

## *Virtual Mentor*

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### **FROM THE EDITOR**

#### **Commemorative Issue: A Physician by Any Other Name**

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What's in a name? In Act II, scene ii of *Romeo and Juliet*, William Shakespeare's young hero says: "That which we call a rose/ By any other name would smell as sweet." It didn't matter to Romeo that Juliet bore the surname "Capulet," a name despised by his own Montague family. He loved her for who she was. In affairs of the heart, lovers may be both blind and "illiterate" to the connotations of names and titles, but as Shakespeare's most famous tale demonstrates, the consequences of their "illiteracy" can be fatal.

In the medical realm as with other social ecosystems, the names we use to identify various participants matter a great deal; they reflect and shape the identities, obligations, and expectations of those in relationship. Until recently, terms used to refer to those we seek out when we are sick have changed very little. The term "physician" has been around since the days of Hippocrates, and derives from "physik," an ancient Greek word for "nature." Hippocratic physicians understood illness as part of the natural order (as contrasted with those healers who believed that illness was part of the supernatural order--punishment from the gods) and sought explanations for illness in the physical world.

The term "doctor" came into usage in the Middle Ages (13th - 15th centuries) when the education of physicians shifted to the university setting. "Doctor" signified a physician who had received formal university training, usually with a heavy emphasis on the teachings of Aristotle and Aristotelian logic. Thus if one wanted to be technically correct in applying the terms "physician" and "doctor," one would say that Hippocrates was not a doctor, although he was a physician.

Beyond etymology, an individual who is sick and seeks the care of a doctor has certain expectations about this interaction and the professional obligations of the physician. Patients expect their interests will be put above those of the physician. Patients rely on their doctors to keep sensitive information private and confidential. Patients count on their physicians to treat them with empathy and compassion, especially when that is all that can be offered. And patients expect their doctors to act as caregivers, not as purveyors of a health care service. In essence, patients must trust that when they seek the care of a doctor at a time of illness and thus vulnerability, the physician will employ his or her specialized expertise and educated judgment on behalf of the patient's health and well-being.

Today's lexicon is increasingly muddled. Physicians are commonly referred to as health care providers, a name change that is anything but benign. In our increasingly market-driven health care system, the use of such terms as "health care provider" supports the notion that the interaction between patient and doctor is no different than an economic transaction between a buyer and seller. In this commodity model of medicine, health care providers are guided by a market ethic; they are not bound to the professional ideals and obligations that have defined medicine for centuries. To those (perhaps chiefly the young and healthy) who say that our traditional lexicon is outdated, its professional model unnecessary, and that "health care providers" are interchangeable with physicians, I can only reply, "Caveat emptor."

In addition to the profound impact of a market ethic on medicine, other changes with potential to undermine the integrity of the therapeutic relationship confront patients and physicians. The explosion and proliferation of medical information, while empowering the lay person, can erode trust in the judgment and authority that has traditionally resided with the learned professional. Advances in the biomedical sciences, especially the possibility for new treatments and cures opened by unlocking the human genome, are welcome. But they can also redefine our concepts of disease and affliction and ultimately alter whom we choose to treat. Our growing diversity forces us to confront personal differences and individual biases, and the patient-physician relationship is not immune to these changing norms, styles of conduct, and trends in society at large. Each of the changes in the evolving medical landscape challenges the integrity of the patient-physician relationship, the trust that has been at the foundation of this therapeutic dyad for centuries. What will future participants in this special encounter expect from each other when they come together?

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