

## ETHICS CASE

### Do Physicians Have an Ethical Duty to Repair Relationships with So-Called “Difficult” Patients?

Commentary by Micah Johnson

*Editor’s Note: This is the winning essay of the 2016 AMA Journal of Ethics annual Conley Contest.*

#### Abstract

This essay argues that physicians hold primary ethical responsibility for repairing damaged patient-physician relationships. The first section establishes that the patient-physician relationship has an important influence on patient health and argues that physicians’ *duty to treat* should be understood as including a responsibility to repair broken relationships, regardless of which party was “responsible” for the initial tension. The second section argues that the person with more *power* to repair the relationship also has more *responsibility* to do so and considers the moral psychology of pain as foundational to conceiving the patient in this case as especially vulnerable and disempowered. The essay concludes with suggestions for clinicians to act on the idea that a healthy patient-physician relationship ought to lie at the center of medicine’s moral mission.

#### Case

John is a third-year medical student on his first day with a new service during his surgery rotation. On this particular morning, John is going on rounds with the chief resident, Dr. M, and an intern, Dr. S. As the team walks down the hall to the next room, John quickly glances over his rounding sheet for a 48-year-old man, Mr. C. Mr. C had a toe amputation three days ago and suffers from chronic pain and diabetes mellitus type I. He also has a history of using opioids, and his pain medications are being carefully controlled in the hospital.

Before they enter the room, the intern Dr. S softly says to Dr. M, “Hey, just as a heads up, I heard this one was feisty last night. Apparently, the attending physician came down hard on his request for more analgesia. The patient was not happy with the refusal and gave the nursing staff a lot of trouble.” Dr. M responded, “I heard about that. But he’s always been difficult; I saw him in clinic last month.” The team then enters the room.

As Dr. M begins questioning Mr. C, “How are you doing this morning?” Mr. C starts to moan in pain and offers short responses. Dr. M concludes his questions, “Now we’re going to take a look at the toe.” Mr. C begins shouting in pain as John and Dr. S remove the bandages. “Please stop!” he moans. Dr. M tries to soothe him, “I promise we’ll give you more for the pain; I’ll talk to your nurse when we leave. But right now, we need to get this off and take a look at the surgical site.” Mr. C retorts, “You’ve never taken care of my pain! I’ve been asking for help every day, but you don’t listen!”

When John rips open the packet of gauze to apply a new dressing, Mr. C angrily states, “I don’t want to be touched, poked, or prodded anymore.” John and Dr. S pause, bandage in hand, waiting for instructions from Dr. M.

Dr. M responds, “We’re trying to help you, but we need you to work with us.” Mr. C flatly refuses and shouts, “Nobody cares about my pain—you have no idea what I’ve been through.”

Dr. M silently stares for a few seconds at Mr. C who whimpers quietly. Dr. M turns his gaze from Mr. C to Dr. S, mutters “Let’s go—don’t worry about the bandage,” and walks out of the room. John wonders what to do with the bandage he’s holding and how to respond to Mr. C.

### **Commentary**

A fractured patient-physician relationship can be a serious threat to a patient’s health. As a defining influence on patient well-being, the patient-physician relationship must be subjected to careful ethical scrutiny, and the conflict between Dr. M and Mr. C raises one of the key questions: Who is responsible for repairing a damaged patient-physician relationship?

This essay argues that the physician holds primary responsibility. The first section argues that physicians’ ethical duty to treat must be understood as including an obligation to repair damaged relationships that threaten a patient’s health. The second section argues that the person with more power to repair the relationship also carries more responsibility to repair it and concludes not only that physicians in general hold more power in the patient-physician dynamic, but also that Mr. C is particularly disempowered in this case because the conflict involves a dispute over his subjective experience of pain. Finally, John’s role as a medical student is analyzed. Although he is at the bottom of the medical hierarchy, he can leverage his unique role as a learner to encourage thoughtful discussions of aspects of patient care that might otherwise be left to habit and unconscious bias.

### **Physicians' Duty to Treat**

Physicians have an ethical responsibility to treat their patients, which stems both from physicians' professional obligations as well as from patients' right to receive medical care [1-6]. In general, *duty to treat* means that when a patient is under a physician's care, the physician has an ethical obligation to offer interventions necessary for improving the patient's health.

A damaged patient-physician relationship should be understood as a potential threat to patient health that compels the physician to intervene. A systematic review and meta-analysis of 13 randomized controlled trials on the patient-physician relationship found that the quality of the therapeutic alliance had a positive effect on health outcomes [7]. Importantly, the impact of the patient-physician relationship on health outcomes was greater than that found in other studies of common interventions, including aspirin for reducing the risk of recurrent myocardial infarction over five years and the influence of smoking on male mortality over eight years [8]. If the duty to treat gives physicians the responsibility to prescribe aspirin after a heart attack, it must be understood as giving Dr. M the responsibility to repair his damaged relationship with Mr. C, since the therapeutic alliance has an even greater impact on health outcomes.

One possible objection to this view is that physicians' duty to treat applies only to traditional biomedical interventions like offering pharmaceuticals or performing surgical procedures, and thus the patient-physician relationship lies beyond its scope. But the fact that some health-promoting interventions come in the form of pills while others come in the form of personal interaction cannot be a distinction of great ethical relevance. Many varieties of patient education and counseling are essential to high-quality care; the fact that these therapies involve interacting with the patient rather than filling a prescription diminishes neither their importance to patient health nor the physician's responsibility to provide them.

A second objection to holding Dr. M responsible for repairing his relationship with Mr. C is that the duty to treat must be secondary to physicians' primary ethical obligation to "do no harm"—after all, Dr. M might believe that prescribing opioids is harmful to Mr. C, even if refusing his request for analgesia damages their relationship. But this objection fails to recognize that Dr. M's responsibility for repairing his relationship with Mr. C is independent of whether the best clinical decision turns out to be not prescribing more opioids. For instance—regardless of the prescription decision—Dr. M might have responded to Mr. C compassionately instead of walking out of the room: "I'm sorry you're feeling that we haven't paid enough attention to your pain—what makes you say that?" Or Dr. M might be open about the clinical challenge: "We understand that you're in pain. There can be risks to prescribing high doses of opioids; are you willing to work with us to find other treatments to make you comfortable?" By distinguishing the quality of the patient-physician relationship from any particular prescription decision, it becomes clear

that there is no conflict with the obligation to do no harm—repairing the relationship is still likely to benefit the patient and represents an ethical duty in its own right.

A final objection to assigning Dr. M primary ethical responsibility is that if the patient is responsible for damaging the patient-physician relationship, then the patient should be responsible for repairing it. But this reasoning contradicts how we think in general about the relationship between patients' responsibility for their illnesses and doctors' obligation to treat them. Put simply, physicians have a duty to treat even when their patients are in some sense "responsible" for the condition that ails them. Pulmonologists treat chronic obstructive pulmonary disease caused by smoking; endocrinologists treat diabetes exacerbated by poor diet; and emergency physicians repair self-inflicted wounds. One of the most beautiful and essential aspects of medicine is the opportunity for physicians to care for their patients without letting moral judgment or personal bias cloud their compassion for the suffering human being in front of them.

In summary, the duty to treat gives physicians an ethical responsibility to offer health-improving interventions to patients under their care. Since maintaining a therapeutic patient-physician relationship has an even greater health benefit than some other common medical interventions, the duty to treat must be understood as giving physicians an ethical responsibility to repair damaged relationships with their patients, irrespective of whether the best clinical decision might contribute to the damaged relationship or whether the patient caused the initial tension.

### **Power, Pain, and Moral Psychology**

The weight of responsibility for repairing any given patient-physician relationship also depends on which person has greater power to repair the relationship. In ethics, it is sometimes held that "ought implies can": that is, if it is true that a person ought to act in a certain way, then it better be possible for the person to carry out that action [9, 10]. It follows that to the extent that Mr. C lacks the power to repair the relationship, he cannot have the ethical responsibility to do so.

Hospitalized patients like Mr. C are disempowered in numerous ways: they often have impaired mobility, are in significant pain, are stripped of their clothing, are quite ill, and generally lie at the mercy of the medical and nursing staff for their basic needs. In contrast, physicians are respected professionals who hold ultimate control over treatment options and can determine when, where, and for how long patient interactions take place. In general, the power to repair a damaged relationship will lie differentially with the physician.

Medical students like John occupy a unique place between the patient and the care team. On the one hand, being at the bottom of the [medical hierarchy](#) means that John lacks the ability (and therefore the ethical responsibility) to influence certain aspects of the

patient-physician relationship—for instance, he does not dictate treatment decisions, and he cannot directly control the manner in which his senior colleagues interact with the patient. On the other hand, John’s position in the hierarchy creates an opportunity for him to mediate between the patient and the physician. A savvy medical student can use this intermediate position to bridge the wide gap in power between patient and physician, listening to and advocating for the patient without carrying the additional burden of making the final treatment decision in the case.

Beyond these general considerations of the hospital power dynamic, Mr. C faces a special kind of disempowerment in this case because his relationship with Dr. M was damaged by a conflict over the treatment of pain. Pain presents a unique challenge to physicians because it is an irreducibly subjective feature of consciousness [11–13]; there is no lab test or imaging study that definitively measures pain, and thus there is no objective measure that Dr. M can use to know how much pain Mr. C is experiencing. Crucially, characterizing pain as “subjective” does not mean that it is somehow less “real” or important than what we can measure objectively. On the contrary, pain is subjective in the sense that it relates directly to what it means to be a human being and therefore the subject of conscious experience. As with all states of consciousness, clinicians can assess pain’s qualitative character only indirectly—by asking the patient about it. This absolute [reliance on communication](#) and trust makes the patient-physician relationship especially critical in the case of pain. It also means that physician judgments about pain are particularly susceptible to biases and errors of perception.

There is substantial evidence of the presence and impact of implicit bias in medicine, to which physicians like Dr. M are not immune [14]. Such biases may account for findings of [racial and ethnic disparities](#) in the assessment and management of pain [15]. For instance, studies have found racial disparities in the prescription of opioid painkillers in emergency departments [16, 17]. Other studies have documented stigma and bias against patients with a history of substance use disorders, contributing to worse treatment outcomes [18]. Taken together, this evidence—which reveals disparities in pain treatment decisions and that clinicians tend to be biased against patients with a history of substance use—suggests that implicit bias may have caused Dr. M to misjudge the seriousness of Mr. C’s pain, leading Dr. M to minimize the importance of the pain while Mr. C became increasingly frustrated.

Recent work in cognitive science and philosophy of mind introduces an additional possibility: Dr. M’s perceptions themselves might have been influenced by his pre-existing beliefs and biases. Philosopher Susanna Siegel offers an everyday case of “cognitively penetrated perceptual experiences” [19]: Jill believes Jack is angry with her, so when she looks at him, Jack’s face actually presents itself to her as angry. Jill uses this as evidence to confirm her (false) belief that Jack is angry with her. Epistemologically,

something has gone seriously wrong here: Jill's false belief leads to a faulty perception, which itself is used as evidence to reaffirm her commitment to the false belief.

In the case at hand, it is possible that Dr. M's beliefs and biases concerning Mr. C ("he's always been difficult") led him to perceive Mr. C's behavior as disingenuous or exaggerated. If so, this perception is used as evidence to reinforce Dr. M's belief that Mr. C is "difficult" (or alternatively, "drug-seeking") and, by implication, that Mr. C's complaints of pain should be treated with suspicion.

These psychological phenomena have an ethically salient consequence: patients are especially disempowered in cases in which physician bias contributes to damaging the patient-physician relationship, and accordingly physicians take on even greater ethical responsibility to guide its restoration. To understand this powerlessness from Mr. C's perspective, suppose his reports of pain are wholly genuine—once physician bias causes his reports to be doubted, what more can he do to convince his doctors that he really is in pain? Further attempts at convincing his doctors are likely to be self-defeating: by fixating increasingly on his pain or insisting on more medication, he risks being labeled as "drug-seeking." The implication of this catch-22 is that patients are uniquely disempowered when their subjective experiences are doubted. In these cases, physicians hold a special responsibility to ensure that their own biases and errors of perception are not harming the therapeutic alliance.

Clinicians can work to counteract these biases by adopting the default stance that patients' reports of their subjective experiences are genuine, taking the burden on themselves to gather positive evidence that patients might have other motives for their behavior [20]. In particular, the mere fact that patients have a history of substance use cannot be taken as sufficient evidence that they are not experiencing genuine pain—especially a patient like Mr. C who is hospitalized for an acute condition. Physicians and medical students must also be mindful about the language they use to talk about patients. Language shapes perception [21], and labeling a patient as "difficult" or "drug-seeking" may affect how their behavior is perceived and close clinicians' minds to other explanations for the patient's behavior, which in turn may lead to suboptimal treatment decisions as well as damaged patient-physician relationships.

### **Medical Students as Mediators**

Medical students can help combat the impact of implicit bias by leveraging their unique role as learners to ask questions that make the team think critically about their assumptions. For example, John could ask, "I know Mr. C got pretty agitated back there, but he does seem to be in pain—what can we do for him?" or "What's the best way to manage pain in a patient with a history of opioid use?" Since pernicious biases avoid scrutiny by remaining unconscious, a student's questions can be helpful simply by elevating these issues to the level of conscious reasoning. As part of the care team, John

should feel empowered to contribute in ways beneficial to Mr. C's health—whether this means ensuring the right tests are ordered or ensuring the patient-physician relationship stays healthy.

### Conclusion

Physicians should view repairing damaged patient-physician relationships as an ethical obligation on par with providing any other medical intervention essential to patient care and should recognize that their greater power relative to patients comes with greater responsibility to repair those relationships. Furthermore, physicians must recognize that biases can impact their judgments and perceptions—especially for subjective qualities such as pain—and that these biases can disempower patients when their experiences are not believed, leading to worse care. Clinicians can work to counteract these biases by adopting the default stance that patients' reports of their subjective experiences are genuine and by avoiding the reflexive use of labels like "difficult" and "drug-seeking" that can disempower patients and lead to faulty perceptions. Medical students can help repair or maintain healthy patient-physician relationships by using their intermediate position of power to [advocate for patients](#) and ask questions that force the team to reconsider their assumptions. Taken together, these recommendations emphasize that a healthy patient-physician relationship ought to lie at the center of medicine's moral mission.

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