Restoring Intimacy to the Physician-Patient Relationship

BY CARL H. BRENNAN, MD

A young woman came to see me a few days ago, a former patient now in her twenties. She will die soon; nothing can be done. We shared some recollections of the years when I was her pediatrician, and she expressed some regrets that she was to have no future. But she shed no tears. Still, I cannot forget her eyes staring into the distance as though searching for a way to cry. Momentarily, she smiled slightly, kissed my cheek, and was gone. We shall not meet again.

It has been an immeasurable pleasure for me as a pediatrician to have been a part of so many lives, though rarely has one ended so tragically as this. I thanked a generous God recently for having guided my hand over so many problems and so many thousands of trusting young people.

Sadly, the healthcare system that fostered the kind of intimacy I shared with the young woman exists no longer. And the changes have come quickly. Physicians are not the same today as they were just 12 years ago when I began serving on the board of trustees at St. Joseph Hospital in Savannah, GA. Granted, physicians today are much more knowledgeable, but they are also addicted to technology and computerized probing of body secrets that were undreamed of even a decade ago. Patients have changed as well. They are more familiar with medical technology and more knowledgeable about and insistent on their rights.

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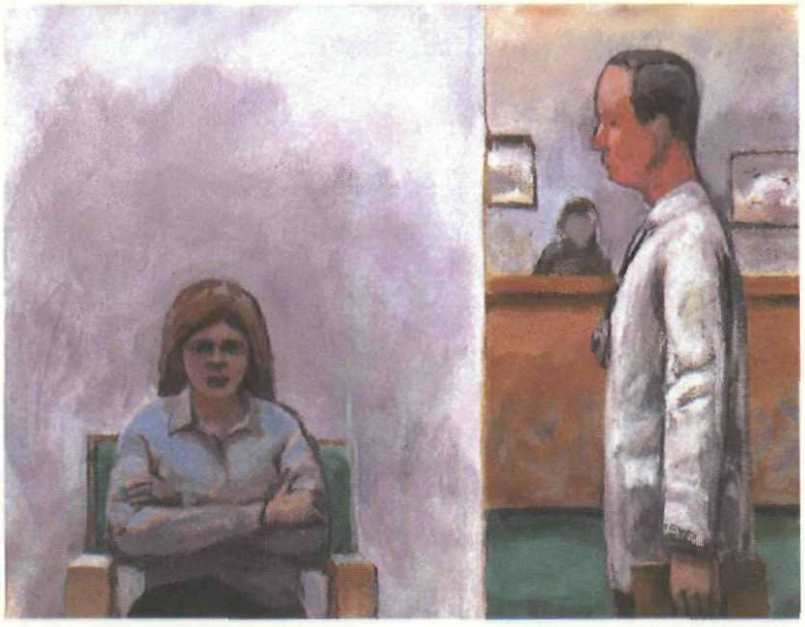

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In fact, new technologies and new laws on everything from abortion to patient self-determination have not only destroyed the old intimacy that characterized the doctor-patient relationship; they have replaced it with confrontations unheard of when I began serving my board term.

Ethics committees were almost nonexistent at that time. When conflicts arose concerning who lived or who died, they were deferred to me as the physician member. In our naïveté, we assumed that no one except a priest or a minister would be competent to question a physician's prerogative in such areas. When a difficult life-or-death decision arose, no subcommittee convened to address the issue; I handled it alone.

Medical ethics has come of age during my board tenure. But the new insistence on patient participation in healthcare decisions and increasingly bitter debates within healthcare leave physicians in a moral quandary. For today's physicians are often caught in a conflict between what they believe they *ought* to do and what they find themselves *compelled* to do. Should their ethics be justice based—that is, derived from rational, scientifically valid rules indiscriminately administered by strangers—or should the care they provide be based on compassion for persons—rules and dollars notwithstanding?

The current demand for patient autonomy challenges the physician's traditional prerogative to answer such questions. What had been an acceptable imbalance of power (with the physician holding the edge) now threatens to become a confrontation. The implementation of the

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Patient Self-Determination Act, which established patients' right to formulate advance directives for treatment decisions, portends a situational ethics, with even greater emphasis on individual rights. We can expect, for example, greater public support for legislation permitting self-*termination* choices. Such support would be a logical outcome of the growing perception that we are owners, rather than stewards, of our bodies.

Care givers are threatened as never before by a public that wants to have its cake and eat it too. Little authority exists within healthcare to resolve conflicts between patients and care givers regarding treatment decisions, and so the issues are often left for the courts to address. But is it ethical for healthcare professionals to throw in the towel and accede to every demand for greater patient autonomy, yet ignore the human cry for relief from pain and suffering that patients cannot face alone?

Care givers who listen can help their patients perceive and accept their limitations. Our mission involves more than merely offering machines, pills, shots, and a comfortable environment. We owe our guests additional help as they strive to find answers to the tormenting questions, Why me? Why this burden, this cross, this pain? We must be able to show them that something better must exist, that their pain is not futile.

If we really hear the patient's lament, we are obliged to point out gently that he or she is not alone. We are all part of the human community. When a person can no longer handle the drama of life and ceases to adjust or compromise, that person dies defeated. Patient suffering ought not to be accepted as frozen in situ. Our failure to find the words or actions to help patients transcend their pain encourages society's acceptance of abominable solutions.

Such burdens weigh most heavily on those outside the social mainstream. In the guise of commiseration and charity, assisted suicide is even suggested by some as a quick fix for fiscal and medical insolubility. But the poor are sicker than the rich in part because of low self-esteem. Can we accept responsibility for helping them arrive at a more positive attitude?

We need to develop a more critical awareness of sickness, poverty, and life's "bad deals." Many of our patients today are indeed afflicted by sickness and disease, but they are also afflicted by other circumstances beyond their control. Who knows their despair, their loneliness, their overwhelming frustrations? To send them away cured of bodily maladies but still mired in their stress and misery is to abdicate our responsibility as healers.

Can today's physicians be kind, caring, competent, and committed in language and manner, yet still respect the newly established patient rights that place such a strain on the patient-physician relationship? Preserving this possibility may, in fact, be one of the primary services an ethics committee can provide. For if these committees can help all parties arrive at tolerable compromises on conflicts over treatment decisions, physicians and patients may remain close enough to identify shared concerns and meet mutual needs. □

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- Strict criteria should be in place, indicating how a vendor's contribution can be used and how the organization will communicate this use to the vendor.
- All of the healthcare organization's employees having any financial interest in a company that is doing business with the organization should sign a conflict-of-interest statement identifying their relationship with the company.
- The healthcare organization should have a policy prohibiting employees from accepting any item of substantial value and favor or hospitality that might influence decisions or actions affecting their organization.

Even when the above conditions are met, internal auditors must carefully monitor each situation to be sure that solicitation and receipt of charitable donations do not influence the healthcare organization in the awarding, evaluation, and renegotiation of business with a vendor, and that a vendor does not misinterpret a solicitation and feel compelled to make a donation. Materiality is a relevant principle in this regard. When a vendor's contract is a small portion of its business (e.g., less than 5 percent) and the vendor's gift is not a substantial portion of the contributions the organization receives (e.g., less than 5 percent), undue influence is probably not an issue.

Fund developers, cognizant that their organizations' financial assets are really those of the community they serve and desirous of maintaining integrity in all dimensions of the giving process, should find potential benefactors appreciative of their vigilance in addressing and preventing conflicts of interest. □