

RESTRICTING COMMUNICATION HINDERS THE PATIENT PHYSICIAN RELATIONSHIP

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Abstract

Laws on the patient-physician relationship are closely related to ethics because they reflect the ethical principles that govern the practice of medicine. In fact, many laws are based on ethical principles, such as informed consent, confidentiality, and the duty to provide competent medical care. However, such laws when restricting communication between patients and physicians, hinder the employment of various models of the patient physician relationship, thereby creating an unproductive interference. Examples of such interferences include confusing patients, compromising informed consent, mandating outdated treatment protocol, and criminalizing evidence-based care.¹ Furthermore, no model of the patient physician relationship is superior to any other, they all describe highly interpretive, differing roles. Instead, the patient physician relationship should be up for the patient's interpretation which the physician would then adopt. In what follows I will explore how the aims of medicine influence patient physician interaction. I will also discuss why these models are subjectively derived and why a patient's interpretation is most valid. Finally, I will discuss how a physician might integrate patient preference when developing this relationship.

¹ S. Weinberger, H. Lawrence 3rd, D. Henley, E. Alden, D. Hoyt, *Legislative Interference with the patient-physician relationship*, (2012), National Library of Medicine, <https://pubmed.ncbi.nlm.nih.gov/23075183/>, (last visited Mar 31, 2023).

At its core, the issue with these restrictions lies within the philosophical purpose of healthcare, towards which the government has a duty to employ laws that allow for the fulfillment of such a purpose.

Introduction

A patient physician relationship is formed on the basis of seeking medical treatment. Therefore, such a relationship resides within the precincts of medicine, thereby requiring its alignment with the aims of medicine: providing treatment in the best interest of the patient. For what purpose would such a relationship serve if the root causes of its formation were not satisfied? Furthermore, the physician works to benefit the patient, exemplifying servitude from the physician.² However, this does not mean the relationship is one sided. Although the physician serves the patient, the patient is also receptive to such service, harboring the ultimate goal of achieving patient health. Therefore, the patient physician relationship has voluntary social characteristics. Although it lacks the closeness of a personal relationship, it meets interpersonal needs and both parties are free to disengage if desired. Furthermore, by combining the interpersonal and professional/medical aspects of the relationship, it is clear that “health” cannot be the only goal as it is too broad. More importantly, the well-being of a patient umbrellas emotional needs as well as physical which requires an understanding of patient values. Therefore it would be more appropriate to define relationship aims as that of providing optimal treatment while upholding patient satisfaction.

4 Models of P-P Relationship

Given that relationship aims are consistent with that stated above, the 4 models of the patient physician relationship consider different degrees of involvement from both the patient and physician in meeting these aims. The paternalistic model prefers physician command while the

² J. Saunders, *The Practice of Clinical Medicine as an Art and as a Science*, (2000), National Library of Medicine, <https://pubmed.ncbi.nlm.nih.gov/12484313/>, (last visited Mar 31, 2023).

informative model prefers patient command. In the article, *Four Models of the Physician-Patient Relationship*,³ the interpretive and deliberative models lie between these relatively one-sided extremes and encourage discourse regarding values and health. The interpretive model guides treatment according to patient values while deliberative is more dependent upon using the consulting practice with the patient. Despite the different approaches offered by each, these models share a commonality in that they assume the roles of the patient and physician and use this assumption to predetermine who is most appropriate for decision making. This is problematic as the roles of the physician and patient are highly interpretive. While a physician may see their job as more of a consulting role and value a patient's lead, the patient may believe a physician's medical experience merits a more authoritative role. This scenario only considers a single patient and physician. When taking into account more patient-physician pairs, the combination of these potentially clashing ideals is infinite. Furthermore, rather than discussing which of these interpretive models is most optimal, it is more efficient to discuss whose interpretation is most valid: that of the patient or of the physician? And who makes that decision?

As previously established, the patient physician model is built on the basis of service, the primary interpersonal need for this voluntary social relationship. Therefore, it is the obligation of the physician to work in the best interest of the patient, not that of the patient to listen to the physician. Although one could argue that the patient also has personal obligations towards their own health and should therefore obey a physician's decision, this argument assumes the physician has knowledge of the patient's values. Also, personal obligations are not social, and therefore outside the realm of the patient physician relationship. Furthermore, since it is the patient who is being served, their desired dynamic is most valid. Although it is the responsibility of the physician to provide efficient

³ E.J. Emanuel and L.L. Emanuel, *Four Models of the Physician-Patient Relationship*, (1992), National Library of Medicine, <https://pubmed.ncbi.nlm.nih.gov/1556799/>, (last visited Mar. 31, 2023).

treatment, it is also their responsibility to uphold patient satisfaction which lies in adhering to a dynamic of the patient's interpretation. In such a case, the physician would assume the patient's desired role.

However, in applied medicine it is usually the physician choosing which model they wish to proceed with in patient interactions, a decision largely derived from personal views. Perhaps it would be in the patient's best interest to discuss what role they would like the physician to play in determining a treatment plan. Such a conversation would set the tone for the duration of their relationship. It is important to note that a patient's preference in a relationship dynamic is not the same as the dynamic favoring patient leadership. In other words, this cannot be equated to the informative model, because such a model favors the patient deciding their course of treatment, while the former favors the patient deciding who shall decide their course of treatment. The patient decides the overarching place of the physician in their treatment, the determination of a treatment would then follow.

Conclusion

The duty to provide competent medical care is also an ethical principle that requires the physicians to provide care consistent with professional standards. This principle is reflected in laws that hold the physicians accountable for providing competent care and avenues for seeking redress if the patient believes their rights have been violated. However, considering the reality that the preferences of patients, may or may not be consistent with the best choices for their medical treatment, and acknowledging that the patient and physician have free communication options between both parties, it seems that the P-P relationship would prove most beneficial and efficient if the controlling factor was based on healthcare concerns. Overall, laws that regulate the patient-physician relationship are closely related to ethics because they reflect the ethical principles governing the practice of medicine. On the basis of such, it is equally as important to reference ethics when examining the effectiveness of medical practice as it is to ensure the practice of medicine

meets the personal needs of the patient, while at the same time offering the best medical options.