



# At the moral margins of the doctor–patient relationship

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The relationship between a doctor and a patient is taken to be one of the most ethically significant dimensions of good medical care. After all, it is within the interactions that constitute this relationship that information is shared, that choices get determined, that reassurances are provided, that decisions are made and, ultimately, that care is given. Medical ethicists have devoted considerable effort to identifying different types of relationships, and in specifying their ideal components, most usually in general or abstract terms. Indeed, I would suggest that medical ethicists are most comfortable when we are comparing different models of this relationship (most famously, perhaps, when discussing the well-known typology introduced by Emanuel and Emanuel<sup>1</sup>), or perhaps when advancing one account of this relationship that can provide the foundations for the most optimal approach to shared decision-making, for example by Sandman and Munthe.<sup>2</sup>

But, in truth, the doctor–patient relationship is most ethically interesting—and intellectually challenging—when scrutinised in its non-ideal forms. Ethicists who turn their attention to the front line of practice have demonstrated a tendency to see this relationship as one that is creaking at the seams, subject to manipulation or side-tracked entirely. So, is it the case that the doctor–patient relationship is under threat in contemporary medical practice?

The answer to this question ought, I think, to be answered in the affirmative, though tentatively so. The role of medical ethicists is to identify precisely how such threats are materialising and to capture these in rich, detailed accounts of everyday medical encounters. Medical ethicists then also have a vital role to play in identifying and responding to these changes in a carefully reasoned way. Sometimes this is likely to involve pushing back and protecting those elements of the doctor–patient relationship that have fundamental value, regardless of context, changing social values, or technological advancement. At other times, it will mean revisiting, refining and potentially adapting the moral foundations of this relationship

in order to steward its future direction in ways that are responsive to well-reasoned accounts of what good practice continues to demand of both doctors and patients.

## RELATIONAL ASYMMETRIES

A number of papers in this issue expose different challenges facing the doctor–patient relationship in its ideal form at the current time. The authors critically examine features of this relationship at its *moral margins*, where, for different reasons, the form and content of this relationship raise ethical concerns that demand analysis and ethical response.

One common feature across these contributions is the view that equal partnerships between doctors and patients are threatened by distinctive asymmetries between these partners. These asymmetries manifest themselves in different ways but are common in the sense that they concern fundamental differences in power between the doctor and patient. The doctor, as the enabler of treatment, possesses the control over how decisions get made and what decisions get made, and he or she has a range of legally-mandated or technologically-supported strategies at his or her disposal to shape his or her interactions with the patient. The result of these asymmetries is multiple sources of ethical concern: concern associated with the outcomes that arise from how the doctor exerts control within this relationship in forging, managing and maintaining in a variety of ways, and concern associated with how the patient is treated as a partner and person worthy of respect.

## ASYMMETRIES IN MEDICAL DECISION-MAKING

Lindberg *et al* (see page 161) take, as their starting point, the fact that healthcare decisions are rarely made instantaneously, and the ethical focus in their paper is the temporally extended nature of treatment decision-making. They note that ‘temporising’ (the time between the doctor determining a decision is to be made and the point at which the patient is approached to make it) is characteristic of doctor–patient encounters and that this

phenomenon potentially undermines the patient’s right to self-determination. Their discussion of whether patient self-determination is threatened wrongfully is nuanced and dependent in part on considering how a requirement to promote, rather than merely respect, patient autonomy should be interpreted and accorded moral weight.

A different kind of asymmetry in the doctor–patient relationship is the doctor’s ability, often enshrined within the law, to opt out of providing or offering certain kinds of intervention on grounds of conscience. Card (see page 168) contributes to the extensive ethical arguments on conscientious objection—many of which have been showcased in this journal previously—by arguing against what has come to be known as the ‘market view’.<sup>3</sup> This view takes the position that doctors’ freedom to determine the scope of their role and responsibilities is ethically important, at least in private practice, thus justifying a far wider range of conscientious objections than are typically recognised. For Card, doctors’ freedom to tinker at the boundaries of their responsibilities to their patients must be constrained by the fiduciary duties that they possess and that shape an overarching professional obligation to advance their patients’ interests.

Nudging, as Thaler and Sunstein<sup>4</sup> famously conceptualise it, is ‘an aspect of choice architecture that alters people’s behaviour in a predictable way without forbidding any options or significantly changing their economic incentives’. The ethics of nudging typically focuses on the health policy context, which is usually the domain in which specific nudges are formulated and introduced. However, Avitzour *et al* (see page 183) explore the ethics of clinical nudging: the nudges introduced by doctors within clinical encounters with patients to alter patients’ behaviour, such as their treatment adherence. Avitzour *et al* critically examine one argument in support of clinical nudging—the empirical evidence that suggests that a healthy majority of the public support this practice—and find it wanting. Partly, this is due to the weaknesses in the quality of this evidence, and partly this is due to the ethical weight that ought to be given to

informed consent and trust, two considerations that are undermined by nudging and that ought to be given additional weight in analyses of nudging that take place within the doctor–patient relationship.

### ASYMMETRIES IN MEDICAL SPECIALITIES

Asymmetries within the doctor–patient relationship are particularly characteristic in certain medical specialities, either because of the specific vulnerabilities facing some patients or the distinctive power dynamics in play. Two papers in this issue explore challenges in psychiatric practice. Gosney *et al* (see page 173) recognise that, in psychiatry, for example, the doctor possesses the power not simply to withhold decision-making opportunities, to influence choice-making options, or to opt out from offering certain interventions, but also to force treatment on patients and deprive them of their liberty. The authors examine the system in place in England to constrain the use of doctors' powers associated with involuntary treatment and find it ethically problematic. One interesting suggestion that is advanced to address a key asymmetry in this review process is an increased role for judicial decision-making in the original decision made by the doctor to detain a patient for compulsory treatment. Inviting a judge into the doctor–patient relationship in psychiatry would, as the authors recognise, have radical implications for professional practice in this context, but one that ought to be considered further nevertheless.

Second, Guidry-Grimes (see page 178) explores how patients' insight into their mental illness can have significant ramifications for the doctor–patient relationship by shifting the role that the doctor allows the patient to play in information

sharing and decision-making. Doctors' interpretations of their patients' insight have important epistemic implications for patients' roles in medical encounters with negative ethical connotations that standardly lead to patients playing a marginalised role in setting care and treatment priorities that are appropriately responsive to their own perspectives on their illnesses.

An entirely different location where ethically problematic asymmetries arise in the doctor–patient relationship is in the management of the dying process. In many legal jurisdictions, doctors have been accorded the powers to assist with the death of a patient who might be terminally ill, in pain, or making a sincere and consistent request to be helped to die. Jansen *et al* (see page 190) look again at the ethical grounds for constraining a doctor's power to assist with a patient's death, and they argue forcefully for limiting assistance in dying to patients with terminal illnesses. Perhaps the most interesting component of this argument is the one derived from their interpretation of the social meaning of the doctor's role—an account that leads them to consider and reject the social legitimacy of extending physician-assisted death to those who are not terminally ill on fairness grounds.

### ASYMMETRIES AND NEW TECHNOLOGIES

New technologies adopted at the bedside have the potential to radically transform the doctor–patient relationship, and this is likely to be an area of medical ethics that will attract considerable attention over the next few years. McDougall (see page 156) makes an important contribution to this emerging literature. While her focus is one specific new technology (IBM's 'Watson for Oncology'), her argument

has implications for a wide range of new artificial intelligence (AI) tools designed to assist doctors in managing patients' care.

McDougall argues persuasively that *how* values are integrated into these tools are crucial to determining their ethical justification. Only if these tools are 'value-flexible', as McDougall puts it, can they be defended on ethical grounds. This requires the diversity of personal values held by patients, as well as broader agreed-upon social values, to be incorporated into how these tools operate to support clinical decision-making. In so doing, AI can help to facilitate shared decision-making in ways that are potentially more efficient than might be possible within human encounters alone. Efficient and more effective shared decision-making is, of course, only one aspect of the doctor–patient relationship that needs to be considered; the broader impact of technology on the quality of interpersonal interaction between a patient and doctor looks to be an important topic for fruitful ethical inquiry.

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### REFERENCES

- 1 Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. *JAMA* 1992;267:2221–6.
- 2 Sandman L, Munthe C. Shared decision making, paternalism and patient choice. *Health Care Anal* 2010;18:60–84.
- 3 Ancell A, Sinnott-Armstrong W. How to allow conscientious objection in medicine while protecting patient rights. *Camb Q Healthc Ethics* 2017;26:120–31.
- 4 Thaler RH, Sunstein C. *Nudge: improving decisions about health, wealth, and happiness*. London: Penguin, 2009.