MANAGING CONFLICT IN CLINICAL HEALTH CARE WITH DIMINISHED RELIANCE ON THIRD PARTY INTERVENTION: FORGING AN ETHICAL AND LEGAL MANDATE FOR EFFECTIVE PHYSICIAN-PATIENT COMMUNICATION

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I. INTRODUCTION

The world of clinical medicine is rife with conflict among caregivers, patients and their surrogates. This should not surprise given medicine’s scientific, psychological, and language complexities, high stakes, fragmentation of care, multiplicity of players, time constraints, institutional politics, cultural differences, competing philosophies and economic dimensions. “Hospital life with its byzantine array of moving parts layered atop the unpredictable rhythms of illness is a permanent state of flux.”

Clinical conflicts that are unmanageable by the disputants themselves, or through informal consultation with others, are ordinarily addressed by one of three processes, all of which involve third party intervention. Most clinical conflicts arise from communication, information, culture and personality-based sources, rather than from classic ethical dilemmas, but the most high profile instances of conflict are “morally aporetic” situations in which parties are deadlocked, while each party advances a morally legitimate

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basis for her stated position. Such conflicts often arise in end-of-life situations.3

Since the New Jersey Supreme Court’s opinion In re Quinlan,4 permitting Karen Quinlan’s parents to withdraw life-support while she survived in a persistent vegetative state, Hospital Ethics Committees (hereinafter “HECS”) have become practically universal.5 HECS have primarily sought to manage conflict through a process known as Clinical Ethics Consultation. Through issuance of recommendations by the committee or its designees, preferred choices, or often a single choice, are rendered as the de facto mandate of the institution. Such a process can be described as “hierarchical” in that conflict is managed by outsourcing to third parties for decision-making.6 Critiques of traditional clinical ethics consultation have been offered by this author and others. Commentators’ many concerns include lack of engagement with patients and their families; predominance of caregiver referrals; and decision-making by questionable “experts” in the face of competing, yet legitimate, moral claims. These concerns characterize a process in which the patient’s role is often subordinated, in spite of her crucial stake in the outcome. Lack of universal training requirements for clinical ethics consultants and the absence of uniform standards for decision-making, have also been cited as problematic.7

An alternative approach to clinical conflict is advocated by those who favor an inclusive, non-hierarchical, non-coercive process, in which consensus is sought among interested parties whose


6 Bergman, supra note 3, at 15.

views are in apparent conflict, while a decision is, nonetheless, required. This approach, termed “bioethics mediation,” or “clinical ethics mediation,” has gained traction in bioethics literature for its humanistic, cathartic and egalitarian features, but faces significant obstacles to widespread implementation as described in earlier publications by this author and others. The mediator’s role is primarily that of a facilitator and manager of the process. “[M]ediation is generally defined as the intervention in a negotiation or a conflict of an acceptable third party who has limited or no authoritative decision-making power who assists the involved parties to voluntarily reach a mutually acceptable settlement of the issues in dispute.”

In lieu of traditional clinical ethics consultation, or bioethics mediation, and, for individual cases in which those processes have proven ineffective, clinical conflict frequently plays out in the legal domain as malpractice litigation. In litigation, judges and jurors constitute third-party neutrals who, unlike mediators, address conflict on an adjudicatory, rather than consensual, model. The costs, social benefits and detriments of litigation are beyond the scope of this article. I will merely allude to the fact that litigation is costly, in various respects, regardless of outcome. In addition to malpractice claims, litigation of issues that might have been resolved within the context of the physician-patient relationship include disputes over medical futility, the right to die, and the right to refuse treatment.

All of the above processes have their merits and their advocates, yet all consume time and money, adding layers of complexity to the practice of clinical medicine. While these dispute resolution mechanisms differ greatly, they are all subject to the criticism offered by Berger that third-party intervention may undermine “the


10 See OFRI, supra note 2, at 185–93.

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doctor-patient relationship that might reduce such conflict in the
future.”12 Siegler goes one step further, suggesting that delegation
of decision-making to institutional ethics committees may consti-
tute questionable abdication of a physician’s ethical responsibil-
ities.13

In an ideal world, the physician-patient relationship might be
structured to increase trust, create mutual respect and incorporate
the diverse competencies of physician and patient, resulting in a
collaborative enterprise. Achievement of that aim, with the poten-
tial for decreased conflict, could diminish resorting to third party
intervention by any of the aforementioned methods. For example,
“It is believed that the majority of malpractice claims would not be
pursued if the patient, or the patient’s family, were not angered
over failures or disappointments in the patient’s relationship to the
physician.”14 One might predict similar reductions in conflict cur-
tently addressed by Clinical Ethics Consultation or Bioethics Med-
diation, as a function of more fully realized physician-patient
relationships.

Section II below analyzes the Dimensions of Physician-Patient
Communications, noting that verbal, non-verbal and emotional/re-

tional communication generate complexity. Communication chal-


genes appear exacerbated by the persistence of traditions and
values antithetical to the development of relational skills.

Section III explores the extent and efficacy of Initiatives for
Reform in Medical Education aimed at improving relational skills
from the inception of physicians’ education and training.

Section IV addresses the Ethical and Legal Sources of a Physi-
cian’s Duty to Communicate Effectively With Patients. This focal
aspect of the article examines codifications of an ethical duty for
physicians to communicate effectively; the ethical implications of
power imbalances in the physician-patient relationship; and devel-


opment of the legal doctrine of informed consent.

The Conclusion reflects tensions arising from the gap between
theoretical acceptance of ethical and legal duties specific to physi-
cian-patient communication, and adherence to those principles in
actual practice. Accordingly, the Conclusion provides recommen-


12 Zackary Berger, Understanding Communication to Repair Difficult Patient-Doctor Re-


tationships from Within, 12 AM. J. BIOETHICS 15 (2012).

13 See Mark Siegler, Ethics Committees: Decisions by Bureaucracy, 16 Hastings Report 22

(1986).

14 Debra L. Roter & Judith A. Hall, Doctors Talking with Patients /Patients


talking with Doctors: Improving Communications in Medical Visits 38 (2006).
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Recommendations for change. Failure to acknowledge a relationship between the economics of contemporary medicine and the attainment of effective physician-patient communications that are the core of this inquiry would be disingenuous. But, managed care, insurance coverage, and implementation of the Affordable Care Act (ACA),\textsuperscript{15} though they interface with the attainment of physicians’ relational skills, are neither the subject of this article, nor within this author’s domain.\textsuperscript{16}

II. DIMENSIONS OF PHYSICIAN-PATIENT COMMUNICATIONS

Effective communication, in any context, requires that content emanating from the sender be comprehended by the receiver.\textsuperscript{17} One dictionary definition of “communicate,” states: “Communicate - To transmit information, thought, or feeling so that it is satisfactorily received or understood.”\textsuperscript{18} The extent to which the requisites of the above definition constitute a challenge for the physician can be appreciated by reference to Figures A and B below.

\begin{figure}[ht]
\centering
\caption{Clinical Communications I}
\end{figure}

\begin{table}[ht]
\centering
\begin{tabular}{ll}
\hline
\textbf{PHYSICIAN} & \textbf{PATIENT} \\
(Sender) & (Receiver) \\
\hline
Verbal and Non-Verbal & \\
> > > > > Information > > > > & \\
\textbf{CLARITY} & \textbf{COMPREHENSION} \\
\textbullet Professional Responsibility & \textbullet No Professional Responsibility \\
\textbullet Precision & \textbullet Cannot ensure receptivity \\
\hline
\end{tabular}
\end{table}

\textsuperscript{16} See ALFRED I. TAUBER, PATIENT AUTONOMY AND THE ETHICS OF RESPONSIBILITY 3, 6, 48, 81, 126, 162–63, 227–28 (2005); OFRI, supra note 2, at 156–58; RENATA SCHIAVO, HEALTH COMMUNICATION: FROM THEORY TO PRACTICE 112 (2007).
\textsuperscript{18} WEBSTER’S NINTH NEW COLLEGIATE DICTIONARY 266 (9th ed. 1991).
Plain Language

“Translation”

Account for potential impact of one’s own emotional state including biases

Confirmation
Did receiver (patient) comprehend message intended?
Propose or Elicit Proposals

Confirmation
Was message satisfactorily received and understood?
Propose or Elicit Proposals

Figure B

CLINICAL COMMUNICATIONS II

PATIENT (Sender)

PHYSICIAN (Receiver)

Verbal and Non-Verbal

> > > > > Information > > > > >

facts, emotions, opinions, values

“Telling Her Story”

No professional responsibility

Professional responsibility

Cannot ensure clarity, coherence, consistency

Listen actively

Probe

Varied levels of sophistication

Acknowledge

Summarize

Varied impact of physical / emotional compromise

Confirm

Respect

Assess emotional content

Propose or Elicit Proposals

Figure A depicts a communication from the physician, as sender, to the patient, as receiver. An expert on biomedical matters—a professional—the physician conveys a complex amalgam of medical facts, professional opinion and emotional content to the patient, an expert on her own personal history, values and feelings. The patient, typically uninformed in biomedicine, receives the communication while in a condition compromised by some, or all, of the burdens common to being a patient. Anxiety, pain, fear,
uncertainty, displacement from one’s normal environment, isolation, confusion, opaque medical terminology, educational deficits, cultural differences and prior history may all contribute to the lack of receptivity and comprehension of the communication. The aforementioned patient states are sometimes described, in the aggregate, as sources of “power imbalance” between patients and caregivers. While the physician also carries an emotional agenda, it is her burden, as a professional, to account for its potential impact on the physician-patient interaction.

Because of compromised patient states, the physician’s likelihood of being understood is dependent on her ability to communicate complex information with precision, and in plain language, often requiring the equivalent of translation from scientific jargon to language comprehensible by laypersons. To ensure comprehension, the physician must find the means to confirm that her message was understood.

Figure B reverses the communication vector so that the patient becomes the sender, and the physician, the receiver. The patient, for reasons previously noted, cannot be presumed to communicate with clarity, coherence, and consistency. Thus, the physician becomes tasked with the processes, enumerated under Caregiver/Comprehension in Figure B, to facilitate her optimal understanding of the patient. Without such comprehension, the physician is ill-equipped to propose diagnoses or treatment options.

While we typically associate communication with its written and verbal forms, physician-patient communication, like communication in other contexts, is highly dependent on non-verbal dimensions. DiMatteo, Taranta, Friedman, and Prince reported on two studies, which conclude that patients of physicians sensitive to the decoding of a patient’s body posture and movement expressed higher levels of satisfaction with those physicians. These studies also suggest a positive relationship between patient satisfaction and the ability of physicians to communicate nonverbal messages of emotion.

Mast similarly affirmed the importance of non-verbal aspects of the physician-patient relationship and concluded that a physician’s non-verbal behavior impacts patient outcomes, inclusive of

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20 M. Robin DiMatteo, Angelo Taranta, Howard S. Friedman & Louise M. Prince, Predicting Patient Satisfaction from Physicians’ Nonverbal Communication Skills, XVIII Medical Care 376 (1980).
patient satisfaction.\textsuperscript{21} Griffith et al. sought to examine the association of non-verbal physician communication with standardized patient satisfaction. Noting perceived deficiencies in the methodology of prior studies that yielded mixed results, these investigators concluded that better non-verbal communication skills correlate with significantly greater patient satisfaction.\textsuperscript{22}

When Roter and Hall describe “The Significance of Talk” they are careful to include that:

\textit{[W]e also mean communication beyond words, the whole repertoire of nonverbal expressions and cues. . . . The smiles and head nods of agreement, the grimaces of pain, the high-pitched voice of anxiety. . . . [A]ll of these nonverbal expressions give context and enhanced meaning to the words spoken.}\textsuperscript{23}

Complexity of communication increases as a function of the role of emotion. Recent literature on effective physician-patient communication addresses demands posed by affect and emotion in physician-patient relationships. The entire range of human emotions, reflected in both physicians and patients, are seen as impacting physicians’ reasoning, sometimes resulting in clinical errors.\textsuperscript{24}

Recognition of the relevance of emotion can be viewed as the corollary of a broader shift in the paradigm for understanding the physician-patient relationship. Two formerly accepted maxims have been subjected to reconsideration and reformulation. First, the belief that a physician’s competence is solely a by-product of technical expertise has been questioned by many whose criteria for competency include broad, humanistic healing powers. Tauber observes that “[s]ince the Flexner Report of 1910, medicine has formally embraced a scientific curriculum and a scientific ideal to govern its pursuits.”\textsuperscript{25} Schenck and Churchill counter that “[b]y paying attention to recent studies of the profound importance of relational factors in healing, we have an opportunity to develop a

\textsuperscript{23} Roter & Hall, \textit{supra} note 14, at 3.
\textsuperscript{24} Id. at 15–16, 26–28, 73–74; Jerome Groopman, \textit{How Doctors Think} 8, 25 (2007); David Schenck & Larry Churchill, \textit{Healers: Extraordinary Clinicians at Work} 13–14 (2012); Oeri, \textit{supra} note 2, at 64–94.
\textsuperscript{25} Tauber, \textit{supra} note 16, at 16 (citing Abraham Flexner, \textit{Medical Education in the United States and Canada Bulletin Number Four (The Flexner Report)} (1910)).
new paradigm for medicine integrating the best of the basic sciences with humanistic skills.”

The belief that a physician’s effectiveness rests on her ability to maintain detachment from the patient for the exercise of dispassionate professional judgment has been similarly challenged. In 1992, Emanuel and Emanuel described four models of the physician-patient relationship and observed a chronological shift from the “Paternalistic Model” to an “Informative Model,” in which the physician provides all relevant information, the patient selects medical options, and the physician executes them. Objections to the “Informative Model” by the authors were attributed to its emphasis on specialization and detachment over a caring approach that accords centrality to the patient’s value system.

Ofri notes that William Osler’s 1898 “canonical” valedictory address at the University of Pennsylvania titled “Acquanimitas” proposed that “a certain measure of insensibility is not only an advantage, but a positive necessity in the exercise of a calm judgment . . . .” According to Halpern:

In the Oslerian tradition, physicians aim for equanimity, or what Fox and Lief call “detached concern” not only to treat diseases but also to address patients’ emotional needs. The ideal of detached concern is justified by the argument that only an unemotional physician is free to discern and meet patients’ emotional needs without imposing his own.

But Halpern’s own view, to the contrary, is that “this model of unilateral emotional influence . . . denies the ongoing emotional field between patients and physicians.”

Groopman, in his introduction to How Doctors Think, summarizes with approval, many of the conclusions reached by Roter and Hall in their analysis of thousands of interactions between doctors and patients. Roter and Hall’s studies led to the conclusion that emotions pervade all interactions between physicians and pa-

26 SCHENCK & CHURCHILL, supra note 24, at 186.
28 OFRI, supra note 2, at 4.
31 HALPERN, supra note 30.
32 GROOPMAN, supra note 24, at 17–26.
patients; that physicians’ and patients’ cognition and behavior are influenced by emotions in their interactions with one another; that both physicians and patients display emotions even when attempting to suppress them; and that physicians and patients judge one another’s emotions.33

Schenck and Churchill characterize the traditional view, which subordinates emotion to technical competence, as “a dualism that separates cognition from feeling, competence as a technical skill from compassionate communication. . . . Our interviews have shown this to be operational nonsense. It is also educational nonsense.”34 The authors implore that “[r]ather than an irritating distraction from the business of medicine, problems with emotional and stress dimensions constitute a major component of medical practice.”35

The foregoing perspectives are intended to heighten consciousness of the verbal, non-verbal and emotional dimensions of physician-patient communications. Awareness of the complexity of physician-patient communication underscores the challenges facing physicians in attaining relational competence.

III. REFORM INITIATIVES IN MEDICAL EDUCATION FOR IMPROVEMENT OF PHYSICIAN-PATIENT COMMUNICATION

In the preface to their second edition of Doctors Talking With Patients/Patients Talking With Doctors: Improving Communication in Medical Visits, Roter and Hall allude, with anticipation to the introduction, beginning in 2002, of added competency requirements for medical graduates in core skills, inclusive of interpersonal communication.36

The June 2013 “Standards for Accreditation of Medical Education Programs Leading to the M.D. Degree”37 include:

33 Roter & Hall, supra note 14, at 15–16.
34 Schenck & Churchill, supra note 24, at 188.
35 Id. at 13.
36 Roter & Hall, supra note 14, at xi.
37 Liaison Committee On Medical Education, Functions And Structure Of A Medical School: Standard For Accreditation Of Medical Education Leading To The M.D. Degree (2013), available at www.lcme.org/publications/functions.pdf [hereinafter Liaison Committee On Medical Education].
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ED-19. The curriculum of a medical education program must include specific instruction in communication skills as they relate to physician responsibilities, including communication with patients and their families. . . . 38 (emphasis added).

ED-23. A medical education program must include instruction in medical ethics and human values and require its medical students to exhibit scrupulous ethical principles in caring for patients and in relating to patients’ families. . . . 39 (emphasis added).

_The medical education program should ensure that medical students receive instruction in appropriate medical ethics, human values and communication skills before engaging in patient care_ 40 (emphasis added).

The “Teaching and Evaluation” section specifies that:

ED-28. A medical education program must include ongoing assessment of medical students’ problem solving, clinical reasoning, decision making and communication skills (emphasis added). 41

The above requirements are not designated as optional. Repeated use of the words “must include,” and employment of the word “ensure,” could not be more definitive, nor could a requirement that the contemplated instruction be received “before engaging in patient care.”

A Virginia Commonwealth University study examining the importance of communication in health care found that a group trained in six hours of communication workshops with theater faculty was better at communicating with patients than the control group, which received no training. 42 A number of studies suggest that exposure to dramatic theatrical performances can enhance empathy in medical students and practitioners. 43

38 Id. at 11.
39 Id.; see also Edmund D. Pellegrino & Thomas K. McElhinney, Teaching Ethics, The Humanities, and Human Values in Medical Schools: A Ten-Year Overview (1982) (discussing concerns for the inclusion of these subjects in the medical school curriculum that were advanced long ago).
40 Liaison Committee On Medical Education, _supra_ note 37, at 11.
41 Id. at 13.
In their comprehensive work on physician-patient communications, Roter and Hall conclude that “at this point, a solid foundation of behavioral science research demonstrates that training improves the communication of physicians. Communication skills training during medical school has been shown to have effects lasting as long as five years.”44 Halpern, in her seminal work, From Detached Concern to Empathy: Humanizing Medical Practice, states that it is “practical for all physicians to learn more about emotional communication and to use this knowledge to empathize more effectively with patients.”45

The scholar and practitioner of narrative medicine, Rita Charon, focuses on “narrative competence,” which entails the capacity “for human beings to absorb, interpret and respond to stories.”46 Charon advocates the teaching of literature and narrative writing in medical schools and praises the formation of reading groups, all in the service of nurturing self-awareness, understanding the patient’s experience, and facilitating the therapeutic dimensions of medical practice.47

A recent review of the admissions websites for three of the nation’s leading medical schools—Harvard,48 Stanford,49 and the University of Pennsylvania50—reflect curriculum inclusions which incorporate communication skills. A 2001 article, Communication Challenges for Experienced Clinicians: Topics for an Advanced Communication Curriculum, by Vanderford et al. determined that while most medical schools had already incorporated communication training within their curriculum, experienced clinicians, even after training, found that they lacked various communication competencies.51 The authors believe that “[d]evelopment of curricula for advanced medical students and practicing physicians can meet many of these currently unmet needs.”52

44 ROTER & HALL, supra note 14, at 176.
45 HALPERN, supra note 30, at xii.
47 See generally id.
52 Id. at 281.
The Jefferson Scale of Patient Empathy (JSPE) developed by Hojat, assessed medical student empathy and reports that empathic engagement with patients by physicians leads to better health outcomes. Related studies conclude that “empathy can be enhanced effectively by dedicated educational programs but notes that such programs face many obstacles in the context of current medical education.”

A study by Krasner et al. examined the effects of a one-year course for practicing primary care physicians in “mindful communication,” and concluded that participants became more present and attentive with increased ability to empathize with patients. Like Hojat, however, the authors expressed concern regarding introduction of these ideas to skeptical colleagues. Schenck and Churchill opine that “relational skills in patient care are not mystical attributes but practices that can be identified and taught.” The authors reviewed “mounting scientific evidence that practitioner-patient relationships are an important factor in how patients get better.” Yet, the chapter concludes that “the current dominant model of medical education does not provide adequate opportunity for students to develop relationship skills.”

A Canadian study by Buckman posits “abundant evidence that empathic communication is an essential medical skill set that can be taught.” Despite evidence of a positive correlation between empathy and clinical competence, Buckman notes that empathy declines during undergraduate medical training in Canada and elsewhere. Training in medical school is viewed as a positive initiative, but one that must be reinforced in post-graduate and continuing medical education.

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54 Mohammadreza Hojat, Ten Approaches for Enhancing Empathy in Health and Human Services Cultures, 31 J. HEALTH HUM. SERVICES ADMIN. 412, 413 (2009).
55 Michael S. Krasner, Ronald M. Epstein, Howard Beckman, Anthony L. Suchman, Benjamin Chapman, Christopher J. Mooney & Timothy E. Quill, Association of an Educational Program in Mindful Communication with Burnout, Empathy and Attitudes Among Primary Care Physicians, 302 JAMA 1284 (2009).
56 SCHENCK & CHURCHILL, supra note 24, at 4.
57 Id. at 170.
58 Id. at 188.
59 Robert Buckman, James A. Tulsky & Gary Rodin, Empathic Responses in Clinical Practice: Intuition or Tuition?, 183 CAN. MED. ASS’N J. 569 (2011). Consistent with the author’s
In *What Doctors Feel: How Emotions Affect The Practice of Medicine*, Ofri concurs with Buckman regarding the decline of empathy in students during medical school, but questions whether the emphasis should be on teaching empathic skills or selecting students who already possess them. The author concludes that both initiatives are required. Ofri also believes that teaching functions should largely be performed by clinicians supervising students and interns in wards, rather than in classrooms. Numerous studies have documented a loss in moral sensitivity as a by-product of medical students’ professionalization.

Tauber succinctly summarizes the arguments for and against ethics training within the medical curriculum and notes apparent agreement on basic goals, which include “the routine explanation of risk . . . what constitutes adequate information, the ability to appropriately communicate such information, the ability to distinguish persuasion from coercion;” and “[t]he ability to know when it is morally justified to withhold information.” Yet, Tauber acknowledges that “not surprisingly, a uniform curriculum evades adoption. In recent surveys of U.S. medical schools at least thirty-nine different topics are covered and only six content areas were taught in a majority of schools.”

This review of select literature on the enhancement of physician-patient communication skills through education does not purport to be comprehensive. It demonstrates that agreement on the utility of training physicians in communication skills coexists with the status of these initiatives at the margins, rather than the core, of the educational enterprise.

As Schenck and Churchill eloquently convey:

belief in the need for post-graduate communication training, see Accreditation Counsel For Graduate Medical Education, ACGME Common Program Requisites 9 (2013), available at http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/CPRs2013.pdf.

60 Ofri, *supra* note 2, at 54; see Ass’n of Am. Med. Colleges, Core Competencies for Entering Medical Students, http://www.aamc.org/initiatives/admissionsinitiative/competencies/ (last visited Sept. 8, 2013) (The competencies are recommended to all medical schools by the AAMC which is without authority to compel their adoption).


64 Id. at 211.
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We have worked so long in the shadow of the Flexner Report and the valorization of the basic biological sciences as the only essential elements of medical education that . . . relational awareness and self-reflection has often been thought of as a desirable “add-on” but not a feature of the core curriculum.65

The state of medical education for acquisition of relational skills described in this section relegates those skills to an aspirational ideal, rather than a baseline requirement for physician competency. Such ambiguity presents obstacles to universal acceptance by physicians of an ethical and legal duty to communicate effectively. Thus, medical education bears a measure of responsibility for the current state of physicians’ relational competency.

IV. ETHICAL AND LEGAL SOURCES OF THE PHYSICIAN’S DUTY TO COMMUNICATE EFFECTIVELY WITH PATIENTS

A central hypothesis of this article is that universal acceptance of an ethical and legal duty on the part of physicians to communicate effectively with patients would place greater urgency on the development of empathic communication skills by physicians, leading to higher levels of relational competency, and less frequent resort to third party intervention for the management of conflict. In Section III, we examined the limited extent to which reforms in medical education have facilitated that acceptance. Notwithstanding those limitations, there are numerous sources from which a duty of effective physician-patient communication emanates.

In the American Medical Association Code of Medical Ethics,66 Opinion 10.015 addresses the “patient-physician relationship” by proclaiming that “[t]he practice of medicine . . . is fundamentally a moral activity that arises from the imperative to care for patients and alleviate suffering”67 (emphasis added). This characterization constitutes a broad ethical mandate that, arguably, encompasses

65 SCHENCK & CHURCHILL, supra note 24, at 188; FLEXNER, supra note 25.
67 See id.
the scope of accepted ethical duties embraced in bioethics literature.

The bioethics principles of beneficence, non-maleficence, patient autonomy, and social justice are widely accepted. Each of these concepts signifies a range of behaviors necessary for its effective implementation. It is difficult to conceive of adherence to any of the aforesaid principles in the absence of effective physician-patient communication. For example, one can only understand the meaning of beneficence, in context, with reference to a patient’s personal perspectives on the meaning of life, health, and disease. Those perspectives cannot be acquired in the absence of effective patient-physician communication.

Opinion 10.01 of the AMA Code of Medical Ethics identifies “Fundamental Elements of the Patient-Physician Relationship” that provide in pertinent part “the health and well-being of patients depends upon a collaborative effort between physician and patient. . . . Physicians can best contribute to this alliance by serving as their patients’ advocate and by fostering these rights.”

(1) The patient has the right to receive information from physicians and to discuss the benefits risks and costs. . . . Patients should receive guidance . . . as to the optimal course of action. . . .

(2) The patient has the right to make decisions regarding the health care that is recommended. . . .

(3) The patient has the right to courtesy, respect, dignity, responsiveness and timely attention to his or her needs (emphasis added).

All of the enumerated rights implicate physician-patient communication issues. The “right to receive information” would be meaningless without an implied requirement that the information be accurate, comprehensible, and comprehensive. Such implications impose a duty of effective communication on the physician. The same is true of a discussion of “benefits, risks, and costs.” Communication that is inaccurate, incomprehensible, or uncomprehensible would serve no purpose as it would fail to provide a sound basis for the patient’s “right to make a decision.” Finally, the requirements of “courtesy, respect, dignity, and responsive-

69 Council On Ethical And Medical Affairs, supra note 66, at Op. 10.01.
70 See id.
ness” could, in some cases, be considered violated by a failure of effective communication. For instance, if a physician’s behavior is so curt and dismissive that the patient is intimidated, and incapable of asking questions, might the patient’s assessment of “benefits, risks, and costs” be deemed impaired or non-existent?

To “collaborate” has been defined as to “work jointly on an activity or project.” Collaboration has been equated with joint problem-solving in the negotiation literature. Indeed, one commentator views collaboration as associated with situations in which stakeholders have disparate resources and power, problems involve technical complexity, and the parties are seeking consensus in a way to proceed because unilateral efforts are inadequate. These elements are clearly present in the physician-patient relationship. Collaboration, by its very nature, is dependent upon effective communication between physician and patient.

Tauber proposes that, in the early twenty-first century view of clinical medicine, the remnants of paternalism have been abandoned in favor of greater respect for patient autonomy. “In this view, collaboration is required. . . . [P]eople must be informed of medical decisions affecting their care.”

Breaking the Cycle: How to Turn Conflict into Collaboration provides a pragmatic approach to the management of conflict in physician-patient relationships. In focusing on the role of “Physician as Collaborator” the authors propose a methodology by which communication skills are utilized to create “shared-decision making,” in which “both parties participate, information is exchanged and agreement is ultimately reached on how to proceed.”

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71 CONCISE OXFORD ENGLISH DICTIONARY 280 (2011).
72 See KENNETH W. THOMAS & RALPH H. KILMANN, THOMAS-KILMANN CONFLICT MODE INSTRUMENT 6, 10 (1ST ED. 1997); G. RICHARD SHELL, BARGAINING FOR ADVANTAGE: NEGOTIATION STRATEGIES FOR REASONABLE PEOPLE 11–12, 171–72 (2D ED. 2006).
73 BARBARA GRAY, COLLABORATING: FINDING COMMON GROUND FOR MULTIPARTY PROBLEMS 10 (1989).
74 TAUBER, supra note 16, at 57.
75 See id.
76 See GEORGE F. BLACKALL, STEVEN SIMMS & MICHAEL J. GREEN, BREAKING THE CYCLE: HOW TO TURN CONFLICT INTO COLLABORATION WHEN YOU AND YOUR PATIENTS DISAGREE (2009).
77 Id. at 28–30.
78 See Cathy Charles, Amiram Gafni & Tim Whelan, Shared Decision Making in the Medical Encounter: What Does It Mean? (Or It Takes At Least Two to Tango), 44 SOC. SCI. MED. 681 (1977).
79 BLACKALL ET AL., supra note 76, at 28.
In his work, On Apology, Lazare states that “[t]oday, experts . . . generally agree that a negotiated approach best describes what actually happens between physician and patient.” Various commentators have described physician-patient relationships on a negotiation model. Groopman, Dubertret, and Chen all portray the physician-patient relationship in terms that are descriptive of a negotiation process. Rapport-building, active listening, probing, letting the patient tell her story, the use of plain language, tolerance of silence, and trust are highlighted by these authors as critical elements of the communication process. Curiously, healing relationships are viewed by the clinicians whose experiences inform the content of Healers: Extraordinary Clinicians at Work, as overlapping and often synonymous with those aspects of negotiated relationships noted above.

The centrality of therapeutic relationship building reaches its zenith in the views of those who assert the healing power of the relationship itself. “Not only is relationship understood as the basis of all healing work that is to come, it is depicted as healing in and of itself.” R. Lukoscheck et al. found that the personalized exchange of information between provider and patient is a major factor in the reduction of “morbidity and mortality for chronic diseases.”

The idea of “clinical empathy,” comprehensively explicated by Halpern, is predicated, in part, on substantial research demonstrating that emotional communication, in the context of a physician-patient relationship, has a positive influence on healing.

While a nuanced understanding of clinical empathy is beyond the scope of this article, Halpern views it as a form of “emotional reasoning” that transcends either detached cognition, or sympathy, in favor of an experiential model in which the physician imagines a patient’s emotional meanings.

80 AARON LAZARE, ON APOLOGY 204 (2004).
81 See GROOPMAN, supra note 24.
82 LOUIS DUBERTRET, PATIENT-BASED MEDICINE, 20 J. EUR. ACAD. DERMATOLOGY AND VENEREOLOGY 73, 74–75 (2006).
83 See PAULINE CHEN, FINAL EXAM: A SURGEON’S REFLECTIONS ON MORTALITY (2007).
84 SCHENCK & CHURCHILL, supra note 24, at 3–25.
85 Id. at 51.
87 HALPERN, supra note 30, at 68, 94 n.1; OFRI, supra note 2, at 48.
Empathic communication enables patients to talk about issues that relate to their health that might otherwise never be disclosed, thus leading to a fuller understanding of patients’ illness experiences, health habits, psychological needs, and social situations. . . . Empathy supplements objective knowledge . . . and other tools for making accurate diagnoses.\textsuperscript{88}

Halpern acknowledges that the meaning of clinical empathy has been subject to numerous, sometimes conflicting, interpretations.\textsuperscript{89} With deference to Halpern’s more erudite exposition, I utilize the term “clinical empathy” as receptivity to emotional pathways discoverable in the physician-patient relationship. The healing process is enhanced through the patient’s perception of having been understood in ways unattainable through pure cognition. Understanding refers to the physician’s capacity to identify with a patient’s subjective experience of illness, without the physician actually experiencing it herself, thereby facilitating meaningful dialogue.

The concepts of shared decision-making, physician as collaborator, a negotiated model of the physician-patient relationship, and clinical empathy, are associated with the contemporary ideal of “patient-centered care.” “A patient-centered medicine directs clinical attention beyond the scientific and technocratic aspects of treating disease to a more psychosocial appreciation of illness.”\textsuperscript{90}

The Hospital Accreditation Standards of the Joint Commission,\textsuperscript{91} with respect to a patient’s rights to effective communication, are, in some ways, more concrete than the AMA’s formulation of physician’s duties previously considered.\textsuperscript{92}

An Introduction to Standard RI.01.01.03 provides an extraordinarily clear conceptual basis for the prescribed requirements for effective physician-patient communication:

Because communication is a cornerstone of patient safety and quality care, every patient has the right to receive information in a manner he or she understands. Effective communication allows patients to participate more fully in their care. When a patient understands what is being said about his or her care, treatment, and services, that patient is more likely to fulfill critical health care responsibilities. Communicating effectively with patients is

\textsuperscript{88} Halpern, supra note 30, at 94.
\textsuperscript{89} See id.
\textsuperscript{90} Tauber, supra note 16, at 22.
\textsuperscript{91} The Joint Commission, Accreditation Hospital, Hospital Accreditation Standards RI-5 (2011).
\textsuperscript{92} Council On Ethical And Medical Affairs, supra note 66.
also critical to the informed consent process and helps practitioners and hospitals give the best possible care. For communication to be effective, the information provided must be complete, accurate, timely, unambiguous, and understood by the patient (emphasis added).93

These Standards reach beyond the right to information and speak to the quality of communication required. Standard RI.01.01.01 declares that “[t]he hospital respects, protects and promotes patient rights.94 The Elements of Performance for RI.01.01.01 include:

A1. The hospital has written policies on patient rights.
C5. The hospital respects the patient’s right to and need for effective communication.95

Medical institutions often encapsulate the aforesaid spectrum of duties to patients in their institutional “bill of rights” which can be even more comprehensive and specific than the Accreditation Standards.96

Both the ethical mandates of the AMA Code of Medical Ethics and the Hospital Accreditation Standards are consistent with, but more expansive than, the legal requirements for informed consent. The doctrine of informed consent requires that physicians have a duty to disclose material risks of a treatment, the alternatives to that treatment, and the likely outcome of non-treatment.

93 THE JOINT COMMISSION, ACCREDITATION HOSPITAL, supra note 91.
95 See id.
96 Penn Medicine at the University of Pennsylvania has published and distributed its own policies in Penn Medicine, Patient Bill of Rights and Responsibilities, U. PA. HEALTH SYS., available at http://www.pennmedicine.org/health-system/patient/quality-outcomes/patient-bill-rights/. These policies include, in pertinent part:

You have the right to full information in layperson’s terms, concerning diagnosis, treatment and prognosis, including information about alternative treatments, and possible complications. . . .
You have the right in collaboration with your physician to make decisions involving your health care.
You have the right to be communicated with in a manner that is clear, concise and understandable.
You have the right to respectful care given by competent personnel which reflects consideration of your personal values and belief systems and which optimizes your comfort and dignity.
You have the right to participate in the consideration of ethical issues surrounding your care.

Id.

In \textit{Canterbury v. Spence}, the court noted that:

\begin{quote}
[T]he patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arms-length transactions. His dependence upon the physician for information affecting his well-being . . . is well-nigh abject. . . . More recently, we . . . have found “in the fiducial qualities of the . . . relationship the physician’s duty to reveal to the patient that which in his best interests it is important that he should know.” We now find . . . a similar duty of reasonable disclosure of the choices with respect to proposed therapy and the dangers inherently and potentially involved.\footnote{98 See \textit{Canterbury}, 464 F.2d 772.}
\end{quote}

The court thus imposes a fiduciary standard on a physician's duty to communicate comprehensively, in the patient's best interest, and explicitly applies that standard to the duty of informed consent. The widely used text, \textit{Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine}, by Jonsen, Siegler and Winslade,\footnote{99 See \textit{ALBERT JONSEN, MARK. SIEGLER & WILLIAM WINSLADE, CLINICAL ETHICS: A PRACTICAL APPROACH TO ETHICAL DECISIONS IN CLINICAL MEDICINE} (6th ed. 2006).} acknowledges the fiduciary duties applicable to physicians. “As defined in the law, a fiduciary gives undivided loyalty to clients and must work for their benefit. Fiduciaries have specialized expertise and are held to high standards of honesty, confidentiality and loyalty.”\footnote{100 \textit{Id.} at 163.}

The level of dependency recognized by the \textit{Canterbury} court embraces the burdens of being a patient and the resulting power imbalances identified in Section II above.\footnote{101 \textit{See supra} notes 1–16 and accompanying text.} Those power imbalances give rise to a reliance on the physician that supports the extraordinary obligations imposed by the \textit{Canterbury} court. A transmittal “that is satisfactorily received or understood” is central to the notion of being “informed.” The burden of transmittal, in both the legal and ethical formulations of the duty to inform, resides with the physician. It is consistent with Halpern's observations that “physicians . . . are also someone to whom people go
when they are particularly vulnerable.” 102 Similarly, in Conversations on the Edge: Narratives of Ethics and Illness, Zaner observes that “the very fact of illness (patients) or distress (family) itself compromises both spiritual and bodily abilities; thus, too, language, plain thinking and listening.” 103

All of the foregoing indicia of rights and duties, in a context of patient dependency and inequality, constitute a reasonable basis for Halpern’s conclusion that, as recognized in Figures A and B supra, 104 “Doctors have a duty to understand the affective worlds of their patients . . . but patients do not have a duty to explain themselves to their physicians.” 105

Development of the legal doctrine of informed consent may be viewed as a corrective to the powerful paternalism and authority evident in medicine from ancient times through the mid-twentieth century. Tauber states that: “The paternalistic attitude is easily traced to ancient medicine which was dominated by Hippocrates, whose famous oath makes no reference to physicians’ obligation to converse with patients.” 106

A shift in the ethos of medical practice from physician authority to patient autonomy appears positive on its face. A problem arises, however, when patient autonomy and the related legal principle of informed consent are viewed in contemporary application. Given the disparity in physician-patient technical expertise, and inevitable instances of patients’ lack of emotional capacity for decision-making in their own best interests, how is the balance between patients’ rights and physicians’ responsibilities to be achieved? 107

The issue is not the patient’s legal capacity, but the extent to which suffering and its secondary consequences, e.g., confusion or hopelessness, become an obstacle to her meaningful assertion of autonomy. Halpern characterizes the problem as a misguided equation of physician non-interference with true autonomy. 108 “Non-interference places the emotional process involved in working through bad news and re-forming goals inside the patient’s

102 Halpern, supra note 30.
104 See supra Figures A and B.
105 Halpern, supra note 30, at 122.
106 Tauber, supra note 16, at 66.
107 Id. at 125–55.
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head rather than in the social world, which includes the physician-patient relationship.109

The nexus between the moral idea of patient autonomy, and the legal requirement of informed consent, is succinctly formulated by Tauber:

[T]he practices that are proposed for securing or respecting autonomy in the medical context have been too often reduced to informed consent, and the much-discussed triumph of autonomy is mostly a triumph of informed consent requirements (O’Neill 2002, 38). . . . ‘Sign on the dotted line’ captures typical practice, and perhaps more importantly, too often distinguishes informed consent from patient autonomy.110

In this view, well-motivated development of the doctrine of informed consent has been co-opted by forces for expediency, resulting in reduction of the moral force of our commitment to patient autonomy. The antidote to this corrosive influence is arguably effective physician-patient communication and the resultant physician-patient relationship.

Expressions of resistance to change frequently appear in media and the arts. In 2011, New York Times columnist Maureen Dowd wrote “there have been baby steps away from the Omnipotent Doctor.”111 More recently, a Times article focused on Emily Oster, the author of a book on her own pregnancy. Oster, a non-physician, perceived that “her ob-gyn issued decrees without explanation, much as a parent says ‘no’ and expects compliance.”112

In the film 50/50, a physician advises his patient of a cancer diagnosis using incomprehensible medical jargon muttered into a recorder, without eye contact or affect.113 The patient responds, accordingly, with confusion and distress which he carries into life outside the clinic. Range of Motion, a film in which the husband of the central character is injured and respirator-dependent, depicts physicians’ cavalier and dismissive delivery of an assignment to hospice care, pending probable death, to which the wife responds: “You call yourselves healers. You’re hypocrites! You don’t care

109 Id. at 106.
112 Catherine Saint Louis, Pregnant, and Disputing the Doctor, N.Y. TIMES, Aug. 20, 2013, at D5.
113 50/50 (Summit Entertainment 2011).
about Jay! What you care about is your percentages, your statistics! Well my husband is not a statistic! He’s my husband!”

While observed changes in the acknowledgement of ethical and legal duties owed by physicians should portend new thresholds for competence in effective physician-patient communication, we have observed the persistence of deeply rooted, contrary traditions reflected in both scholarly discourse and popular perception.

V. Conclusion

Section II above\textsuperscript{115} defined complex challenges for achievement of effective physician-patient communication, while Section III\textsuperscript{116} described the extent to which these challenges have been nominally addressed by reforms in medical education. Section III also posited wide agreement that educational reforms to date are inadequate to the formidable task of physicians’ acquisition of relational skills.

Section IV\textsuperscript{117} chronicled fundamental shifts since the mid-twentieth century in the theoretical acknowledgement of legal and ethical duties owed by physicians to their patients in the domain of communication, as reflected in scholarship, professional codes, and case law. Despite the recognition of such duties in principle, we identified numerous obstacles to the acquisition and implementation of qualitative skills demanded by the concepts of patient autonomy, beneficence, informed consent, patient-centered medicine, clinical empathy, and collaboration. In combination with the limited efficacy of reforms in medical education, and the economics of contemporary medicine, these obstacles have resulted in resistance to, and limited implementation of, the requirements for effective physician-patient communication.

The status quo thus fails to provide a sound basis for the management of clinical conflict within the physician-patient relationship. I have concluded that, in the absence of universal acceptance of an ethical duty for physician attainment of relational skills, it is unlikely that third-party intervention in the management of clinical conflict can be diminished. The scholarship, case law, codifications of physicians’ ethical duties, and requirements for hospital or medi-
cal school accreditation described in this article can be characterized as primarily aspirational, consistent with Tauber’s sober conclusion that “[f]ew would oppose such an ideal but the obstacles for its implementation are formidable.”

In light of the foregoing, it is recommended that the following initiatives be vigorously pursued:

1. Broaden and deepen reforms in medical education at the core curriculum level, including adoption of enforcement measures for noncompliance with curriculum requirements for accreditation. Through oversight, ensure that curriculum reform is substantive and not simply a matter of nomenclature.

2. Study and implement means for enforcement of the AMA Code of Medical Ethics and its published Opinions in the area of physician-patient communications. Increase physician and public awareness of the AMA standards and promote their advocacy by state, local and specialized medical associations. Organize conferences and symposia by medical associations, medical schools, and hospital associations around topics referenced in this article, including communications, collaboration, relational skills, clinical empathy, shared decision making, and patient-centered care.

3. Create realistic enforcement mechanisms for implementation of the requirements for both medical school accreditation and hospital accreditation. Ensure that accreditation is granted on a provisional basis until deficits are cured. Continued non-compliance should result in denial of accreditation, pending compliance.

4. Leverage hospital accreditation requirements to ensure that individual institutions enforce their own published requirements for effective physician-patient communication. Issue non-compliance notices to clinicians and hospital departments with resultant education requirements, and ultimately, increased sanctions for repeated failures of performance.

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118 Tauber, supra note 16, at 27.
119 Council on Ethical and Medical Affairs, supra note 66.
120 Liaison Committee on Medical Education, supra note 37, at 11, 13; The Joint Commission, supra note 94.
121 See Patient Bill of Rights and Responsibilities, supra note 96.
5. Recognize and reward clinicians for exemplary performance of relational skills as determined by their peers and patients. Encourage medical schools to consider humanistic relational skills within the scope of their qualifications for admission.  

6. Support research on statistical relationships between effective physician-communication and the filing of litigation emanating from clinical conflict.  

7. Acknowledge tensions between the economics of contemporary medicine and a physicians’ ethical duties to communicate effectively. Increase efforts, at every level, to address tensions by improving physicians’ relational skills, in spite of these obstacles, while seeking reforms in the practice of medicine more hospitable to the nurturance of relational skills.  

8. Advocate for health care reforms oriented at preventive care and compensation for positive medical outcomes.  

Attainment of the goals presented in this article will not be easy and may not be possible. The recommendations offered will require deep commitment and prodigious efforts on the part of proponents. Systemic inertia and economic roadblocks will persist. The author finds hope in the dedication to humanistic ideals embodied in so many sources on which this article is based. The implementation of reforms contemplated in the Affordable Care Act with respect to preventive care and outcome-based compensation may also provide opportunities for positive change. Finally, the possibility that we are on the cusp of an era that promises “personalized medicine” may precipitate debate over reliance on technology and algorithms in medical care to the exclusion of clinical acuity forged within a meaningful physician-patient relationship. 

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122 See OFRI, supra note 2, at 54; CORE COMPETENCIES FOR ENTERING MEDICAL STUDENTS, supra note 60 (giving some attention to this suggestion).  
125 Such an eventuality might be deemed ironic in light of personalized medicine’s basis in the science of genetics. Yet, an Op-Ed piece in the New York Times by Ezekiel J. Emanuel, coincident with completion of this article, raises the prospective resurgence of physician “house calls” related to studies under the Affordable Care Act and other ‘initiatives,’ indicating that the pro-
Perhaps Pellegrino’s 1979 characterization of the “healing relationship” as “the center of medical ethics”\textsuperscript{126} will one day be realized. For now, those engaged in the improvement of conflict resolution mechanisms dependent on third-party intervention should continue their efforts unabated.

\textsuperscript{126} EDMUND D. PELLEGRINO, HUMANISM AND THE PHYSICIAN 123 (1979).