ETHICAL ISSUES IN ATTENDING PHYSICIAN-RESIDENT RELATIONS: A PHILOSOPHER'S VIEW*

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CERTAIN very simple moral issues exist about which nobody needs philosophers to instruct them. Everyone knows that nobody ought to lie to a patient about who is to perform or who performed a surgical operation on him. Everybody knows that nobody ought to take money for services which he did not actually render. These are not problems of specifically medical ethics; indeed, these are not *problems*. So, when I disagree sharply, as I shall, with some of the assumptions of the so-called Lifflander Report, it is not because I have the least interest in defending questionable practices.

What the contributions by Dr. Joseph Post and Dr. Stuart Orsher brought home to me was the large discrepancy which now exists between the way in which we have all been trained to think and talk about the relation of the resident to the attending physician and the complex institutional settings in which those relations exist and the ways in which we all—physicians, surgeons, nurses, orderlies, administrators, patients—actually behave. What we say and think tends to reflect a now too often past division of labor in which roles were interdefined in one way; what we do, particularly in teaching hospitals but also more generally, is the outcome of a number of historical changes which have destroyed the patterns to which we still pay verbal allegiance.

It is a safe empirical generalization about the advanced professions of our culture that any rise in the incidence of use of the word "team" signals a rising incidence of role confusion. So it has been in medicine, although medicine is far from being the only culprit. The often unrealistic talk about the "team" character of modern surgery, of which the Lifflander Report is

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rightly suspicious, is a case in point. What those who talked about teams actually betrayed was their own uneasy consciousness of how far traditional descriptions of the physician-patient or the surgeon-patient relation have become mythological. In what way is this so?

All the characterizations of that relation which we have heard today, and equally the characterizations included in the Lifflander Report, embody the fiction that the status of the attending physician derives from a free choice by which the patient determines who is to be his or her doctor. But this notion that under modern conditions the patient can make a genuinely free choice of a physician in any meaningful sense is quite unwarranted. Patients under a variety of pressures and circumstances happen upon some physician or other and lurch into a particular physician-patient relation. The patient is in general afforded neither the information nor the opportunity to make any kind of free and rational choice between physicians. Moreover, the physician whom the patient is said to have chosen is quite likely, medical mobility being what it is, to disappear between one encounter and the next. Even if this does not happen, the patient—general social mobility being what it is—is quite likely to move on to another physician. And even if neither of these changes transpire, the physician who actually examines and prescribes for the patient—the contemporary medical division of labor being what it is—is very likely to change from occasion to occasion. Mobility and the division of labor have, to a large extent, destroyed the traditional physician-patient relation.

Hence, the notion of the attending physician as the patient's freely chosen physician at whose instance and under whose direction other doctors operate is indeed a piece of mythology. For many and perhaps most patients the only genuine relation is with the hospital, with the whole institutional setting, and not with any particular individuals. It is the hospital that gives or fails to give adequate care and cure; individuals function only in their roles within hospitals. Individual physicians, even individual surgeons, are, so far as the patient is concerned, eminently replaceable by others. To have understood this is a necessary preliminary to understanding the inappropriateness of one influential and even dominant conception of the physician-patient relation, a conception that is the unquestioned presupposition of the Lifflander Report. The conception to which I refer is that according to which the individual patient's free choice of one particular physician has led to a contract between doctor and patient in which technical services are exchanged for payment. From this point of

view, what matters about ghost surgery—and a good deal else—is that it constitutes a breach of contract. The patient has not received that to which he or she has a contractual right. The doctor-patient relation is characterized entirely in terms provided by the categories of legal and economic individualism. And just as the Lifflander Report's diagnosis is framed entirely in such terms, so is its remedy: we have to try to make this type of contract enforceable.

What is wrong with conceiving the doctor-patient relation as primarily contractual? (I do not, of course, want to deny that a contract is involved.) The same thing that would be wrong with conceiving the relation of husband and wife in marriage as primarily contractual, although once again, of course, marriage involves a contract. But what is wrong with adultery is not primarily that it is a breach of contract. What matters about adultery is that it is a gross injury to a relation of caring; and it is the same thing that is wrong with the actions of physicians or surgeons who fail their patients morally. But what is the relation which is injured? It is usually, if my earlier contentions are correct, a relation between the patient and institutionalized medical practice, often in the form of a clinic or a hospital, or perhaps a particular ward or area of a hospital.

Both patients and doctors are, of course, under tremendous pressure to falsify their experience of relation by thinking of it in exclusively individualistic contractual ways; what happens to them is analogous to what happens to a married couple who fall into the hands of divorce lawyers. We badly need to avoid legal modes of thought which always lead far too quickly to the question, Who is to blame? and all too rarely to the question, How is reconciliation to be effected? Yet, even physicians and surgeons who are not influenced by legal modes of thought are encouraged, almost forced, to think in individualistic and contractual terms by another element in the situation, contemporary methods of reimbursement. What we have—even when payment for medical services comes from an insuring agency—is naturally enough capitalistic medicine, and there is an important tension between the capitalism and the medicine. If we think of physicians and surgeons as individual entrepreneurs offering technical services for fees, we are thrust back into the ideological world of the Lifflander Report. It becomes crucial to identify who actually performed the service to decide who ought to get the fee. Dr. Kempner's argument in this symposium presupposes that this is of central importance.

So far, I have suggested that we need to think of physicians and

surgeons not as individual entrepreneurs but as having roles within the cooperative life of medical institutions. I now want to suggest that we need to alter our conception of patients in a parallel way. This is the point in the argument where my only professional expertise becomes relevant. I am a habitual patient. But what is it that patients have to know to be good at being patients? We rightly worry a great deal about the notion of informed consent in relation to the particular illnesses or disorders of particular patients. We worry much too little about the kind of information and the kind of consent that is required for a patient to have intelligent transactions with the whole institutionalized system of medical care and practice. Yet, to remedy this would not be difficult. And if it were remedied, it is to be hoped that patients would then learn that a patient has an active part to play in the life of a hospital or clinic.

We all too often treat patients—the etymology itself suggests this—as essentially passive recipients. The contract model, of course, reinforces this tendency and leads to a view of the hospital as supermarket. In fact, of course, not only does the patient bring, or fail to bring, to the hospital certain qualities of character which are indispensable for the treatment of his or her own illness or disorder, but if the patient really were to understand the character of medicine he would realize that a patient is always offering the resident, the medical student, and the attending physician a new opportunity to learn.

Dr. Martin Kempner talked about how the burden of being teaching material is imposed upon patients. It seems to me that we can only think of this as a burden if we also believe that there is some mode of being a patient in which one is not teaching material. The moment that one puts himself into medical hands, one constitutes himself as an opportunity for medical learning, a specimen of a particular kind, perhaps an interestingly ambiguous one, perhaps a dull routine one, but one way or another this is one's role in relation to the doctor. And this is one of the things that makes being ill interesting and worthwhile, not burdensome. Being ill is a very important part of human experience, and potentially a very positive part of human experience. That potentiality can only be realized when the patient is seen as somebody who offers his physicians training of a particular kind.

Finally, we have to notice that if we started thinking of the role of the patient in this way, it would be necessary for the patient to learn the facts about medical error. I mean by this that the patient would have to learn not only that doctors in general make mistakes, but that making mistakes and

learning from them how not to make them is a part of medical education, as it is of all education. The clinical judgment of residents will improve as they gain experience; and this means that some patients have to be treated by the less experienced. Knowing this is part of being an intelligible and responsible patient to whom both resident and physician can stand in an intelligible relation within the context of total medical care.

What I suggest is that the key to the relation between residents and attending physicians lies in the way that the relation of the patient to both of them in an institutional setting is conceived. To understand the role of the patient aright will, of course, be practically as well as conceptually difficult. If my arguments are correct, not only individualism but the masquerade of medical infallibility will have to go. Yet, difficult as it may be to abandon these, it is clear that immediate rewards will follow in the form of a solution of many other problems which now appear intractable.