Although doctors are expected to acquire many competencies in training and play many roles in practice, patients and the public view doctors primarily as clinical healers. Most doctors who enter medical school state their intentions as that of wanting to help their fellow humans to relieve their pain and suffering and aid in the healing of their illness, beyond the cure.

The doctor assumes a healer’s (therapeutic) role when a patient seeks his professional skills for diagnosis and treatment of medical illness. The doctor uses his medical knowledge, skills, clinical methods and experience in making a proper medical assessment. He next proceeds to formulate the goals of therapy or a therapeutic plan, after determining the patient’s concerns, expectations and preferences. He then proceeds to get the consent of the patient before starting with the treatment.

Respect for persons

The fundamental professional ethical principle for the doctor to abide by is that of respect for persons. This ethical principle consists of two parts, namely: respect for the persons’ (patients’) wishes and concern for their welfare. Throughout the doctor-patient relationship, the doctor balances support for the patient’s wishes (autonomy) while maximising her welfare. Most of the time, when a patient is seeking medical help, her wishes and welfare interests are congruous. However, it is not uncommon for the two to be divergent or asynchronous. In times of conflict involving a competent and informed patient, the patient’s autonomy takes precedence. The reasons to support respect for autonomy over beneficence is that medical illness and treatment are considered private affairs and are as such best left for the individual to decide. Respect for patient’s autonomy builds trust in the doctor-patient relationship and contributes to the healing process. Coercion leads to breakdown of the relationship and impairs healing. In addition, the principle of respect for persons encompasses respect, empathy and sincerity which are essential components for a healing relationship.

However, if a patient suffers from an infectious disease which is serious, highly likely to be spread to others (which the patient cannot control) and risks public health, patient autonomy will be overridden and the patient can be confined and made to undergo therapy. In these situations, there is legislation that authorises public health officials to violate patient autonomy in the name of greater public good.

Respect for a patient’s wishes and autonomy is not upheld when a patient requests for unprofessional, illegal or inappropriate use of medical knowledge such as physician assisted suicide in Singapore. As a healer, the doctor’s goals of medical therapy should coincide with and be guided by the goals of Medicine, so as to avoid the inappropriate use of his medical expertise (see Table 1).

However, when a patient’s capacity is diminished, the doctor’s first action should be to remove temporary factors that impede her capacity (e.g., sedative drugs, infections, pain, hypovolemia or hypoxia, etc). He should then proceed to make attempts at enhancing the patient’s autonomy by using understandable language and use of decision making aids like pictures and diagrams. The most common cause for diminished capacity in clinical situations is the lack of explanation and understanding of illness and the risks and benefits of therapy, provided in an understandable and empathic manner. Again, the lack of respectful, empathic and sincere communication leads to a breakdown in the doctor-patient relationship. Discharge against medical advice, popularly known as AOR (at own risk), is the common consequence.

When a patient lacks capacity because of a mental disorder or psychiatric disease, the doctor promotes the patient’s best interests and makes her welfare his primary concern. Patients lacking capacity are more vulnerable and may need to be protected from harm, by their own decisions and actions. Persons who lack capacity are considered to be not autonomous and thus welfare or medical beneficence takes priority.

Respect for persons involves demonstrating sensitivity to patients’ individual and cultural characteristics and providing appropriate care regardless of race, gender; socioeconomic status, ethnicity, religion, sexual orientation, political beliefs or any other traits. Respect for persons extends to applying medical knowledge and skills with an understanding of each patient’s needs in order to provide patient-centred care.3

Table 1

The goals of Medicine:3

- Prevention of disease and injury and promotion and maintenance of health
- The relief of pain and suffering caused by maladies
- The care and cure of those with a malady and the care of those who cannot be cured
- The avoidance of premature death and the pursuit of a peaceful death
Fiduciary nature of the doctor-patient relationship

It is assumed that the impact of illness, causing pain, disability and anxiety impairs a patient’s autonomy (some more so than others). This makes medical decision making difficult. In addition the doctor-patient relationship is marked by an imbalance of power, knowledge and expertise. Even if a patient knows the diagnosis, she is not empowered to write a prescription nor do a surgical procedure without the doctor’s authority and expertise.

In the therapeutic role, the doctor has a legal and ethical duty to place the patient’s medical welfare and interests above his personal interests and those of third parties. This principle of the dedication to the primacy of the patient’s interests is essential not only to correct the imbalances of the relationship but also displays altruism that is essential to build trust and confidence. Only when a patient has developed trust in her doctor will she consent to investigations and comply with therapy. Trust in the competence and conduct of the clinician is essential in the healing process.

Duty to manage conflict of interest

Patients place their trust in their clinicians to always act in their best interests. When a clinician places his private gains or personal interests above the patient’s interests, conflicts of interest (COIs) occur. COIs introduce bias, impede good clinical judgements and compromise clinical outcomes. Even the perception of COIs could lead to erosion of trust and confidence. The imbalance of power and knowledge makes a patient vulnerable for financial exploitation and being used by clinicians for academic and research advancement. Disclosures do not necessarily help a patient make appropriate decisions, as she is unable to determine if other interests would be influencing the clinician’s judgment. Therefore, it is best for the doctor to avoid financial and other COIs in a healing relationship.

Duty to inform

Doctors in a therapeutic relationship have an ethical and legal duty to inform patients on their disease, the type of investigations planned and therapy. The doctor has to inform his patients of present and future risks of surgery and therapy. The principle of respect for patient’s autonomy is expressed in answering patients’ questions and concerns in a shared decision making and informed consent process. Consent for therapy is usually implied but explicit written consent would be required for non-routine or higher risk procedures such as surgery.

Shared decision making and informed consent essentially allows the patient to understand her illness and also allows the clinician to understand the patient’s preferences, concerns, and expectations. It is a powerful tool in building mutual trust and respect. A doctor should answer his patient’s queries with respect and provide the information she wants or needs in a way she can understand. Devaluing or ignoring the patient’s questions or concerns is a sure way to erode trust and create the predisposing factors for complaints of professional misconduct and legal claims.

Therapeutic privilege is the legal and ethical doctrine by which a doctor may withhold information regarding the patient’s medical condition and risk if such disclosure will be detrimental to the patient’s care and best interest. This privilege should be exercised in exceptional situations and after careful consideration.
Duty to integrity and honesty with patients

The doctor is expected, at all times to be truthful (veracity) in all his dealings and communications with the patient and her family. He must at all times eschew deception or misrepresentation, and must make appropriate and timely disclosure when adverse outcomes or medical errors have occurred. Although there are cultural differences in disclosing bad prognoses to patients, most patients need to know accurate and adequate information for appropriate decision making. However, patients vary in their need to know and what is considered to be adequate. Truth-telling reduces anxiety and uncertainty and helps a patient seek recompense in cases of medical negligence. When a patient is informed of the truth from sources other than the treating clinician, trust is damaged. Truth-telling is not only a mark of respect for patient autonomy but, in the case of bad news, is also delivered as an act of compassion.

Duty to attend

The doctor should continue to serve the patient and provide appropriate access to care in a timely manner. The doctor has an ethical and legal duty to attend as required by his patient’s needs and should not delegate critical duties to juniors. If a doctor delegates duties to another clinician, he must ensure that the attending clinician is adequately informed and competent. The doctor should never abandon his patient, and should continue care for her until an appropriate transfer to another equally competent doctor is completed.

Duty to refer

A doctor must not practice beyond his competence and make appropriate and timely referrals. He should emphasise the urgency of the referral when critical and facilitate such referrals. When referring, he should share all important and relevant information. He should collaborate effectively with colleagues, healthcare teams, and professional associates to ensure effective patient care.

Duty to maintain confidentiality and privacy

Information that a patient shares with her doctor should be used only for her benefit. The doctor must protect this privileged information given by his patient in confidence by maintaining confidentiality of all information, even that which was acquired outside the doctor-patient relationship. Although breaching confidentiality may not lead to physical harm, it significantly erodes trust and confidence and leads to damage to the relationship. Disclosure should only be made by the doctor with the patient’s consent, for the patient’s therapeutic benefit and where the doctor is legally required to do so.

Duty to maintaining appropriate relations with patients and their families

Recognising the inherent vulnerability and dependency of patients, physicians must avoid inappropriate relationships with patients. No clinician must ever exploit a patient for any sexual advantage, personal financial gain, or other private purposes. Informed consent is not an adequate defence for inappropriate relationships. A doctor should cautiously refrain from extending doctor-patient relationships with patients and families into social relationships, whether in person or using social media. If a doctor has already established social relationship with a patient or family member, he should endeavour to draw clear boundaries between the two relationships. The doctor should highlight to his patients the benefits of having clear boundaries so there is no compromise in clinical care and judgements. As a general rule, doctors should refrain from treating their close family members, but if they do so, then they should insist on formal consultations in the clinic, and ensure that standard of care and good clinical records are kept.

Conclusion

For effective healing, patients need competent, compassionate and trustworthy doctors who make the care of their patients the first concern. The therapeutic doctor-patient relationship is an alliance marked by mutual respect and trust, empathy and sincerity. The art of healing is embedded in science, wisdom and altruism.

References


Dr T Thirumoorthy is an associate professor at Duke-NUS Graduate Medical School.