

SEARCHING FOR MORAL CERTAINTY IN MEDICINE: A PROPOSAL FOR A NEW MODEL OF THE DOCTOR-PATIENT ENCOUNTER*

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PREVIOUS speakers at this conference have indicated that the physician-patient relationship is changing and remains in a state of flux. I think that assertion is incontestable, perhaps with the proviso that the relationship is changing for some patients and for some physicians, whereas others maintain more traditional notions. Despite changes in the character of the relationship, my remarks today will suggest that if moral certainty exists in medicine (that is, if it is possible to determine which actions taken in a medical context are moral and ethical, which are right and wrong), such moral certainty will be discovered not by recourse to formal laws, moral rules, or moral principles, but rather in the context of the particularities of the physician-patient relationship itself.

A problem in this line of reasoning is obvious. If the moral rightness of actions in medicine are to be discovered in the physician-patient relationship, and if the relationship is in an unstable state in which a societal consensus no longer exists regarding it, how is it possible to derive any moral guidelines from such a shifting relationship? If my thesis is correct that whatever degree of moral certainty exists in medicine is to be discovered in the physician-patient relationship, it becomes necessary then as a crucial preliminary step to develop a new and acceptable model of the doctor-patient encounter. Hence, this paper has two goals. First, the thesis will be presented and defended that if moral certainty is to be found in medicine it is to be discovered in the particularities of the physician-patient relationship, and, second, to develop a bilateral dynamic model of the doctor-patient encounter that avoids the unilateral, static notions of

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either a physician-dominated, paternalistic model or a patient-dominated, consumerist-libertarian model of medicine.

SEARCHING FOR MORAL CERTAINTY IN MEDICINE

The thesis of this paper is that moral certainty in medicine is not an entity to be discovered like a truth of nature, rather that it is defined and created in the context of a physician-patient encounter which I refer to as a physician-patient accommodation. A crucial preliminary step, then, is to understand how patients and physicians currently behave and how they describe and justify their interactions before formulating a theory for such actions. Although society's understanding of medicine is in a state of flux, the central event in medicine has not changed. This unchanging event is the clinical encounter between a person seeking help in the care of his health and the health professional—usually, the physician—whose help is sought. Although the relationship between the patient and doctor is and, frankly, always has been molded and constrained by social, political, and economic forces, there still remains enormous latitude in American medicine of 1980 for individualization of the clinical encounter and for negotiations between patient and doctor.

The approach I propose to understand moral behavior in medicine—an examination of the accommodations reached by patients and physicians in the medical encounter—must be contrasted with alternative and more traditional attempts to determine medical morality by a formulation of general moral considerations such as rules, principles, and laws. In the latter instance, one begins with such general considerations as autonomy, fidelity, and veracity, and then strives to determine whether the general consideration arises in particular cases and, if it does, how the rule or principle is to be applied to determine a proper course of action.

For example, rules concerning respect for autonomy, for truth-telling, or for fidelity to patients consistently fail to provide physicians and patients with a means of knowing what their actual duties are in particular settings and circumstances. To illustrate this point, I would like to examine briefly the concept of autonomy.

AUTONOMY

Autonomy is a form of personal liberty of action in which individuals determine their own course of action in accordance with their own life

plans.¹ The principle of respect for autonomy surely recognizes that different autonomous individuals will wish to be treated in different ways by health professionals. An adequate understanding of autonomy would also include the possibility that individuals within a relationship might voluntarily and autonomously choose to relinquish or to waive a degree of independence to pursue other immediate interests. The critical question to be faced by both patient and physician is how much independence is a patient willing or eager to renounce autonomously by choosing to enter into a therapeutic relationship with a health professional. Further, if the principle of respect for autonomy applies to patients, presumably it applies with equal force to physicians. How much personal liberty of action and independence of judgment must a physician relinquish when he chooses to enter the profession of medicine? What duties, obligations, and responsibilities does the physician incur, voluntarily and autonomously, when he chooses to become a physician?

The point I am making is that the invocation of the concept of autonomy fails to provide sufficient practical guidance to morally conscientious physicians and patients to enable them to determine where on a spectrum of paternalism/consumerism or dependence/independence their professional relationship will and ought to stabilize. Invoking the principle of autonomy does not resolve the dilemma facing clinicians and patients; it merely highlights it; perhaps, at times, it even exacerbates it.

It should be noted that the principle of respect for autonomy may prove an essential regulatory component of the final arrangement between physician and patient, an arrangement that balances the respective rights and responsibilities of the two parties. But the practical clinical dilemma of how individual physicians and patients ought to establish the details of their relationship can only be understood by examining their interactions in the particularities of the clinical encounter. A clinical example may be useful to establish this point.

A TALE OF TWO CITIES

A professional ballet dancer who suffers from moderately severe asthma moved to Chicago from New York. Upon arriving in Chicago, she became a patient of a famed specialist in asthma who is a superb clinical scientist. Within six months, the Chicago physician appeared to have managed and mastered her condition, or at least her wheezing. Despite this, she was unhappy. She called on me for another opinion and reported

that she was distressed because she missed having a physician—like her New York physician—who worked with her to achieve her personal goals. She felt she now had no say in her own care. Her new doctor would not listen to her concerns or ideas. Finally, the multiple and prolonged courses of steroid drugs used to control her wheezing had caused increased muscle weakness and fluid accumulation and, as a result, the quality of her dancing had deteriorated. She didn't live just to breathe, she said; she breathed so she could dance.

I am certain that the New York doctor could have manipulated this woman's medications in the same way that the Chicago doctor did to relieve her wheezing entirely, but rather the New York physician had chosen to work with the woman to achieve alternative and important life goals which included an adequate but imperfect control of her asthma that enabled her to function effectively as a dancer. Unfortunately, the Chicago physician, although a thoroughly competent clinical scientist, could not tolerate much patient participation in medical decisions, and, more important, could not accept an alternative endpoint to that of a patient totally free of wheezes. As a result, her disease was managed, but the meaning of her life, as measured by happiness, contentment, and the ability to function as a dancer, had deteriorated.

This clinical example introduces us to three autonomous individuals, the patient and the two physicians. There is not the slightest suggestion that any of the three involved was coerced or manipulated into the two patient-physician encounters described. Each invested considerable emotional energy in developing a physician-patient bond. It must be remembered that the patient remained voluntarily in a clinical relationship with the Chicago physician for at least six months.

My concern is that the principle of respecting autonomy does not appear to resolve entirely the specification of the rights and responsibilities incurred by both patient and physician in such medical settings. Presumably, the Chicago physician believed that he acted responsibly in controlling the symptoms of the patient's disease and that she exercised her rights voluntarily and responsibly in returning for continued care and in taking her prescribed medications. The patient agreed that the Chicago physician exercised the responsibilities he believed he had assumed—to treat disease—when he became a physician. As described, the medical relationship was a failure on both a technical and a moral plane, not because it intruded on the autonomy of either patient or doctor, but because it failed to conform to the best standards of medicine.

This example reinforces my notion that if moral certainty exists in medicine, it must be explored and understood in the context of specific physician-patient encounters and cannot be deduced *a priori* from the application of general moral considerations and such principles as autonomy. This observation leads me to the second part of this paper, in which I attempt to develop a dynamic, bilateral account of the physician-patient encounter, which I refer to as the doctor-patient accommodation.

A PROPOSAL FOR A NEW MODEL OF THE PHYSICIAN-PATIENT ENCOUNTER

The traditional paternal model of medicine was premised on trust in the physician's technical competence and moral sensitivity and was characterized by patient dependency and physician control. This model is being replaced gradually by one in which patients are increasingly involved in decision-making concerning their own medical care. The rise of consumerism and the associated emergence of "rights" language in medicine has encouraged some individuals to view medicine as a "serving" profession and to regard themselves not as patients but as "medical consumers." Such "medical consumers" sometimes wish to invert the traditional model of medicine and to make the physician a passive agent, a hired technician who practices under the direction and control of his "client." However, despite these changes which affect some patients and some physicians, many patients and physicians continue to interact in a fairly traditional, paternalistic physician-patient relationship.

Both the old physician-dominated paternalism and the new patient-dominated consumerism are unilateral models in which one or the other party in the relationship is seen as dominant. By contrast, the physician-patient accommodation model I propose is a bilateral one in which the moral and technical arrangements of a medical encounter are determined mutually, voluntarily, and autonomously by both patient and physician.

In *The Methods of Ethics*, published in 1874, Henry Sidgwick considered how the moral obligations of individuals were modified when a social promise to the community (e.g., the promise of medicine) was in a state of incomplete redefinition. Sidgwick noted:

... The promise ought to be interpreted in the sense in which its terms are understood by the community; and, no doubt, if their usage is quite uniform and unambiguous, this role of interpretation is sufficiently obvious and simple....

... It seems clear that when the process [of redefinition of a community promise] is complete, we are right in adopting the new understanding as far as good faith

is concerned. . . . But when, as is ordinarily the case, the process is incomplete, since a portion of the community understands the engagement in the original strict sense, the obligation becomes difficult to determine, and the judgment of conscientious persons respecting it becomes divergent and perplexed.²

In this period of consumerism and "rights consciousness," we appear to be in a phase of incomplete redefinition of a social promise, the promise of the medical profession. Possibly we have reached the stage described by Sidgwick, in which judgments of conscientious persons have become divergent and perplexed and in which a societal consensus no longer exists.

Moral dilemmas (and practical dilemmas, too) arise more frequently in periods of social uncertainty and change. The old paternalistic model of medicine held way for millenia; it was widely embraced and rarely questioned. The proper ends and limits of medicine were broadly accepted, and the determination of these ends usually was assumed to be the province of the medical practitioner. Of course, the practitioner and the patient frequently shared a common understanding in these matters. But now that a new model of medicine is evolving, one characterized by changing expectations and uncertain understandings between patient and physician, old moral quandaries again rise to the surface and some new ones seem to spring full-grown from the sea.

The central moral and practical dilemma facing concerned patients and conscientious physicians at this time is to balance the rights of patients and the responsibilities of physicians—and the rights of physicians and the responsibilities of patients—at a time when societal values and expectations are changing. This is the critical challenge facing medicine in the coming decades. This paper will suggest an approach by which the tenuous equilibrium between the rights and responsibilities of patients and physicians might be re-established on a more stable foundation. This approach will involve returning to the central event in medicine—and one which I believe remains the only possible locus of moral certainty in medicine—the physician-patient encounter.

THE PHYSICIAN-PATIENT ACCOMMODATION

The physician-patient accommodation, as I shall describe it, is both a process and an outcome. This process involves a degree of testing by both parties to decide whether this patient and this physician wish to work together. The process is one of communication and negotiation—some-

times short and to the point, sometimes extended—as to what rights and responsibilities each participant wishes to retain and which will be relinquished in the context of their medical relationship.

The accommodation process depends on all of the particularities of the medical encounter. The nature of the patient involved—his personality, character, attitude, and values—and the factors which led him to seek a medical encounter with this particular physician are central components of the process. Similarly, the personality, character, attitude, values, and technical skills of the physician affect the accommodation. Further, the quality of the interaction between patient and physician—the chemistry of the interaction—modify the process. Of course, the nature of the medical problem, including its type, acuteness, gravity, and its potential for remediation, will be a major determinant of whether a physician-patient accommodation is achieved. For example, the entire process will be modified profoundly and telescoped if the patient is acutely or critically ill and alternative medical resources are unavailable. Finally, other considerations which may affect the achievement of a physician-patient accommodation include the clinical setting, e.g., a hospital, doctor's office, or the patient's home; the organization of the medical service, Health Maintenance Organization, or fee-for-service; and also, occasionally, the claims of relevant third party interests such as those of family, insurers, or the state.

If the process of negotiation referred to as the physician-patient accommodation is concluded successfully, the result will be an outcome also called a physician-patient accommodation. In this outcome a joint decision is reached on whether this patient wishes to place his care in the hands of this physician subject to mutually agreed upon rights and responsibilities, and in which the physician also agrees to care for this particular patient. There are as many results and styles of outcome for the accommodation as there are configurations of the variables that enter into the process of negotiating the accommodation.

The physician-patient accommodation is not a permanent, stable, and unchanging relationship between a physician and a patient; it is a dynamic model and is always in flux. In one sense, the accommodation as an outcome exists only as a concept; it is always in the process either of developing or of dissolving. Patients and physicians must achieve accommodations repeatedly, even regarding the same basic conditions for which the original accommodation was concluded. For example, a patient's

agreement to be cared for by a cardiologist for anginal chest pain would not commit the patient to agree with the cardiologist's recommendation to undergo coronary angiography or to accept a subsequent recommendation for cardiac surgery.

Some physician-patient accommodations are stronger than others. The resilience of an accommodation is determined largely by the extent of trust and confidence exchanged between patient and physician. However, the stability of an accommodation is constantly threatened by new circumstances because changes in the patient, the physician, or the disease all may result in a reassessment of the accommodation and perhaps a failure to reach an accommodation on the same or a new issue. If an accommodation is not achieved on an important matter (a situation roughly analogous to a prime minister who loses a vote of confidence), patient or physician legitimately could decide to dissolve their professional relationship, again with the proviso that the patient's emergency health care needs are attended to.

In contrast to previous descriptions of the physician-patient relationship which tend to regard it as an established, static arrangement between doctor and patient,^{3,4} the physician-patient accommodation provides a more dynamic and more realistic model of the medical encounter. Perhaps physician-patient relationships as such rarely exist; rather, what we regard as a relationship may really be repeatedly negotiated physician-patient accommodations. More likely, a physician-patient relationship represents a specific and increasingly uncommon variant of the accommodation. It is one characterized by mature and enduring exchanges of trust between patient and physician that establish an almost insunderable bond. A decline in personal medical care and a rise in high technology and in institutional, specialized medical care probably has accelerated the decline of the traditional relationship model and has contributed to the emergence of the accommodation model.

FURTHER REFLECTIONS ON THE PHYSICIAN-PATIENT ACCOMMODATION

Either the patient or the physician may decide not to conclude an accommodation. We could surely imagine reasons for patients not wishing to enter or continue an accommodation with a particular physician. For example, if the physician had a poor bedside manner, seemed incompetent, had the wrong diplomas on the wall or none at all, maintained a

shabby office, charged excessive fees, had too long a queue, didn't have the proper hospital privileges, or had a personality or value system which clashed repeatedly with the patient's, the patient might choose to go elsewhere. The patient has a choice, at least in our current medical system.

Although the physician may be less free to choose than the patient (e.g., legally a physician-patient relationship may exist from the time of a physician's first encounter with a patient), the accommodation model encourages or even obligates the physician to make a conscious decision to assume the care of the person who asks for medical assistance. A physician's decision to care for a patient is based on two determinations: his ability to help the patient, which remains a central concern in clinical medicine, and his own concept of professional standards and norms of behavior for physicians.

Therefore, a physician may be obligated not to enter a physician-patient accommodation if he believes that he is unable to help the patient or if he believes that even if he could help the patient, he could do so only by sacrificing his own conscientious standards of what it means to be a good and responsible physician and human being. Some reasons why a physician might believe himself unable to help a particular patient could include a lack of technical skills to respond to a particular problem, personality conflicts with the patient serious enough to impair the healing relationship, a profound incompatibility of goals being pursued by patient and physician, or a determination that the patient was unwilling to assume responsibilities to work jointly with the physician in the care or maintenance of the patient's health. A physician might also refuse to enter an accommodation because of a belief that his involvement would violate his personal sense of responsible conduct. This might occur when the physician considers an action to be illegal or immoral or when he believes that a patient's problem is not legitimately a medical matter and could be handled more appropriately in another institutional setting.

Some of these positions may appear controversial, particularly the notion that a physician may be obligated not to enter a physician-patient accommodation if doing so would violate the physician's conscientious sense of professional and personal responsibility. One could justify the rights of both parties to refuse to enter an accommodation on the following grounds:

- 1) If medicine is aimed at achieving desirable ends for patients, it is to

both parties' advantage that they exhibit prudence and discretion in not entering into accommodations doomed to failure. The healing relationship is bilateral and depends on trust and confidence as much as on pills and surgery to achieve its goals.

2) The model of medicine implied by an emphasis on the need for patient and physician to achieve an accommodation is one of mutuality, voluntariness, and respect for autonomy. The freedom of both patient and physician to enter an accommodation is the core of morally acceptable medical practice.

3) The alternative, in which neither patient nor physician were free to determine these arrangements, would result in an inferior, mechanical form of medicine, such as that described by Plato (in *The Laws*) as being practiced by slave physicians on slave patients.⁵

CONCLUSION

This paper has attempted to locate the moral center of medicine in the particularities of encounters between patients and physicians. In times of social change, these encounters must develop within the context of unclear social expectations and indistinct senses of obligation. It seems necessary, under these conditions, to articulate a new and more widely acceptable model of the physician-patient encounter. This new arrangement, referred to as the physician-patient accommodation, is based upon mutuality, voluntariness, and respect for autonomy.

The physician-patient encounter is the site of human agency, the point at which individuals possessed of special needs and personal perspectives and values interact. The physician-patient accommodation model describes both the *process* of achieving a voluntary and mutually acknowledged arrangement, and the *outcome* itself, which will reflect the particular configuration of moral, medical, and personal factors which shaped the accommodation. The accommodation model focuses upon the process by which, for example, *this* physician and *this* patient under *these* circumstances negotiate *this* relationship committed towards *these* ends. By such painstaking attention to the site, conditions, and factors of human agency and medical practice, the accommodation model permits us to offer a model of medical practice which describes the processes and outcomes of physician-patient encounters and to place the locus of moral certainty in the very processes and outcomes that constitute each new arrangement. One is gradually led to the conclusion that the principles upon which the

physician-patient accommodation is based may themselves be the central determinants of morally acceptable medical practice.

As a model of medical practice which describes the processes and outcomes of physician-patient encounters, the accommodation model offers unique conceptual, methodological, and clinically pragmatic insights.

By providing a powerful conceptual schema, the accommodation model may allow us to understand better the nature and extent of the deterioration of social consensus concerning the proper limits, means, and ends of medicine. Attention to the outcome of physician-patient accommodations is likely to provide information from a plenitude of cases from which an "understanding of the community" may be derived. From the facts of a number of cases (the accommodated outcomes of which can be expected to reflect personal, medical, and moral positions) we may more readily discern the social and professional "rules of the game" as they exist in practice. At least, the general outline of procedural principles appropriate to this period of uncertainty may be made visible.

Conceptually, the accommodation model permits analysis of a critical dimension of medicine without the biases found in either the paternal or consumer/libertarian models. These other models simply do not help to predict the true sources of conflict and to prescribe remedies that can be applied broadly. Viewing the physician-patient encounter as an authoritarian intervention, adversarial conflict, or exercise in consumer choice obscures the fact that the actual character and form of medical relationships depends upon a variety of factors and varies widely for different patients and physicians.

As a methodological guide, the accommodation model encourages us to examine the influence and interaction of such diverse factors as clinical setting, the nature of the medical problem, possible third party interests, and, most important, the attitudes and values of physician and patient. And because each accommodation must take place within a social context characterized by uncertainty, and because the uncertainty concerns such issues as autonomy, responsibility, and obligation, attention to physician-patient accommodations is attention to precisely those areas of controversy which manifest themselves in practice.

Most important, the accommodation model exhibits useful features that lend themselves to the development of more humane and effective clinical practice. The model allows for maximum flexibility of decision-making for both physician and patient, while searching for that equilibrium point

at which voluntary and mutual actions can be agreed upon. The patient retains the ability to claim or to relinquish various degrees of autonomy and the opportunity to inform the physician of relevant personal factors that might influence medical decisions. The discretion of physicians for entering an accommodation is limited naturally by direct patient needs; nevertheless, the physician remains an autonomous party to the accommodation. The accommodation model permits a physician better to understand a patient's expectations of him, and a patient more adequately to understand the exact nature of the commitments and expectations the physician is willing to exchange. In this way, use of the accommodation model in clinical practice encourages an ongoing, bilateral analysis of the technical, personal, and interpersonal dimensions of each case. It encourages attention to the elements of accommodation, thus acting to humanize and personalize the physician-patient encounter. Relationships based on mutually understood values and ends are those most likely to result in an exchange of trust, and trust remains an essential component of the healing relationship.

The case of the ballet dancer illustrates the conceptual, methodological, and practical usefulness of the accommodation model. Conceptually, the model enables us to analyze this case as one in which physician and patient were unable to agree upon mutual goals and interests. Methodologically, the model identifies the nature of the medical problem, the values of patient and physician, and the interaction of patient and physician as influential factors in a process which resulted in an incomplete and imperfect accommodation of goals.

In this case, attention to the principle of accommodation might have resulted in agreement upon a technical-medical endpoint which would have satisfied the physician's sense of "good medical practice" and the dancer's sense of adequate control of her condition. As it was, the dancer felt forced to choose between complete control of her asthma and retention of her skills as a dancer. And the physician could not tolerate a treatment failure narrowly construed, i.e., the persistence of wheezes which he could abolish with sufficiently potent medication.

Eventually, of course, this medical relationship dissolved. Perhaps, had physician and patient explored and negotiated together the nature of the expectations and obligations each was willing to exchange by entering a relationship, this conflict might have been avoided. If it became apparent that their conflict of purposes and interests was intractable, not resolvable

even by good faith negotiations, each would have been obligated neither to accept the arrangement nor conclude an accommodation. In any event, attention to the principle of accommodation would have encouraged mutual understanding of the positions of physician and patient and prevented the needless frustration, anxiety, and confusion which characterized this case.

The physician-patient accommodation model is a useful descriptive and theoretical device. Further, an analysis of the constituents of successful, failed, and unconcluded accommodations enables us to gather information about what medical practice *is*, a necessary preparation for discussions of what medical practice *should be*.

The ingredients essential for a physician-patient accommodation—mutuality, voluntariness, respect for autonomy, and communication and negotiation between physician and patient—are surely preconditions for the practice of morally acceptable medicine. These principles of accommodation are also essential for the effective practice of the art of medicine. Thus, the circle comes full course; we find that the same principles which allow us to describe technically satisfactory physician-patient encounters are precisely those necessary for the formation of morally acceptable medical relationships.

Recognition of this fact is not a recent development. In a remarkable passage in Book IV of *The Laws*, Plato describes two different kinds of physician-patient relationships. In one type, in which slave-physicians treat slave-patients, the physician "...never gives him any account of his complaints, nor asks him for any; he gives him some empiric injunction with an air of finished knowledge in the brusque fashion of a dictator, and then is off in hot haste to the next ailing slave...."

In the physician-patient relationship befitting free men, the citizen-physician

...treats their disease by going into things thoroughly from the beginning in a scientific way and takes the patient and his family into confidence. Thus he learns something from the sufferers...He does not give prescriptions until he has won the patient's support, and when he has done so, he steadily aims at producing complete restoration to health by persuading the sufferer into compliance...⁶

The best clinical medicine, Plato tells us, is practiced when physician and patient have concluded a fully human relationship in which technical aspects of care are placed in the context of an appreciation for the most widely construed interests of each. It is in this regard that the principles

and activity of the physician-patient accommodation establish a bond of trust between two individuals who together challenge the mutability that is the only certainty in medicine. And it is to the particularities of the physician-patient encounter that we, as healers, must turn as we seek the center of good, and therefore morally acceptable, medical practice.

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