to society for many reasons. First, patients are usually not in the position to know what is best due to the information asymmetry between physician and patient. Second, some options might just be too monetarily expensive for society at large and the specific insurance in question. Lastly, ethical and jurisprudential considerations might limit what the patient may decide for him/herself. In the end, patient autonomy should be respected – but with limits once we consider the consequences of full patient freedom. Charles E. Gessert, a senior research scientist and physician at the SMDC Health System, notes the impractically of full patient autonomy: "The physician-patient relationship, based solely on respect for autonomy, is incomplete. The practice of beneficence is what connects physicians and patients in a more personal way."[12] *Beneficent*

physicians are genuinely and fairly acting to further the patient's well-being. As long as we can agree that a physician is behaving beneficently, her/his authority and superiority over the patient should be warranted even if it might frustrate the patient's autonomy. When patients enter the system of healthcare, they should expect their *full* autonomy to be suspended.

Balancing Patient Autonomy with Systems of Physician Superiority and Control

A balance exists between the physician superiority (technocratic) approach and the shared-decision-making (integrative) approach. A patient chooses a medical procedure from a set of medical procedures supplied by the physician; a set of justifiable procedures are available based on the technocratic approach of mostly being pegged to scientific research. The underlying nature of the healthcare system creates this approach and endows the physician with superiority as long as the physician's medical judgment is evidence-based. This physician superiority controls the physician-patient relationship to the extent that the patient can reasonably participate in the decision-making process. But what kind of control system is this?

Control systems affect the delivery of healthcare and may undermine the natural superiority of physicians. According to the renowned healthcare economist, Victor Fuchs–borrowing a theory on systems of control from the economist Kenneth Boulding–three general kinds of control systems exist in society. The first kind is the *exchange* system "which means you do something for me because I do something for you" – e.g., the market system.[13] The second kind is the *threat* system "which is when you do something because I tell you to do it and I have the power to make you do it" – e.g., the government system.[14] Lastly, the third kind is the *integrative* system "in which people do things because of who they are and what their relationship is to others" – e.g., the schooling system and the family.[15]

Exchange and threat systems in healthcare naturally undermine the superiority of physicians. For instance, a fee-for-service ("FFS") healthcare system is an exchange system conducive to physicians choosing and over-utilizing procedures driven by profit seeking. This takes away the sound medical judgment that both a patient seeks and a physician ought to have. Likewise, government or managed care presence in healthcare may create a threat system that forces physicians to make decisions that might not be in the patient's best interest. The managed care organization ("MCO") was created to address the issues of the general FFS system, but ironically led to the opposite problem of over-utilization we find in FFS. On the contrary, MCO's tend to disincentivize physicians and cause under-utilization of medically necessary procedures (e.g., through capitation-based or partial-capitation-based reimbursement schedules), because physicians keep the portion of their fee that is not spent on providing healthcare. Either way, exchange and threat systems pose serious issues for the natural superiority physicians must have in the physician-patient relationship.

An integrative system seems to be the best approach to the healthcare system[16], but with a caveat. Patients are integrated insomuch as they comply with decisions of physicians. Patients should not determine what models/procedures of care are more valuable than others, because the physician is the one with such authority through her/his expertise. Instead, patients should stringently adhere to the instructions of physicians. An integrative system should not give the patient power over the physician but should empower the patient to learn and trust the necessary healthcare path provided by physician performance and advice.

Conclusion

The underlying relationship in healthcare, between physicians and patients, calls for physician superiority. The nature of the relationship begs us to take much of the physician's

decisions for granted because of the superior ability of physicians to understand technical choices in healthcare delivery of services. Undoubtedly, lines should be drawn that prevent physician authority when considering bioethical areas of healthcare deviating from typical healthcare procedures. These complicated bioethical areas deviating from typical healthcare procedures tend to be subjected to decisions more related to fundamental philosophical moral intuitions where reasonable minds may differ. On other hand, regarding typical healthcare procedures, no matter how skeptical patients or the general publics might be of physician decisions and consensus, the underlying relationship begs us to trust and grant physicians with superiority and authority in the healthcare system. Regardless of how complicated the healthcare system is, physician superiority seems to be a necessary power the system needs to function.

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[2] 46 AM. JUR. 2D PROOF OF FACTS 373, (originally published in 1986).

[3] *Post-Treatment Lyme Disease Syndrome*, Centers for Disease Control and Prevention, http://www.cdc.gov/lyme/postlds/ (last updated Mar. 4, 2015) (A minority of physicians, and a movement of patients, claim that the Lyme Disease bacterium persists after initial anti-biotic treatment of the disease. They believe the bacterium can lie dormant and still *chronically* affect people who contracted Lyme Disease in the past even if they received sufficient anti-biotic treatment. The Centers for Disease Control and Prevention finds no evidence of "Chronic Lyme Disease" but has concluded that it should be properly called "Post-treatment Lyme Disease Syndrome"—"Most medical experts believe that the lingering symptoms are the result of residual damage to tissues and the immune system that occurred during the infection.").

[4] BOB DYLAN, *Subterranean Homesick Blues*, *on* BRINGING IT ALL BACK HOME (Columbia Records 1965).

[5] GERALD DWORKIN, THE THEORY AND PRACTICE OF AUTONOMY 113 (1988).

[6] Olmstead v. United States, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting) (whether the use of wiretapped private telephone conversations can be used as evidence when federal agents obtain such evidence without judicial approval constitutes a violation of the defendant's rights provided by the Fourth and Fifth Amendments).

[7] Elias Baumgarten, *The Concept of Patient Autonomy*, 2 MEDICAL UPDATES 1 (1999).

[8] *See, e.g.*, JOHN STUART MILL, ON LIBERTY (Gateway Editions, Inc. 1956) (stating that individuals should be free to act upon their own opinions without physical or moral hindrance so long as it is only at their risk or peril).

[9] Elias Baumgarten, *The Concept of Patient Autonomy*, 1 MEDICAL UPDATES 1, (1999).

[10] *Id*. at 2 ("The importance of non-medical values is even more obvious for a patient who has religious objections to certain forms of medical treatment; for example a Muslim woman who interprets Islam as forbidding treatment by male physicians").

[11] *Id*. at 1.

[12] Charles E. Gessert, *The Problem with Autonomy: An Overemphasis on Patient Autonomy Results in Patients Feeling Abandoned and Physicians Feeling Frustrated*, MINNESOTA MEDICINE (Apr. 2008), available at

http://www.minnesotamedicine.com/Past-Issues/Past-Issues-2008/April-2008/Commentary-April-2008.
[13] John K. Iglehart, *Physicians As Agents Of Social Control: The Thoughts Of Victor Fuchs*, 17 HEALTH AFFAIRS, 90, 91-92 (1998).
[14] *Id*.
[15] *Id*.
[16] *Id*. at 92 (also noted by Victor Fuchs: "Medical care, at its best, is clearly an integrative system, with reciprocal rights and responsibilities between patient and physician. Health is produced by physician and patient working together. Good medical care requires an integrative relationship. Neither competition nor government regulation can deal adequately with the complexity of medical care. That's why I keep stressing the importance of professional norms in governing the physician's role").