PART 1
Physician Attitudes toward Patients

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Case

An 8-year-old child with a minor head injury is brought in to the emergency department and is judged by the physician to be completely normal. The parents say that a sibling had a skull fracture under similar circumstances and that they would sleep much better if a skull x-ray were taken. The physician realizes that in cases like this, practically the only significant finding—that is, one that would change care—is relatively rare (namely, a depressed skull fracture). He explains to the parents that an x-ray is not indicated in this case because it would (a) be a waste of money, (b) expose the child to needless radiation, and (c) delay other patients waiting for needed radiographs. The

parents are very anxious, however, and remain adament. Should the physician order the films? Are the parents also his patients? Would it make any difference if the anxious father were also a well-known malpractice attorney? As the custodian of medical resources, how tightly should the physician control access?

Commentary

Several features of this case are not specified but, nevertheless, could be relevant to what the physician should do. We are not told whether the physician is a private practitioner, a member of a physicians group, or an employee of a health maintenance organization. We are not told who will pay the bill—the parents, private insurers, or the government. And we are not told what the practice is among physicians about x-rays in such cases, that is, whether physicians do or do not generally order such x-rays and whether or not there are informal or formal and enforceable rules on such procedures. These factors might make a difference, but for now we will put aside these considerations.

My immediate response is that the physician should, of course, order the x-rays. The discomfort of the parents (and the child) should be alleviated, and it is by no means a waste of money to do this. Moreover, the worries about excessive radiation and delaying others are probably exaggerated. So surely the physician should go ahead. Can this, my immediate response, be defended?

Clearly, one important argument for not ordering the x-rays is based on the increased cost of medical care and the increased demand for services, leading in some cases to waiting lines. This scarcity and costliness suggested a need, at the very least, for not "indulging" in truly unnecessary, nonbeneficial medical therapy, and it may also give rise to a need to ration even beneficial medical intervention. So perhaps the physician needs to draw the line here and refuse to indulge the parents' concerns simply because we can no longer afford such things.

In Table 16 and in the text that follows, I make some distinctions which, I think, will help us to delve deeper into these issues.

Let us say that medical care is *patient-centered* if the physician takes it as his or her primary duty to do whatever would be medically beneficial for the patient. In making judgments, the physician is to exclude not only his own self-concerns but also, and more importantly, the concerns of other patients and of the wider society. The particular

Table 16.
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1. *Patient-centered.* The physician takes it as his or her primary duty either: (a) to do whatever would be medically beneficial for the patient or (b) to be guided by the patient's refusal or acceptance of the recommended treatment, without regard for the interests of society or other individuals.
   a. *Paternalistic.* The physician makes the crucial decisions concerning patient care, for the patient's benefit (as the physician sees it).
   b. *Autonomous.* The physician provides information and advice concerning diagnostic and treatment options, but the (competent) patient makes the final decision.
2. *Society-inclusive.* The physician takes it as his or her primary duty to do whatever is beneficial for the patient, acknowledging limitations imposed by the scarcity of medical resources and the urgent needs of others in society.

patient is to come first, and his or her interests have sole claim on the physician. Clearly, this patient-centered ethic is central to the dominant ideology of American medicine.

It is important to realize, however, that patient-centered medical care is not necessarily medical care which allows the patient significant choice in the available medical procedures. Concern for the patient above all is compatible with various degrees of paternalism which leave it up to the physican to make the crucial decisions, so patient-centered care may well be, let us say, *paternalistic* care also. The alternative to paternalistic care is a relationship in which the patient is adequately informed as to procedures and alternatives and makes the crucial decisions. Of course, the physician will provide not only information but also advice and his or her best judgment; ultimately, however, the patient (that is, the competent patient) will decide. Let us call this *autonomous* medical care. Clearly, the difference between paternalistic and autonomous medical care will be one of degree, with different physician-patient relationships falling on a line between these.

I think there has been movement in recent decades from paternalistic to autonomous forms of the physician-patient relationship. Surely the issue has been much debated, and paternalism has come under frequent and severe attack. But both paternalistic and autonomous medical care can be instances of a patient-centered ethic; they are different ways of giving primacy to the particular patient's interests and needs.

The alternatives to a patient-centered ethic is a relationship in which the physician does not give *sole* concern to the particular patient but takes into account the interests of others in such a way that the physician is prepared to refuse medically beneficial treatment to a particular patient. Let us call this the *society-inclusive ethic.* Such an ethic *does not mean that the particular patient will be treated callously, indifferently, rudely, or bureaucratically.* It is compatible with great concern for the particular patient and total devotion and care to his or her needs *up to a limit,* with that limit being where scarcity makes urgent the needs of others. Even beyond that limit, treatment can be refused with concern and honesty which expresses a basic respect for the patient. This is why I have called this care "society-inclusive" rather than "society-centered." It does not substitute society for the patient; rather, it makes society relevant in a way that the patient-centered ethic does not. It is, of course, possible that any actual society which moves to a society-inclusive ethic for medicine will become callous, bureaucratic, and so on. But I am not convinced of this, and I am content here just to assert that this is certainly not involved in the *concept* of the society-inclusive ethic.

As is noted above, there has been movement in recent years from paternalistic to autonomous models of the physician-patient relationship. This movement has taken place within the patient-centered point of view and might be thought of as an increase or deepening of that point of view. It emphasizes not only the patient's well-being but also his or her capacity for decision making, and through it the patient is seen not only as a body to be cured but also as a person whose choices are to be respected. That scarcity is now motivating a move toward a society-inclusive perspective is somewhat ironic, since just as the patient-centered ethic has come into its own, it is threatened by a new set of difficult circumstances. A large challenge ahead is to strive to keep a significant part of the deep concern for the patient central to the autonomous patient-centered ethic as we as a society move to a view which brings the general welfare more directly into focus in particular patient decisions. I think that means, among other things, that we retain an area in which the physician is able to practice with the interests

of the patient as his sole concern; in other words, the patient-centered point of view is practiced up to that point where social interests must be considered.

It is natural to think that the physician should order the x-ray on the basis of the patient-centered rather than the society-inclusive ethic. But before reaching these conclusions, let's look into this more carefully. Let's say that a medical procedure or therapy (surgery, hospital stays, physician consultations, drugs, tests, etc.) is *medically useful* to a patient if there is some probability, however small, that it will alleviate his illness, reduce his pain or suffering, or prolong his life. The opposite of a medically useful procedure is a medically useless one. On this definition, however, a procedure may be medically useful but not appropriate from the point of view of the patient, since it may involve risks and undesirable side effects which make it not worth the expected benefit. Let us then call a procedure for which the expected benefits are, in fact, worth the expected risks for the patient a *medically beneficial* procedure. Clearly, whether or not a procedure will be medically beneficial in this sense will frequently be a matter of judgment and controversy. Moreover, the disagreement will be exacerbated by different conceptions of what is beneficial and of what sorts of things are to be considered as "costs." There will, however, be clear cases of the beneficial and clear cases of the nonbeneficial. (There are also procedures which are neither medically useful nor medically beneficial in the senses defined but are still appropriate: for instance, cosmetic surgery is a medical procedure which might be said to be "socially beneficial.")

Practically everyone would agree that medical procedures ought not to be done unless they are medically (or socially) beneficial. But why is this? What if a person wants a procedure which is not, everyone agrees, beneficial? We have so arranged things that the patient cannot get such a procedure and any physician who "supplied" it would be subject to both legal liability and moral censure and his or her action would be described as unprofessional conduct. The reason for this raises, in turn, the question of the type of governmental paternalism that is involved when people are prohibited from purchasing dangerous consumer goods. Medical care is similar to other goods regulated for safety in this way. The question of what justifies such paternalism is a big one which I will avoid here, for our question is a different one: When might care that everyone agrees is beneficial be denied?

IMPLICATIONS OF PATIENT-CENTERED ETHIC

From the point of view of the patient-centered ethic, should the x-ray be ordered? From this perspective, the decision should be made solely on the basis of the patient's "cost-benefit" ratio—the interests of others are not to be taken into account. The sole question is whether it is worth it to the patient. The fact that the x-ray would use taxpayers' money is irrelevant. If the benefits of the x-ray outweigh the costs—to the patient alone—it should be provided. Another issue is the question of the relationship between the parents and the child. The case study asks whether the parents are also the patients of the physician. I think this is wrongly put; of course the parents are not, in any strict sense, patients. The patient is the child. But the parents are authorized to make decisions for the child and to stand to the child in such deep and obvious relations of affection and identification that their interests are obviously relevant. If performing the test to relieve the anxieties of an adult patient is justified, I think it would be justified to relieve the anxieties of the parents, given their identification with the child and the way their own well-being is tied up with the child's. Of course, this point of view assumes

a normal parent-child relationship where such ties of sentiment do exist in an unperverted form. But let's assume this.

We are left, then, with the third and crucial issue: What is the relevance of relieving the parents' or the patient's anxiety? Is that a good enough reason for performing the test? There are two questions here. Is relieving worry a relevant reason at all for performing a medical procedure? And if it is generally relevant, is it decisive in this case? With respect to the first question, it seems to me quite obvious that relieving anxiety is a legitimate and important function of medical care. Human beings are creatures who take an interest in their future, who make plans and naturally worry about what might happen to defeat their plans. Such worry can be excessive, but it is probably, in moderation, highly functional in providing motives for anticipating and dealing with problems. An illness threatens our basic well-being, perhaps our existence. Accurate knowledge about just what is happening can be extremely useful to us, given the kind of creatures we are, and it seems hardly to need arguing to hold that medical care should provide this knowledge. This point is very well made in *Securing Access to Health Care* (p. 17), a report from the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research:

> *The special importance of health care stems in part from its ability to relieve worry and to enable patients to adjust to their situation by supplying reliable information about their health. . . . Though information sometimes creates concern, often it reassures patients either by ruling out a feared disease or by revealing the self-limiting nature of a condition and, thus, the lack of need for further treatment. . . . Even when a prognosis is unfavorable and health professionals have little treatment to offer, accurate information can help patients plan how to cope with their situation.*

Clearly, medical care is the sort of good we desire not just for its effects in relieving physical ailments but also for the information it provides us. That it will relieve distress is, therefore, clearly a good reason for ordering the x-ray.

But is it a good enough reason in this case? It surely is not a decisive reason in all cases. The cost of relieving anxiety might be too high: too dangerous, too unpleasant, too expensive, etc. But I think this is unlikely for our case. So from a patient-centered ethic I think the x-ray is clearly acceptable. I want to make clear, however, that not everything is justifiable for relieving anxiety. Suppose, for instance, that the only test available to rule out a depressed skull fracture is one which is fatal in 2% or more of the cases of its use. Then the test would not be justified. The anxiety should be tolerated. I assume that the danger of the x-ray is not near this.

IMPLICATIONS OF SOCIETY-INCLUSIVE ETHIC

From the point of view of a society-inclusive ethic, what should be done? Here the costs to others begin to play a role, and it matters that social resources are used up and other patients are made to wait. The benefit to the parents must be weighed against additional costs and may no longer be "worth" it. But whether it is or not and what the particular physician should do will depend on a number of factors, factors which themselves raise rather large questions.

Clearly, relieving a patient's or a parent's anxiety is a less urgent concern than saving someone's life or improving someone's health. If the ability of a given society to provide x-rays is so limited that ordering the child's x-ray severely interferes with the health of others, it should be foregone. A full account here, however, would require

saying much more than I can say about the relative urgency of different medical needs and desires.

It might be thought, however, that it is unlikely that a single, "ordinary" head x-ray would seriously deprive another person of needed care. And this is a reasonable judgment at the (micro) level of care for particular patients. But a society might reasonably consider it prudent to decide what its general budget for x-rays (and other tests) meant to relieve distress could be used to meet more urgent medical needs. In such a case, the particular x-ray would not be appropriate—even though it would cause no harm to others—because of the beneficial effects of the overall policy.

This raises a further question about the general system in which the physician operates. The physician may operate in a climate where there is no consensus and no common practice about what medically beneficial procedures should be foregone in the common interest. Or the physician may be bound by rules and a common practice which require that certain procedures be omitted. The latter clearly occurs in for-profit medical institutions and health maintenance organizations and is more and more dictated by insurers. It is clearly a modern trend. I think that the context in which the physician operates matters. Suppose, for example, that it would be a good policy to forego x-rays in general in our case (because it would redirect funds to more urgent needs) but, in fact, no such policy exists or is enforced in any way. Should a particular physician deny the parents the x-ray, when he has no assurance that other physicians would act the same way or that the saved funds would be used for other beneficial purposes? I think not. In such a case, the denial of care to the patient is neither fair nor effective and so, in my view, not warranted.

On the other hand, I see no problem when there are established rules, for then the denial is both fair and effective. In sum, when there are no rules which make rationing sensible and just, I am inclined to think that the physician is fully justified, even required, to practice in accord with the patient-centered ethic. The society-inclusive ethic, to be fair, requires a background of consensus. I suspect, further, that over time the consensus will so change expectations of both physicians and patients that the denial of care will be understood and accepted, just as the inability to get other scarce consumer goods is accepted.

These remarks help answer the question as to how much a physician should control resources. I have argued that the decision on what procedures to forego must be a common or a collective one. It is appropriate for the individual physician to continue acting in a "patient-centered" way, and thus not exercise much control over resources, until he or she has the assurance that restraint for social purposes will be, as mentioned above, effective and fair. And this requires consensus, common decisions, similar expectations. This can, of course, occur through formal, legal decision making by government bureaucracies, or through formal decision making by health care institutions and insurers, or through the informal development of common practices over time. I think we are in an era in which all three are moving us toward a society-inclusive ethic which will provide the background consensus on such matters. But until there is such a consensus I find it hard to justify particular physicians' restricting care when the assurance and coordination conditions needed to make this efficient and fair are unmet.

One last question remains to be answered: Who is paying for the x-ray? So far in this discussion of the issue from the perspective of the society-inclusive ethic I have assumed that the cost will not be borne by the parents. But suppose the parents are willing to pay for it, even though public and private insurers will not support it and

there is a consensus against such procedures. Then what? This, of course, raises the large question of whether people should be permitted to purchase, from their own funds, medical procedures which society has decided not to support. Familiar liberal versus egalitarian arguments are available on both sides. The arguments against permitting this are that it is unfair to allow one's ability-to-pay to play such an important role in health care and that such an arrangement is likely to create a qualitatively differentiated "two-tier" system. On the other side, there are arguments based on the liberty to purchase what one pleases with funds one has earned. I will avoid the issue here, but it is surely an important question whenever a social decision has been made to forego *any* medically beneficial procedure.

In sum, from the perspective of the society-inclusive ethic, whether or not the physician should order the x-ray depends on the extent of the scarcity and on the background system of rules, among other things. If systematically denying such care would save funds which would be effectively used to meet more urgent needs, I would find it justifiable. But relieving worry is an important, though not the only, function of medical care, and we should not sacrifice it in given contexts unless and until we are sure the return is worth it.