The phenomenon of the doctor-patient relationship and its application

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- Presentation is a summary of thesis of the phenomenon of the doctor patient relationship
- Short cases
- End-of-Life (EndCare) Erasmus+ EU project

The Nature of the Doctor-Patient Relationship

Health Care Principles through the phenomenology of relationships with patients

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About this book | Reviews

This book serves to unite biomedical principles, which have been criticized as a model for solving moral dilemmas by inserting them and understanding them through the perspective of the phenomenon of health care relationship. Consequently, it attributes a possible unification of virtue-

The nature of the relationship

- The aim was to address through phenomenology Edmund Pellegrino's recommendation of retaining Principles but supplementing them more fully by insights from other ethical theories and importantly ground principlism more fully in the phenomena of the doctor patient relationship.
- Hopefully this also addressed reconciling principles with virtue based theories

Some previous attempts at approaching the for principles

- Beachamp and Childress: use of specifying and balancing.
- Veatch – Lexical Ordering
- Engelhardt – principle of permission
- Clouser and Bert – strongest criticism at the time – suggest common morality
- Pellegrino – Noted that Autonomy has 'shifted the centre of gravity from doctor to patient
- *Nevertheless* they have become common language in medicine

Which principle reflects the true phenomenon:

- Proposed that Beneficence is the *phenomenon* of the d-pt relationship
- Nonmaleficence is a *manifestation* of the phenomenon
- Justice is a phenomenon of society
- Principle of respect for autonomy is a manifestation of Justice
- However Justice in health care is also a phenomenon of beneficence

- Definitions used made use of Heidegger's *Being and Time*.
- Hence, a phenomenon manifests itself in itself, whilst the manifestation is a result of the phenomenon.
- From MacIntyr we have the interesting terms:
  - Goods internal
  - Goods external

- Goods internal are inherent goods of finding fulfilment in one's vocation, for example, More importantly is the will to do good and address the seeking-of-help by patients.
- Goods external are issues like prestige, money etc.
- Unfortunately in time *paternalism* grew, which was also a result of better education amongst the general population.

Why patients seek help?

- Fact of illness
- Injury
- Nowadays for prevention
- Historically:
  - Shamans
  - Witch doctors
  - Priests
  - Hence a great overlap with spirituality and transcendentalism.

- One therefore understands that any philosophy of medicine must address common morality which often traditionally is reflected in laws and spiritual institutions and more recently ‘social constructs’.
- Illness has often been seen as something coming from God or a god. It may have been seen as a punishment. Hence the invocation of healing and spirituality.
- But the D-Pt relationship remains a *Fiduciary* relationship – it is based on *Trust*. It cannot simply be written off as a ‘contract’.

Other jargon:

- ‘they’
  - The ‘they’ reflects epistemology, praxis, tradition, and respecting autonomy
- ‘authenticity’
  - We ask what is the true authenticity of the d-pt relationship; e.g. what do we mean by *being*‘patient-centred’; being virtuous (e.g. fortitude in the face of difficulties)
- ‘care’
  - ‘being-wth-one-another’ – a reflection of what it means to be in a community and hence the phenomenon of Justice and justice in health care.

- In short a manifestation is the flower on the plant (the phenomenon
- Autonomy is the flower on the plant of Justice
- Nonmaleficence, Respect for autonomy, and Justice in turn are manifestations on the plant of beneficence

Proposed model of ‘subjective doctor’

- Use of history-taking to create rapport
- Being patient-centred
- Being virtuous and non-judgmental
- ‘return to basics’ (RCP) eg.g in EoL care

Graphical representation

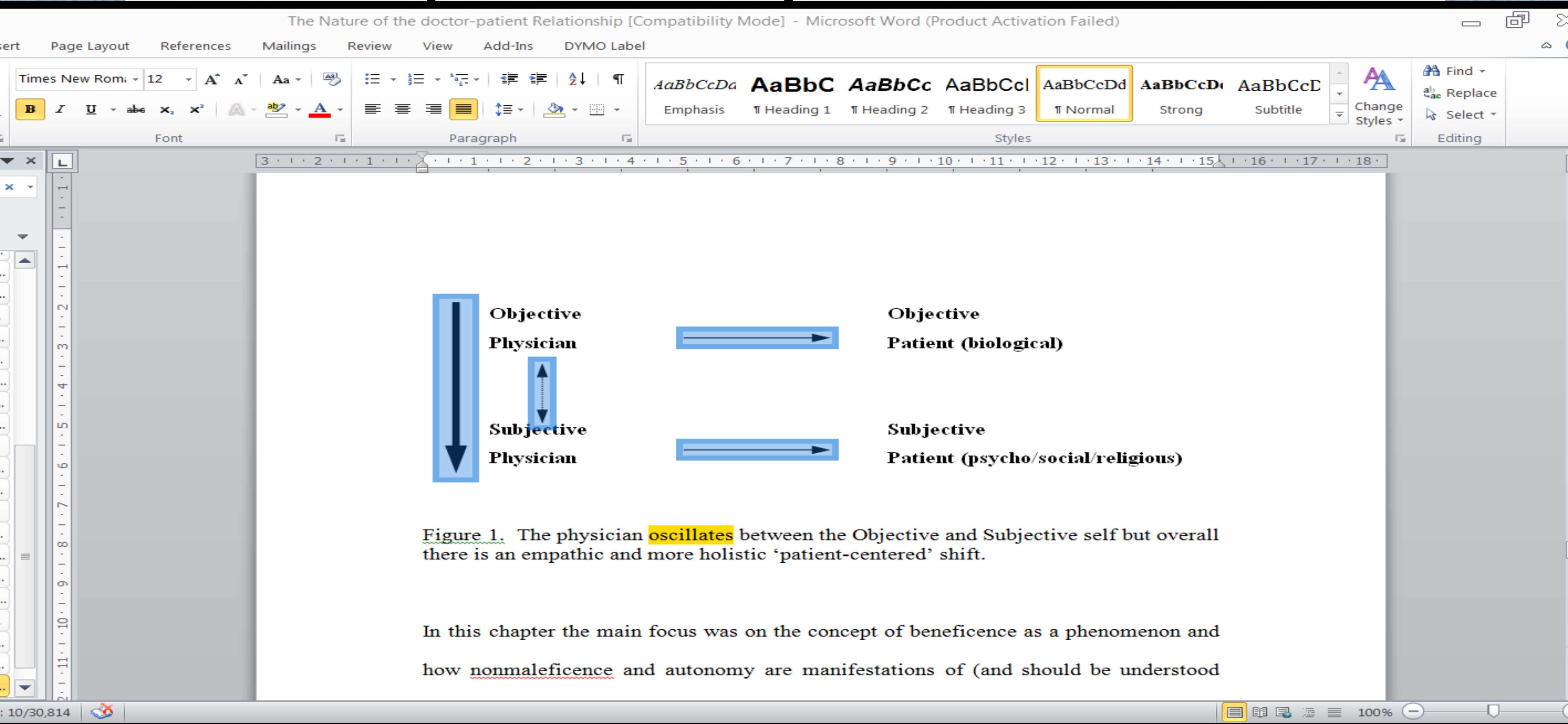
The Nature of the doctor-patient Relationship [Compatibility Mode] - Microsoft Word (Product Activation Failed)

Figure 1. The physician oscillates between the Objective and Subjective self but overall there is an empathic and more holistic 'patient-centered' shift.

In this chapter the main focus was on the concept of beneficence as a phenomenon and how nonmaleficence and autonomy are manifestations of (and should be understood

E.g. a Woman requesting an abortion

- History:
  - Tell me how I can help
  - How did you find out
  - Has this happened before
  - Did you tell anyone
  - Were you using contraceptives
  - Have you considered alternatives? (RCGP CSA)
- Time to reflect
- Feedback

- Being patient-centred
- Nonjudgemental
- What does it say about a doctor who does not spend 10-15 minutes but is concerned only with moral objection (doctor-centred).
- Remain on patient's side – e.g. offer to follow up

Some cases we use in tutorials:

1. Abortion
2. End of Life
3. Sending elderly to a home
4. 15 year old wanting help for drug abuse and confidentiality
5. STDs
6. Truth telling
7. Virtue ethics (case of hospitalisation from a drug you have given)

EndCare

- Problems
  - Started with LCP
  - Malta – concerns about lack of legislation and lack of education
    - Futile treatment, pain relief
    - Lack of Catechism (or religious) education by society
- Stakeholders
  - HCP
  - Patients
  - Politicians
  - Legislators
  - Law

- Partners
  - Dublin City University
  - University of L'Aquila
- Experts
  - UNESCO
  - Pontifical Academy for Life
  - Islam representative
  - France, UK, Italy, Belgium, Iran
  - Faculties of Laws, Medicine, Theology
  - Curia
  - Politicians

Harmonisation of end of life care

- By Harmonisation we mean harmonising within an institution or country and not making it the same, for example, across europe.
- Each place has different problems
- Curriculum
  - Retreats, summer schools
- Consensus statement and document
  - Between faculties of Medicine, Laws, Theology
  - Medical Council, Bioethics Consultative Comm.

Issues

- When to remove ANH
  - Is itright that all patients die with a drip attached
  - What about discomfort – wanting to evacuate bladder
- Can we legitimately (not only morally) stop futile treatment
- Advanced Care planning (e.g. right to refuse life-prolonging treatment such as respirator)

- Summer Schools:
  - Identify problems
    - Inter-, intra-professional communication
  - Identify personal issues
    - Need for communication skills
    - Updates
  - Identify professional issues
    - Need for palliative care training
  - Legal and moral issues
    - Addressing legislators and religious institutions.
  - Coming up with a personalised curriculum to harmonise EoL care

- Updates
  - Gawande, A. – Insurance studies in the US
  - Does pain relief shorten life?
  - What is considered futile
  - Patients' right to decide what is ordinary and what is extraordinary for themselves
  - Dialogue – new approaches to:
    - The consultation
    - Clinical ethics
    - A changing society
    - What is a true dialogue – agape/kenosis/perichoresis
      - *"Dialogue or diagoues"*