

CHAPTER 14

MODELS OF NURSE/PATIENT PHYSICIAN RELATIONS

Richard T. Hull

[Hull suggests three views of humanity—religious, individual, and community. Three models of patient-physician relationships follow—the priestly, the contractual, and the collegial. The corollary for the nurse’s role in handmaiden for the first, a role largely rejected today. The third is the ideal but may not be realistic, while the second offers the best general compromise.]

Most first year nurses experience a bewildering diversity of opinions and attitudes on such matters as abortions, truth-telling, informed consent and death and dying. Because these diverse attitudes are often emotionally charged, and because our emotional responses are usually directed towards persons in such situations, it is easy to explain the great bulk of that diversity as due to individual personality differences. One is likely to hear psychological or sociological explanations for why someone behaves or believes in a certain way. “Dr. A once lost a patient through suicide when he told her she had breast cancer; that’s why he doesn’t tell his patients much.” “Nurse B came from a large family that was very poor and she had an abusive mother; that’s why she’s so eager to assist in abortions.” Or, one hears attitudes accounted for in terms of one’s memberships in particular groups: “That social worker was raised a Catholic: that’s why she works with retarded kids.”

Now, these are perfectly ordinary and correct forms of explanation, of a very general casual sort. It is undeniable that a physician’s early experiences with patients, especially if they are particularly satisfying or traumatic, can markedly influence later behavior. There’s no question but that childhood experiences can predispose one towards a favorable or unfavorable stance for abortion on demand. There are certainly high

From *Kansas Nurse*, 55, October 1980, 4–5, 21–24. Reprinted with permission of the Kansas State Nurses’ Association.

correlations between membership in certain religious groups and preference for careers of service to the handicapped. For their reasons for these attitudes, beliefs and patterns of behavior, one is likely not to hear the types of facts just cited. Rather, one is more likely to be given explanations characterized by the presence of words like “best interests”, “rights”, “obligations.” The physician in the earlier example is likely to say, “It isn’t in the best interests of most patients to be told everything about their cases, because it is likely to unduly frighten them.” The nurse may say, “An unwanted child has a right not to be born.” The social worker might say, “We have a particular obligation to provide loving care and opportunity for special children who are less fortunate than ourselves.” In other words, the types of explanations which people give for their own attitudes, beliefs and behaviors frequently tend to be moral explanations, rather than psychological or sociological ones. They seek to provide justification of attitudes, beliefs and behaviors, and they then press others into agreement or into giving defenses of contrary views.

The diversities which nurses encounter in patients and their families, in physicians, in other nurses and other allied health personnel are rooted in alternate views of humankind, not merely in individual personalities or group identities. We need an understanding of the philosophical and ethical presuppositions, not only of our own views but of those with whom we disagree. This should enhance one’s ability to deal effectively and productively with situations of ethical conflict to assist patients and their families in reaching and implementing ethically viable decisions about their care, and to influence the policy-making processes that go on in one’s place of employment. Such understanding may also be instrumental in helping to resolve in one’s own mind the areas of uncertainty and conflicting values that each of us occasionally confronts.

We shall briefly examine three images of humankind—views on both the essence of what it is to be human and the associated principles of rights and obligations. Next, we will connect each of these to one of the models of the relationship between the patient and the physician that has been developed in the literature on medical ethics in recent years. This will permit us to examine those models for the best characterization of nurse/physician and nurse/client interactions one would like to promote.

A. THREE VIEWS OF HUMANITY AND ITS ETHIC

Three alternative approaches to the essence of being human seem to be discernible in our culture.

The first image of humankind is the traditional, religious one; humans as creatures of God. In this view, the creator is thought of as the giver of moral law, intended to guide human conduct so as to conform with the divine will's purposes.

The value of each individual human being is measured in terms of the relation of creature to creator under the revealed purpose which the creator has intended for that creature. For humans this special relationship is sometimes captured under the rubric, "the sanctity of human life." This axiom, that each human life is sacred by virtue of being created by a supreme being, has a corollary. Each human life is equal in value to each other human life—that a person who has but a few moments to live is of no less value than one who has 70 years to live. A person who is handicapped and cannot service the needs of society is not less a human because of that. This is frequently the basic view behind individuals' opposition to abortion, whether of a normal fetus or one identified through amniocentesis as abnormal, and to mercy-killing or even to any instance of "benign neglect."

The second image of humanity is that of individualism. A human is viewed as essentially a creative being in a universe otherwise lacking value, purpose and meaning. Only individual human acts of valuing can generate value; there is no order of value which is either absolute or independent of individual human preferences. The enormous importance that this individualistic ethic places on the individual raises the autonomy of the individual to the highest point. What is in an individual's interest is a function of his or her set of preferences, goals and capacities. Thus the individual is in the best position to determine whether a proposed course of medical intervention is in his best interests. Since he is in the best position to know his own value preferences, capacity for pain and suffering, future business and social plans, and religious beliefs to evaluate the desirability of a particular treatment . . . (1)

With this view, and in contrast to the previous one, there is no basis for a waiver of informed consent, except when incapacity prevents one from exercising the power of choice autonomously. In the first view, there is an absolute and invariant standard of human conduct. In the second philosophical approach, there is no ethical standard, apart from my own values, against which to measure my behavior. My informed consent is thus essential to making an intervention right.

The third view of humanity is that the essence of being human lies within community. The value of the individual is expressed in his or her contribution to the whole. As in the second view, there is no divinely ordained moral order to which human behavior must conform. It is also

the case that the moral order is not limited to, or even constituted by, the individual's self interest and acts of valuation.

Utilitarianism is the most common form of this ethic. The central point is that the individual's interests, to be legitimate, must accord with those of other individuals so as to maximize the general welfare. It is the general good that is to be served by individual choices and general policies. Where individual preferences do not conflict with the interests of others, individualistic and utilitarian ethics may not diverge. But where serving one individual's desires and wishes detracts from other's welfare, then, this ethic dictates the subordination of the individual's interests and desires.

B. THREE MODELS OF THE PATIENT-PHYSICIAN RELATIONSHIP

Three characterizations of the relationship between physician and patient have appeared in recent medical ethics literature. These are not the only ones. But they are useful to illustrate how medical ethics presupposes one or another view of the nature of humanity. The three models are the *Priestly*, *Contractual* and *Collegial or Team* model.

In the traditional religious view, human obligations in medical decision making are few and uncomplicated. This does not mean that they may be clearly and without difficulty applied to every case in a manner which yields a clear-cut decision. It does mean that the task of ethical assessment is simpler. There is little or no involvement of considerations about future consequences. There is a somewhat comforting aura of finitude that surrounds the decision-making process in medicine. There are limits to what is expected of us. Above given limits of wisdom and farsightedness we should not and need not aspire. One frequently encounters among those of this persuasion the admonition that one ought not to "play God", or try to relegislate morality in the light of increasing technical power.

Descriptions of the Priestly model vary according to the sympathies of the writer. One philosopher-physician, Howard Brody, writes, "In the 'Priestly Model' . . . the physician plays a role that is frankly paternalistic. The patient (who, we might say, has somehow 'sinned' by getting sick) comes for treatment, counsel, and comfort. The decisionmaking is placed in the physician's hands, and the patient who does not follow the doctor's orders is adding an even greater 'sin' on top of his illness . . . (A) chief sign of this model is the 'Speaking -as-a' syndrome: 'Speaking as your doctor, I feel that it is definitely time for you to undergo surgical

sterilization.' The decision here is a moral, not a medical one; but the priest-doctor is presumed to have competence in both areas by virtue of his M.D. degree." (2) Clearly, this author doesn't have much patience with the priestly, paternalistic role into which doctors sometimes slip.

The physician may be relatively clear about the prescribed duties that are pertinent in a given case. The physician may have the clearest understanding of the empirical possibilities and contingencies. There may not be a conflict among the relevant moral rules that do apply. Here the physician is probably in the best position of those involved to make a valid judgement about the course of action that is required ethically. If there appear to be conflicting rules involved in a particular case, or if that case doesn't clearly fall under any moral prescription known to the physician, his or her limited expertise as a kind of amateur theological ethicist may be insufficient to provide clear guidance. In this situation, the physician, like the analog parish priest, would turn to the system of higher authorities which exist, in part, for the purpose of interpreting the moral law. But the search for higher authority is not likely to lead to the patient in this tradition.

There is another dimension to the patient-physician relationship which is illuminated under the Priestly model. It is not uncommon that a patient's diseases or disorders are partially due to behavior which is in the patient's control. Insofar as the religious ethic contains such admonitions as "The body is the temple of the soul" and thereby enjoins humans toward circumspection and moderation in consumption of food and drugs, in sexual activity, in rest and exercise, one whose disease stems directly or indirectly from a failure to behave in accordance with these injunctions may well be seen as having sinned. For a physician who has the point of view that so characterizes the patient's disease, the analogy between his role and that of the priest may recommend itself irresistibly. The patient, like the penitent sinner, suffers the pains of his wrongdoing and comes for a treatment which aims at rectifying his or her wrong as far as possible. The physician, like the priest, encounters the patient in a position of considerable potential to exert an influence that may alter the wrongdoer's ways. Even medical problems may traceable causally to the behavior of the patient are frequently viewed by patients as chastising visitations inflicted in retribution for wrongdoing. The analogy between physician and priest ultimately breaks down. But when viewed under the scope of traditional religious ethics, it illuminates why some feel most comfortable in the role of either patient or physician as characterized by the Priestly model.

The accompanying traditional view of the relationship of nurse to physician has been variously characterized as that of a handmaiden, (3)

or a tool,(4) in the hands of the physician. The emphasis, of course, is on the nurse serving without questioning medical decisions. Various reminders of this subordinate status have existed in such practices as nurses rising when physicians (and even medical students) enter the room.(5) The common sociological explanation is that most nurses are female and most doctors are male. But this sociological fact receives additional explanation under the Priestly model. Being female, nurses are poor candidates for a paternalistic role in which religious authorities have been called "father" in recognition of their status as representatives of the divine masculine Personage. Finally, the meaning of the term "nurse" (one who nurtures, as a mother), characterizes the relationship between nurse and patient beyond that involved in the notion of physician's handmaiden or tool.

A second model of the patient/physician relation described in recent literature is the Contractual model.(6) This seeks to replace the paternalistic approach with recognition that inner-directed, highly independent individuals respond better to therapeutic regimens which they help to choose.(7) The "contract" is usually an implicit understanding between the patient and the physician concerning their mutual obligations and benefits which calls for a sharing of the decision making. Where there are significant, life-altering decisions to be made, the physician recognizes and respects the legitimacy of the patient's informed decision making in regards to value-laden matters. Once the general goals are agreed to, the patient accedes to the physician's superiority in making the technical decisions needed to implement them. Thus, the patient does not need to be kept informed on all the technical details, but expects to be consulted on decisions involving major courses of action, even when alternatives differ significantly on the probability of the desired outcome. For example, this view would recognize the legitimacy of a patient's preference for medical or radiation treatment over that of amputation, even when the latter had the greatest chance of saving life.

An important reservation that the physician makes on the Contractual model is the right not to enter into the contract if the patient's wishes would, if implemented by the physician, force the latter to violate his or her own moral values. Thus, a physician would not be obligated to respond positively to a patient's request for an abortion if that ran counter to her/his deeply held convictions. A physician would be obligated to bow to a patient's wishes to increase the dosage of morphine for otherwise intractable pain, even if doing so increased the risk of a somewhat shortened life span. (There is some dispute among proponents of the Contractual view on whether a physician retains the right to with-

hold a standard medical service, such as abortion, on personal moral grounds if he or she represents the patient's only realistic alternative.)

The Contractual model appears to hold considerable attraction for nursing and its aspirations. First, it provides a recognition, in the principles of individualism, of the importance of providing nurses the same rights and respect captured for patients and physicians in the model. Extrapolating the model to nursing, we see that the nurse enters into a tacit agreement with both physician and patients (or clients) in which the rights and obligations of each party are recognized and respected by the others. Nurses and physicians accept that patients have the right to determine the major objectives of medical intervention aiming at the general ends of the patient. Physicians and patients will accord to nurses primary authority in determining the details of nursing care. Second, just as physicians reserve the right not to provide even standard medical treatments to patients where providing those treatments would be morally repugnant, so the nurse would seem, on the Contractual model, to reserve the right to refuse to participate in actions that would violate strongly held personal values. Finally, insofar as the mutual agreement between all parties is to cover benefits as well as rights, nursing finds in the Contractual model and individualistic ethics a basis for negotiating improvements in compensation, working conditions and other areas of needed reform.

The final model considered here is more closely coordinated with the image of humans as essentially social beings. Specific obligations of a moral character arise out of a general duty to seek to maximize the welfare and happiness of the greatest number of individuals possible. As indicated earlier, the status of individual interests and desires is one of conditional legitimacy—the condition being that they not be pursued to the detriment of others. The Team model (which has been called the Collegial model by others(8)) suggests that the physician and patient, rather than seeing themselves in a relationship suggestive of bargaining and legalism, see themselves as colleagues. They are coinvestigators pursuing the common goal of identifying and eliminating the illness and restoring the health of the patient. This is a relationship characterized by mutual trust and harmony, with an equality, if not coincidence, of value considerations. It aims at the utilitarian's maximization of welfare. Individuals are better off in active, participating roles even as patients than when forced to suffer either the passivity of the Priestly model or the rather limited decision-making functions of the Contractual model. The possibilities of involving the patient as a colleague have recently been eloquently explored by Norman Cousins.(9) John Gunther(10) has also provided a moving account of how, in the special situation of parental

colleagueship, the parents of a young cancer patient participated actively and constructively in the planning of his treatment. And Renee Fox(11) has recounted the active participation and contribution of patients in kidney research programs.

The potential of the Team model to transform nurse/physician relations has not received the kind of attention in the public press as has its power for the physician/patient relationship. But it is evident that, among colleagues who accord to one another an equality of dignity and respect and who acknowledge shared responsibility and accountability for their actions, there is a greater likelihood of consensus as to mutual ends and means. This does not appeal necessarily to a consensus model of diagnostic or therapeutic decision making. Each involved party can be accorded the right and responsibility to have primary input and final say over that portion of the case where his or her expertise is most relevant. At the same time, the mutuality of respect and the sense of common purpose which members of the team accord to one another creates an atmosphere in which the checks and balances of constructive criticism and review can operate in a wholesome and non-threatening way.

It may be that the circumstances and stage of the case will dictate that some one member of the team fulfill the role of captain, the one charged with generating the major decisions for that stage of the case. That captaincy, however, is not automatically determined by rank or title or degree, but rather by the character and stage of the case. The physician is only one member of the team, whose ascendancy comes at the points of diagnosis and interpretation, perhaps again at the point of treatment implementation. One of the chief functions of the physician, however, is to issue an accurate set of conditionals: "If you want to maximize your chances of surviving this throat cancer, then present statistics indicate you will do so only by a combination of surgery and radiation therapy; if it is more important to you to lead a relatively normal next few months than to maximize your chances of surviving five years, then radiation therapy alone is indicated," and so on. But the physician who diagnoses may be neither the one who operates nor the one who delivers radiation therapy. And in terms of planning daily postoperative care, the importance of any physician may be vanishingly small in contract to that of the nurse, the physical therapist and the dietician. And the ultimate decision as between the conditionals offered by the physician may be made by the patient or by the patient's proxy, who thereby determines the points and times of the ascendancy of other members of the team to its captaincy. Rather than representing each of these individuals as entering into a contractual relationship that is characterized by potentially competing self-interests (as in the Contractual model), and rather than auto-

matically deferring to the physician's authority, the Team model characterizes the mutual relationship as centering around a set of common values and goals adopted by the members of the team in consenting to participate in the joint venture.

C. LIMITATIONS AND RELATIVE MERITS OF THE THREE MODELS

There are several reasons why the Priestly model is the least satisfactory of the three. First, it presupposes a religious orientation that is not universal, even among believers. The system of specially appointed protectors of morality is not common to a sufficient portion of religions and religious sects to make that mode of behavior on the part of the physician comfortable for most patients. This is especially true when one is increasingly unlikely to have the same physician throughout one's life and thus unlikely to develop a sense of that individual being thoroughly knowledgeable and wise about one's needs and individual quirks. Second, the model runs counter to so many other movements and trends (e.g., the patients' rights movement) as to be something of an anachronism. Third, it is widely and increasingly perceived as derogatory and demeaning of the nurse, and even as promoting an unhealthy image of the doctor whose "status is a function of the vacuum created by the nurse's low self-esteem".⁽¹²⁾ Certainly it is less than ideal as a model to be emulated by a profession working to improve its own image. Its major merit is to serve as a reminder that there are patients who need a paternalistic approach, even to the point of believing that the physician is in total and complete charge.

The Contractual model, of course, will not work as well with that type of patient if he or she is forced into the position of actively processing information and deciding between alternative courses of therapy. However, it is possible to avoid this consequence by noting that it is certainly legitimate in the individualistic approach (although not very laudatory) for one to assign to a proxy (family member, friend, physician, nurse or whoever is willing to take it) the decision making function. This is probably what goes on when a patient, confronted by a doctor who is carefully explaining the options, comes up with, "whatever you say, Doctor." That is a patient who is attempting to contract with the physician to play according to the Priestly model's rules.

A deeper flaw of the Contractual model stemming from its roots in individualism is that it virtually capitulates to a kind of relativism of morals, in which each individual is his own source of morality and any

one individual's ethic is as good as any other. The Contractual model does not impose any general goals for the negotiating parties. Each is free to lay down his or her limits as to what services to offer or withhold on moral grounds and the patient is free to elect the least promising alternative on the basis of whim or even of a desire to end life. This model provides no incentive or even justification for the kind of counseling that can bolster a flagging spirit and transmit the resolve to seek the longer, more painful therapy which has the better chance of success. In short, the Contractual model is essentially amoral and can work well, but to the detriment of the patient. Nor is the health care professional immune to this sort of effect. Provided that what the patient elects is not inherently offensive to the moral sensitivities of the physician or nurse, the latter have no basis in the model for refusing to cooperate or even for advising the patient that they believe his choice to be ill-advised. To object would presuppose some standard of value external to the patient's own choice-making and individualism denies that possibility.

While the Team model with the presupposition of a utilitarian ethic seems to have a remedy for many of these foregoing defects, it too is not without its problems. First and perhaps foremost, there are extraordinary interpersonal problems that can arise in seeking to implement the Team model among professionals who have been used to other approaches. Physicians seem notoriously inclined to regard the increased participation of the nurse as an usurpation of their responsibility and authority and the transfer of comprehensive functions as not a delegation but a surrender of them.(13) This potential for a sense of professional encroachment is increasingly familiar to nurses as they view the development and spread of Physician's Assistant programs. It would seem that a precondition for the successful application of the Team model would be the successful negotiation of the division of labors and responsibilities by the prospective members of each team.(14) A second source of resistance to the team approach can be the individual nurse who may be unprepared for the increased leadership, responsibility and participation in decision-making functions. A third source of conflict in implementing the Team model is the fact that economic differences among team members may be greater than seem justified to individuals who have come to regard one another as colleagues and as increasingly equal in interprofessional status.(15) Finally, a major source of resistance may be encountered in the patient who is accustomed to conducting all negotiations through the physician. It is clear that the education and realignment of all members of the team will be a major task. Insofar as present structuring of medicine and health care delivery does not

make for constancy of association among relatively small groups, that education and retraining may well be ongoing.

The possibilities of opting effectively for the Team model seem at present rather limited, restricted to relatively small groups that are thrown into close and continual professional proximity. Where those conditions can be met, and there is successful negotiation of the many issues involving shared responsibility and accountability, it can be an enormously pleasant and rewarding form of professional interaction. The Contractual model perhaps offers the best general compromise. It provides for the Priestly model, where tradition and personality type make that the most effective mode, without endorsing the general applicability of that kind of physician-centered structure. The Priestly model will continue (although perhaps with decreasing frequency) to be encountered by the nurse. The tensions between the three models are lived out by all nurses. It is hoped that this discussion will enable the nurse to recognize her situation(s) and better change them for her patient's and her own well-being.

ENDNOTES

1. Charles Montagne, "Informed Consent and the Dying Patient," *Yale Law Review* 83 (July 74), 1646.
2. Howard Brody, *Ethical Decisions in Medicine*; Boston: Little, Brown, 1976, p. 31.
3. Cf. Larry Churchill, "Ethical Issues of a Profession in Transition," *AJN* 77 (May 77), 873.
4. James Gustafson, "Mongolism, Parental Desires and the Right to Life," *Perspectives in Biology and Medicine* 16 (Sum 73), 548.
5. Churchill, *op. cit.*
6. Robert Veach, "Models for Ethical Medicine in a Revolutionary Age," *HCR* 2, No. 3 (June 72), 5-7.
7. Rue L. Cromwell, Earl C. Butterheid, Frances M. Brayheld & John J. Curry, *Acute Myocardial Infarction: Reaction and Recovery*; St. Louis: Mosby, 1977.
8. Veatch, *op. cit.* Brody, *op. cit.*
9. Norman Cousins, "Anatomy of an Illness," *NEJM* (23 Dec 76), 1458-1463. *Id.*, *Anatomy of an Illness as Perceived by the Patient*; NY: Norton, 1979. *Id.*, *The Healing Heart: Antidote to Pain and Helplessness*; NY: Norton, 1983.]
10. John Gunther, *Death Be Not Proud*; NY: Harper & Brothers, 1949.
11. Renee C. Fox, *Experiment Perilous*; Glencoe: Free Press, 1959.
12. Churchill, *op. cit.*