**Topic: Models of the doctor-patient relationship**

**In 1972 Robert Veach postulated four** models of the doctor-patient relationship[1]:

(1) Priestly (The paternalistic),

(2) Engineering,

(3) Collegial,

(4) Contractual

The **Priestly** Model dates back to the Hippocratic tradition: "I will use treatment to help the sick according to my ability and *judgment*, but I will never use it to injure or wrong them". In other words, the physician makes all decisions regarding medical care of the patient based on his medical expertise and assessment of the patient's best interests, without consulting the patient. The Hippocratic, priestly physician operates on the *medical model*, which treats patients as illnesses, not as persons. The priestly physician does not take into account a patient's value system which includes a broad range of considerations beyond illness that might impact decision making. The paternalistic, Priestly Model of the doctor-patient relationship remained dominant from the time of Hippocrates (4th century B.C.) until the 1970s when Veach first wrote on the subject.

The **Engineering Model** switches the locus of decision making from physician to patient. The physician becomes a "hired gun" who relays the medical facts to the patient who then has full authority to select whichever treatment option he thinks is most consistent with his needs and desires, and then the physician implements the patient's decision. In this model, the physician is like a plumber

[1] Veach R. "Models for ethical medicine in a revolutionary age*". Hastings Center Report*: 1972 (June): 2(3)

who, hired by a client, uses the skills of his trade to make repairs and flush out clogged pipes. He is a reservoir of scientific knowledge and dispenser of medical facts, presenting options to the patient without sharing his personal recommendations.

In the Priestly Model the patient relinquishes his moral authority and puts full decision-making responsibility in the hands of the physician; contrariwise, in the Engineering Model the physician abdicates his moral authority, reduces his role to that of a scientific expert who presents medical findings in a factual, value-free way and then places the full responsibility of decision-making in the hands of the patient.

Over the past 4 decades the once dominant Priestly Model with its centuries-old Hippocratic ethic has lost ground to the Engineering Model which better describes the dominant physician-patient dynamic in the modern medical marketplace. The movement from primary care to specialization in the medical profession, with emphasis shifting from conversation with patients to performance of procedures, is one manifestation of its emergent influence. Another is the growing perception that medical care is a commodity to be bought and sold at a competitive price. Physicians are referred to as health care *providers*, not health care *professionals*; patients are *consumers* of a health *product*.

From the times of Hippocrates until the 1970s, physicians were guided by the principle of beneficence to the extreme of paternalism (looking out for the good of the patient as they understood it and acting unilaterally in decision making). Beginning in the 1970s the doctor-patient dynamic began to change dramatically with a growing recognition of the importance of patient autonomy in decision making. The newer models of the doctor-patient relationship reflect a trend toward more interaction and dialogue between patient and physician in a collaborative process to discern the health care decision that is not only “medically indicated” but also most aligned with patient values.

A strong advocate of patient autonomy and critic of the Hippocratic tradition, Robert Veach in 1972 was the first to postulate a **collaborative model** of the physician patient relationship.

In the **Contractual Model** of collaboration, physician and patient forge a mutually agreeable contract, more like biblical covenant than legal construct. There is true sharing of decision making in such a way that both physician and patient can be confident of retaining their moral integrity. The basic principles of autonomy, fidelity, voracity, avoiding killing and justice are essential to their contractual relationship. Physician and patient, through open discussion and exchange of views, establish a mutually agreeable value framework for medical decision making. In this way the physician is able to make the myriad decisions regarding medical care on a daily basis without consulting the patient on every detail.

Twenty years after Veach, Ezekiel Emanuel and Linda Emanuel proposed 4 Models of the physician-patient relationship. The first two are very similar to Veach's: Paternal Model (like Priestly) and Informative Model (like Engineering). However, their two collaborative models (Interpretative and Deliberative) spell out the role of the physician in greater detail than Veach[2].

In the **Interpretative Model**, the physician acts like a counselor whose role is to elucidate and interpret the patient's values, and then to assist him in determining the medical interventions which would best realize the specified values. It presumes that people are often unclear about their values and that discussion with another would help them apply their value system to clinical situations. The counselor physician acts as a facilitator in the process and does not introduce his value structure into the discussion. He helps the patient reconstruct his goals and aspirations, his character and life commitments. Once the physician understands the patient's value system, he determines which tests and treatments would best

[2] Emanuel EJ and Emanuel L "Four Models of the Physician-Patient Relationship". *Journal of the American Medical Association* 1992: 267 (16); 2221

realize these values. This final step resembles Veach's Contractual Model since it's not necessary that patients be involved in every detail of decision-making once the patient's value structure is established. Yet in both models, the patient is the center of decision-making and has full moral authority.

In the **Deliberative Model**, the physician takes a much more active role in the collaborative dynamic. He presumes that the patient's values are open to development and revision through moral discussion. He articulates and persuades the patient of the most admirable values. Like a teacher he explains what course of action in his judgment is not only "medically indicated" (Informative Model) but also most noble. Thus, the physician presents his medical and moral judgment up front in the discussion and uses his skills of persuasion based on clinical experience and firm opinion, yet ultimately he leaves the final decision to the patient.

It seems that none of the models apply in all clinical circumstances. In an emergency, clearly the Priestly/Paternalistic Model would apply since there is no time for discussion about values and preferences. It may also apply in some agrarian, third world cultures where the patient traditionally places all decisions in the hands of the physician and defers to his family all discussion with the physician. But in our modern pluralistic society, it would be foolish to presume physician and patient would espouse similar values and views of what constitutes a benefit, thus this paternalistic model would rarely apply now.

The ***Engineering***/Informative Model would be operative when medical facts are all that's needed, e.g. when a specialist is consulted for a second opinion to confirm a diagnosis. But it erodes the virtue of caring so integral to the medical profession by reducing the role of a physician to a medical technician, disengaged from any meaningful relationship with his patient. It seems that both physician and society bear responsibility for the rising influence of this model. Doctors may be reluctant to make firm recommendations for fear of litigation if their opinion leads to a bad patient outcome. And in a consumer society, medical goods are like other

commodities that can be bought and sold at the marketplace. Doctors need to be more courageous and society needs to regain its moral bearings.

It encourages the physician to state frankly and directly his specific treatment recommendation and to explain how the decision is consistent with the patient's most noble values. It seems to me this depth of deliberation is rarely possible in one visit, but rather requires a history of ongoing relationship. A primary care physician who sees a patient over a long period of time is in a perfect position to use the deliberative dynamic without much difficulty. And in the context of intensive care, an intensivist who sees patient and family at least daily can use the deliberative dynamic more easily than with a specialist who sees the patient only once or twice.

Theoretical models are helpful for discussion but do they apply in real life clinical medicine? In a provocative article entitled "No more models: just ask the patient", Clark et al argue that the common theoretical models of "preferred" decision making relationships do not correspond well with clinical experience[3]. The theoretical models of doctor patient relationship treat the patient alone outside of his or her family and social context. Yet typically the patient does not want to make decisions alone. Most patients prefer family or friends to be involved and they want advice from a spouse, son or daughter before they make a final decision. And at times they delegate decisions to someone they think has better judgment or a better grasp of the facts. As long as the physician patient model is that of an individual autonomous patient and a single physician in a decision making context, the preferences of such patients would be ignored. In short, there appears to be considerable variety in patients' preferences for decision models, so the search for a single best model is based on a misguided assumption that one protocol fits all.

[3] Clarke G, Hall RT and Rosencrance G. "Physician-Patient Relations: No More Models". *The American Journal of Bioethics* 2004: 4(2), 16- 19.

Physicians will be guided in the right direction, and will actively take into account the differences between individual patients, if they begin the process by asking the patient a few simple questions:

(1) how do you want communication and decision-making to be handled?, (2) who do you want to be present for support and advice when the physician discusses treatment options with you?,

(3) how much information about the case do you want the doctor to tell you?,

(4) in which of the many clinical decisions do you want to participate?

The answer to these questions would set parameters for the collaborative process of decision making within the family and social context of the patient's life. Given the variety of patient desires concerning communication, it seems unreasonable to believe that any one model of decision-making will fit all patients.

Medicine is a traditional profession, such as law, education and clergy. The words «profession» and «professional» come from the Latin word «profession», which means a public declaration with the force of a promise. Professions are groups which declare in a public way that their members will act in certain ways and that the group and the society may discipline those who fail to do so. The profession presents itself to society as a social benefit and society accepts the profession, expecting it to serve some important social goal.

*The marks of a profession are:*

- competence in a specialized body of knowledge and skill;
- an acknowledgment of specific duties and responsibilities toward the individuals it serves and toward society;
- the right to train, admit, discipline and dismiss its members for failure to sustain competence or observe the duties and responsibilities.

The historical model for the physician-patient relationship involved patient`s dependence on the physician's professional authority. Believing that the patient would benefit from the physician's actions, patient's preferences were generally overridden or ignored. For centuries, the concept of physician beneficence allowed this paternalistic model to thrive. During the second half of the twentieth century, the physician-patient relationship has evolved towards shared decision making. This model respects the patient as an autonomous agent with a right to hold views, to make choices, and to take actions based on personal values and beliefs. Patients have been increasingly entitled to weigh the benefits and risks of alternative treatments, including the alternative of no treatment, and to select the alternative that best promotes their own values. The patient–physician relationship entails special obligations for the physician to serve the patient's interest because of the specialized knowledge that physicians hold and the imbalance of power between physicians and patients.

The physician's primary commitment must always be to the patient's welfare and best interests, whether the physician is preventing or treating illness or helping patients to cope with illness, disability, and death. The physician must support the dignity of all persons and respect their uniqueness. The interests of the patient should always be promoted regardless of financial arrangements; the health care setting; and patient`s characteristics, such as decision-making capacity or social status.

At the beginning of a patient–physician relationship, the physician must understand the patient's complaints, underlying feelings, goals, and expectations. After a patient and a physician agree on the problem and the goal of therapy, the physician presents one or more courses of action. If both parties agree, the patient may authorize the physician to initiate a course of action; the physician can then accept that responsibility. The relationship has mutual obligations: the physician must be professionally competent, act responsibly, and treat the patient with compassion and respect, and the patient should understand and consent to the treatment that is rendered and should participate responsibly in the care. Although the physician should be fairly compensated for services rendered, a sense of duty to the patient should take precedence over concern about compensation when a patient's well-being is at stake.

The patient demands from the physician both a high level of competence (both judgment and skill) and a concern for the patient's well-being. For healthcare professionals to behave in a responsible or trustworthy way requires both technical competence and moral concern-specifically, a concern to achieve a good outcome in the matter covered, which is sometimes called «fiduciary responsibility», the responsibility of a person who has been entrusted in some way. The moral and technical components of professional responsibility have led sociologist Bernard Barber to speak of these as two «senses» of trust. However, if the patient trusts the surgeon, it is not in two senses; the patient trusts the surgeon simply to provide a good, or perhaps the best, outcome for the patient. To fulfill that trust, the surgeon has to be both morally concerned for the patient's well-being (or at least health outcome) and technically competent.

Starting in the last quarter of the twentieth century, attitudes and practices towards disclosure of clear-cut medical error changed from guild-like self-protectionism to more forthright, perhaps preemptive truth-telling. That is, both medical ethicists and risk managers now counsel practitioners to tell patients or

their legally authorized representatives (parents, guardians) when an obvious error occurs. Few now suggest hiding an overdose, administration of a mismatched blood product, or some clearly preventable difficulty in the operative field.

At the end of the twentieth century, mistakes in medicine began to receive attention appropriate to their contribution to morbidity and mortality in the healthcare system. Public policy began to concentrate on recurring, systematic underlying causes of medical error and borrow concepts from cognitive science, social psychology, and organizational behavior to address the pervasive problem of medical mistakes. Whether this approach to improving patient's safety will reduce the incidence or seriousness of medical error remains to be seen, especially as industrial thinking has not paid close attention to the actual and powerful culture of medicine. Also unclear is the effect that an impersonal line of attack on the problem will have on professional morality. Too great an emphasis on technical fixes may erode the sense of personal ethical obligation to patients that society wants its healthcare professionals to hold dear.