Originally, bioethics occupied a small niche in which a small group of scholars/clinicians discussed ethical issues. It has changed its focus throughout the years and has moved toward topics that are inherently more political.

Originally, bioethics occupied a small niche in the corner of medicine in which a small group of scholars and clinicians discussed ethical issues. However, in recent years, bioethical issues have become part of public policy debates, local elections, and national elections. Although some people say that ethics has become over-politicized and is a relatively arcane field, others can see that the field of bioethics has become central to political discourse in recent years. **The 1960s and 1970s:** In its earlier incarnation in the 1960s and 1970s, bioethics focused on the doctor-patient relationship, which was inherently a private relationship. Although this relationship is not embedded in the public policy debates we see today, there was a set of implicit political assumptions about the doctor-patient relationship that were not drawn out to any great extent. For example, the discussion around autonomy, patient autonomy in particular, was linked to discussions about personal liberties (a classic topic for political philosophy) and to a growing mid-century movement of consumerism. **The 1980s:** In the 1980s, the doctor-patient relationship began to focus on certain situations, such as use of reproductive technologies, surrogacy, artificial insemination, and in vitro fertilization (IVF). In the 1980s, the role of the government as it related to these topics became much more obvious. Should the government enforce the contracts that people were writing for their exchange of gametes in a surrogacy context? Should the government regulate either the safety or the morality of IVF? In the 1980s, because of changes in the administration in Washington, DC, abortion began to be discussed, which previously had been only a doctor-patient discussion. The abortion discussion began to move into the U.S. Supreme Court and out into areas such as research ethics. It had a profound influence on the regulatory response to infertility treatments and IVF. **Recent Changes in Bioethics:** As time passed, bioethicists began working on topics that were inherently more openly political. They consistently began to ask about when and how the government should be involved. Since then, we have only added to that collection of topics. We now discuss the role of the government in deciding whether life-sustaining technologies can be withheld or withdrawn, and if so, with what levels of proof and documentation. We discuss the role of government in making decisions about which therapy should be available (or not available) to people based on a moral judgment about the effect on society. Therefore, we now need to be thinking about both what is right and wrong for an individual patient (or for the doctor-patient relationship) and what is right and wrong for the government to do by law. (Reviewer-).
Much of what physicians do is influenced by government laws and regulations, though clinicians may not notice this fact. Therefore, many “medical debates” cannot take place free of political influences.

Some clinicians say that issues of life and death and the withholding or withdrawing life support are primarily issues for the doctor-patient relationship and not political issues. However, I find it difficult to talk about these topics outside of a political context because much of what physicians do is embedded in law and government, though clinicians may not notice this fact. The government is involved in setting standards for the education of physicians, for their licensure, for the quality of products that they use, for the level of information that their patients are entitled to receive, for management of patient records, and for the oversight of research using living patients, their records, or their stored tissue. Clearly, the role of clinicians is influenced by government regulations and laws. Are Bioethicists Objective? One of the impressions/expectations that people have is that bioethicists carry out their role in an objective, dispassionate, and morally neutral manner. Can bioethicists be objective and morally neutral? This discussion may remind you of the many hearings for Supreme Court appointments that tend to revolve around the question of whether a nominee can be dispassionate and free of external influences. I find myself persuaded that it is not possible to divorce one’s self completely from either external influences or one’s own instinctive political philosophy.

For example, in the context of decisions around whether to withhold or withdraw an intrusive medical treatment, one common approach among bioethicists is to say that the patient is the person most primarily affected by this decision, and one of the most important things a patient can have may be the only thing left to a patient, which is the dignity that comes with being in control of his or her future. Because of this, a patient should to be entitled to refuse treatment or to have it withdrawn. However, others find that arguments of autonomy and personal liberty are far less compelling than their vision of a world in which social justice is primary. Therefore, if patients can order something withheld or withdrawn, then we will have power imbalances, which could lead to certain classes of people (the elderly, the disabled, etc) feeling pressured to agree to withholding or withdrawing expensive, difficult care. As a result, this group of bioethicists would conclude there should be some limits on autonomy. This is not a debate that can take place outside and free of a political philosophy about how society is best organized. (Reviewer-).
Conversations between a physician and patient cannot take place at the bedside without knowing that these discussions are reflected at many other levels: from municipal and state levels on up to judicial levels.

In medicine, conversations about public policy take place at the bedside and at every level above that. For example, imagine a bedside conversation with a patient who wants to advance the process of dying, whether with assisted dying or with the withholding or withdrawing of treatment. To the doctor and patient, this decision may appear to be very private. **Hospital Policies:** The decision to live or die steps outside of the private realm when the hospital, where this decision is taking place, has a policy on assisted dying. In addition, that hospital’s policy may be tied to the nature of the hospital’s mission. This could be a secular hospital, or it could be affiliated with a particular religious tradition that has rules and philosophies about what can and cannot be done. **Municipal Policies:** Whether something is considered a crime is inherently a legal and political decision. Therefore, actions being discussed by a physician and patient may be considered a crime at the level of the municipality in the state where the hospital is located. As a result, we have very active state debates about whether certain actions/decisions can be prohibited completely or whether they should be heavily regulated by law. **Judicial Policies:** At the judicial level, both state and federal constitutions, as well as state and federal statutes, may have some effect on our understanding of the range of rights of a patient or the range of duties of a physician.

**Conclusions:** Therefore, these conversations cannot take place at the bedside without knowing that they are going to be reflected at many other levels. Each successive level tends to answer to different priorities. The physician’s priority may be to best serve the patient and his or her own conscience, while priorities for a state or municipal prosecutor may be about sending a clear signal to the public regarding what is and is not permitted. Remember, one of the rules of criminal law is to deter future crime. For the judicial system, one of the priorities is to answer to our understanding about the meaning of the Constitution of the United States. Is it a living transformative document that reacts to changing times and understanding, or is it something that we need to keep rather static and tied to the most obvious plain meaning of its words? These kinds of considerations -- constitutional for the courts and public order for prosecutors -- will influence how they evaluate what to do in a given situation. Physicians must be aware that the same situation may feel like it has only one priority -- the patient -- yet all priorities will influence how a situation must be handled. (Reviewer-).
When engaged in any kind of moral or political argumentation, physicians must remember which type of judgment they are offering. Is it a professional opinion or is it the opinion of a private citizen?

(1 of 2) Although some physicians like to believe that their decisions are apolitical, they work in a broader social, political, and cultural context than just in the clinic or hospital. Does it make sense to aspire to remain politically neutral at the bedside when discussing issues that have broader consequences and overtones? One of the hardest things for all physicians to do is to learn how to participate in this world as both a professional and as a citizen without getting the 2 identities confused. **Professional Role:** As a physician who is using your professional medical judgment, it is appropriate at the bedside to focus on those things for which you have technical expertise. For example, you understand the nature of infections and infection control, and you look at a patient and try to understand how best to manage that infection. There will still be some irreducible level of political philosophy present in this discussion because the whole question of who is in control -- you or your patient -- is part of a political philosophy, but it is subtle. **Political Role:** When the state legislature engages in a debate about whether some aspect of medicine should be regulated, you wear 2 hats -- the professional physician and the private citizen. In these debates, you should be participating to offer your professional judgment about the effect it would have on medical practice, and as a citizen, you should offer your judgment about whether this matches your notion of where the state should or should not involve itself. **Professional vs Personal Judgments:** The trick is to not use the white coat of authority when it comes to talking about political values. It is one thing to don the white coat to say, for example, that a particular technique for human reproduction is dangerous and it poses a dramatically increased risk of birth defects -- this is a technical judgment. But to don the white coat and say, for example, that this technique is unnatural and wrong and that it should be prohibited is not using your professional judgment -- it is using your personal judgment. When you are engaged in any kind of moral or political argumentation, remember to step back and say, “I am telling you this as a citizen, I am not telling you this as a doctor.” (Reviewer-).
An extremely fuzzy boundary distinguishes between those debated topics for which a physician’s medical expertise is relevant and those for which a physician’s political activism is relevant.

(Card 2 of 2) Many people go into medicine and bioethics with a strong sense of right and wrong. They may have strong opinions about what is appropriate or inappropriate in given medical situations. If physicians become involved in cases for which they have a strong sense that something is not going right or that there is an injustice, then is it appropriate for them to act as political activists as opposed to medical experts? Political Activist vs Medical Expert: In my opinion, there is an extremely fuzzy boundary that distinguishes between those topics for which your professional expertise is relevant and those for which it is not. For example, imagine a debate on assistance in dying. As a physician who wants to make a statement about this, it seems entirely natural that you might testify to your experience watching people die, testify to your best observations as to whether they would have preferred one option over another, testify to the capacity of the pharmaceutical industry to provide the kinds of drugs needed to make this easy and painless, and testify to the psychiatric community’s capacity to distinguish between authentic and inauthentic desire. These are all topics for which medical judgment is both pertinent and essential. However, if you want to organize around the notion that assisting people in dying is somehow against God’s law (not a professional judgment), then you are voicing your religious or spiritual convictions and you need to identify yourself as such. Debates on the Medical Profession: I think one of the trickier in-between grounds is when the debate begins to address the nature of the medical profession. For example, one of the arguments in that debate about assistance in dying has been that it is not the role of physicians to help people die; it is the role of physicians to help keep people alive or keep them comfortable while alive. Some believe that assistance in dying, if it is to be a practice in this society, should be a practice of some other profession. That, to me, seems like a legitimate discussion for professionals about how to define their profession. It is not about whether the practice should be legal or illegal, but it is about the nature of the medical profession as opposed to some other profession being responsible for assistance in dying. (Reviewer-).
How can physicians distinguish when they are involved in a rational argument for a particular medical position or strategy as a medical expert versus when they are involved in a political kind of discourse as a political activist? How different is it to be functioning as a political strategist as opposed to making a rational dispassionate clinical argument? The answer is that these 2 areas are very different. To illustrate the differences, let us look at the debate over stem cell research. **Stem Cell Research:** The area of stem cell research has been hotly debated for a decade because it involved, for many years, use of stem cells that came from early embryos. We are now working on many other options in stem cell therapies. Nonetheless, embryonic stem cell therapy was clearly controversial because of its origins with human embryos, whether the concern was about destruction of the human embryo or about building on the field of in vitro fertilization. Many physicians and scientists entered the debate, which was a political debate about whether there should be criminal penalties for performing stem cell research and, if the practice was not going to be criminalized, should it be funded by the government or by private sources? There were many different versions of political argument at that time. As a result, it was very hard for people who were deep into that debate to remember that one of the primary obligations of professional is to be true to his or her discipline. This means that, as a clinician, you must be true to your best evidence-based judgment about how many people might actually be able to benefit from a particular kind of therapy. Is it a small number or a large number? As a scientist, it can be very hard to remain true to your discipline in which you acknowledge the uncertainty about whether something will work, how long it will take to work, or how likely it is that some other kind of technique will turn out to be easier or better for the same purpose. In the stem cell debate, we saw distortion on all of these topics. We saw distortion on the sheer number of patients who might benefit from embryonic stem cell therapy. We saw distortion about prospects for alternatives, such as altered adult stem cells or induced pluripotent stem cells to substitute for embryonic stem cells. In the end, this was not a debate of which we should be proud. Remember, if you are uncomfortable with where the truth lies, then the answer is to simply decide that you are not going to engage in that debate rather than to distort the truth. (Reviewer-).
Life Science Debates Grow in Complexity as Technology Advances

The Growing Political Debates Over Scientific Issues.

R. Alta Charo, JD

R. Alta Charo, JD - Special Presentation

Many political debates regarding issues in the life sciences have sharpened because we are more buffeted by the wave of options coming at us -- options for which we were not necessarily prepared.

Medicine and science are inseparable from the larger social and political context in which we exist. The question is often asked if over-politicalization of scientific issues has become worse over time or if it is just more visible? Because I am not a historian, I cannot speak with authority on whether it has gotten worse over time on the scale of hundreds of years. Like many other people, I have casually stated that I believe the partisan nature of politics has worsened dramatically. Nonetheless, I have been reminded by my friends who are historians about how incredibly partisan, vicious, and defamatory politics was in the 19th century, meaning that politics is hardly worse now than it was then. Therefore, speaking only to the decades that I can remember, I would say that we, in the life sciences, have developed more capacity to take control of things that used to be out of our control, and with that comes a recurring debate about whether we should exercise that control. Are we mature enough to exercise that control? If some of us are mature enough, but not others, then who decides who is mature enough? Is it the government's role to tell us what we ought to decide, or is it each of us who decides on our own? In previous centuries, we did not have the capacity to make as many decisions. For example, we did not have to make a decision about the direction of human development before about 1979 because we did not have the ability to maintain an embryo outside the body before that time. We never before had to ask questions like whether an embryo had some entitlement to call on those of us who are living, conscious, and capable to do things to nurture it? Could an embryo be sold? Could it be donated? Could it be used for research? If so, who decides these things -- the people who made the embryo, the people who donated the gametes, the government, the doctor, or the laboratory? We would not have asked these questions before because we did not have the capacity to make decisions at that time. This has been true for a number of scientific issues. We now have a capacity to extend life way beyond the stages we could have 50 to 60 years ago, which brings fresh questions about when to extend life versus when to simply surrender to the inevitable. I think this has sharpened the debate, not because we are meaner but because we are more buffeted by the kind of wave of options coming at us -- options for which we were not necessarily prepared. (Reviewer-).

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Keywords: Bioethics, Political vs Scientific Issues

Print Tag: Refer to original journal article
Roles of Bioethics Commissions Vary Widely

Various Roles and Mandates of Bioethics Commissions.

R. Alta Charo, JD

R. Alta Charo, JD - Special Presentation

Some bioethics commissions are formed as think tanks to explore various perspectives on general biomedical topics, while other commissions are formed to help determine public policy on specific issues.

Various bioethics commissions have been in place since the 1980s, and those involved with early commissions were mostly scholars. However, these commissions are playing a much more public role now. Because many different kinds of bioethics commissions have been formed throughout the years, it is difficult to generalize about their roles. **Specific Mandates:** Some commissions have been formed with very specific mandates. For example, in 1994, the National Institutes of Health (NIH) formed the Human Embryo Research Panel to answer a single question with a goal of influencing federal policy: what are the ethically defensible options for NIH funding in the area of embryo research? This question was presented to the NIH after a 12-year moratorium on federal funding. Therefore, after a decade in which they did not have to think about these issues, the NIH needed some fresh eyes with which to assess the question. **General Mandates:** Other commissions have been formed with a much less specific mandate. President Clinton formed the National Bioethics Advisory Commission (NBAC) with a mission to work on topics relevant to the federal agency. The NBAC’s charter gave commission members some suggestions, but there were no demands. In many ways, the NBAC served these purposes: to anticipate the areas into which life sciences and medicine would be expanding and for which federal agencies might have to make decisions but for which no sustained examination of merits, implications, or options for federal action had been performed. For example, the NBAC discussed the topic of research with biological materials because the amount of stored human tissue had increased greatly, along with possible uses for it in genetics research. This was relevant to a number of federal agencies that funded, supervised, or benefited from research. The mandate for the President’s Council on Bioethics under President Bush was to become a national seminar in which to explore points of view and then publish documents that would lay out those arguments without any necessary goal of influencing federal policy. **National Positions:** From 1978 to 1983, the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research actively published very pointed policy-oriented documents that tried to give a single answer to various questions such as how we define death. This particular question was important in everything from who has to continue paying for the hospital stay and the equipment, to whether hospital workers could absent themselves from this patient’s care, to whether organs could be removed to transplant. Thus, this commission was attempting to come up with a single national position on something that had been the subject of chaos at the state level. (Reviewer-).

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Keywords: Bioethics, Politics, Bioethics Commissions

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Although bioethics commissions vary considerably, members may consist of people from various academic disciplines as well as representatives of public and patient groups.

(Card 1 of 3) President Clinton’s National Bioethics Advisory Commission (NBAC) was formed to answer certain questions. I served on this commission, which had approximately 18 members from across various academic disciplines as well as representatives of public and patient groups. This commission certainly was a place to throw hot potatoes, which was especially true when Dolly (the first cloned sheep) appeared. The commission was also given the privilege of picking its own topics. **Public Meetings:** Very early after formation of the commission, we began a series of public meetings in which we explored where medicine was going and where new dilemmas were likely to present themselves. During the course of those meetings, some of which took place at the National Institutes of Health (NIH), we concluded that research with human biological materials was going to become an increasingly important part of the research scene in the United States. Yet, a number of people who testified before us or sent in comments stated that the oversight for research with human biological materials was incredibly confusing: it varied from state to state, and there was a genuine lack of understanding as to what rules actually applied, let alone what rules ought to apply. If I work with human tissues, should I think of myself as somehow not working on human beings? What if the tissue has a name and an address attached, and when I work on the tissue I am learning that Joe Smith has Alzheimer’s disease or prostate cancer. I have learned something about Joe Smith even though I am not working on Joe himself. Should Joe have some protection from my intrusion? These kinds of questions were coming up more frequently as the tissue banks grew, and the range of experiments or research studies that people wanted to propose was also growing. **Information Gathering:** By following this kind of spiraling conversation about what was important and what was confused, we settled on the topic and then systematically began to invite experts to testify before us, write contract papers, and to have staff research the factual elements of this topic. How many tissue banks were there? What kinds of tissues were being stored? Where were they coming from? What do people know about the tissues that were being taken from them? If the tissues are surgical waste, do patients know that these are being taken, and does the surgical waste have any link back to them? How much information about the individual is being stored? Who has access to the information? What kinds of research are being done? What is being published? (Reviewer-).
At the end of all fact-finding and discussion, a bioethics commission may write a set of final recommendations on a given topic. However, the group receiving these recommendations are not required to adopt them.

(Card 2 of 3) Public Input for Principles to Be Applied: After gathering facts on a specific topic, President Clinton’s National Bioethics Advisory Commission (NBAC) stepped back and had a series of public discussions during everyday proceedings about very basic things in terms of principles that needed to be applied. To what degree of personal privacy are U.S. citizens entitled? If it is a matter of debate, what is the range? What are the current regulations that protect personal privacy? What are the regulations about confidentiality where information has been revealed but the universe of people who have access to it is limited? What are the possibilities for breach, and how does breach hurt somebody? Is it dignitary harm only, or does it actually threaten their well-being in terms of employment or insurability for life or health insurance? Formulating Options: With these questions answered, we could then begin to formulate options. We could have a very robust system of oversight for research on these tissues, which would have made it much harder to use them without getting individualized permission from all the people from whom the tissues were taken, and the cost to the research enterprise would be substantial. That was one set of options and we would explore that, and we would try to set out what the world would look like if we made that balance. Then we would ask what the world would look like if we allowed much more access to these tissues. There was a much higher risk that people would feel insulted and betrayed if not actually harmed in their employability, but this would allow more research to go on for breast cancer, prostate cancer, schizophrenia, or any number of disorders with genetic components. Final Recommendations: At the end of all of that, we then wrote up a set of recommendations, and we explicitly decided that the recommendation would be based on the assumption that we were not going to have a wholesale reform of our current system of oversight of human subjects. This was done because we wanted to be useful to federal agencies. We chose a very pragmatic approach and we explicitly said, “Within existing rules, how can these rules be interpreted, applied, and understood so that we can achieve a reasonable balance between the patient’s interests and the vital interests in the research enterprise?” Recommendations made by our commission were sent to the Department of Health and Human Services, which accepted some and rejected others and eventually came up with its own policy, which is the one we have today. (Reviewer-).
Bioethics commissions may give recommendations for appropriate actions or policies. However, the federal agency receiving these recommendations must decide what is best based on the goals of the government.

(Card 3 of 3) **Recommendations:** In the final phase of a bioethics commission’s work, members will write recommendations for a given topic. In the case of President Clinton’s National Bioethics Advisory Commission (NBAC), final recommendations regarding use of human tissue in research were submitted to the Department of Health and Human Services (HHS), which rejected some of these recommendations. The question is sometimes asked about what happens to the published work when recommendations are rejected? The answer is that the work is still available. It is published, so people can read it. Because of the terms of the NBAC’s charter, when some of the recommendations were rejected by Donna Shalala, then Secretary of HHS, she was required to write a statement explaining her reasons for the rejection. In this case, she found some of the recommendations too protective of patients and, as such, would interfere too much with research. In her written statement, she said that the reasons for rejecting the recommendation was that she did not balance the interest of patients and the interest of the research enterprise the same way that our commission did. It was not that she disputed that these were the issues; instead it was that the judgment of the federal government embodied in that department believed that a different balance should be effectuated. Our role had been to clarify what was at issue and then to give our best advice, as 18 individuals, as to what the appropriate balance would be. Her job at the federal agency was also to decide what the right balance would be based on the goals of the government of which she was a part. (Reviewer-).
Physicians Report Real Effects of Political Decisions

The Physician’s Witness Helps Keep Political Decisions Grounded in Reality.

R. Alta Charo, JD

R. Alta Charo, JD - Special Presentation

A physician’s participation in political debates can perhaps best be manifested by his or her testifying to the effects of those group decisions on the many individuals that are served in the clinic or hospital.

Because clinicians are on the “working front” where the effects of many political decisions are felt, physicians should know that they have an important role to serve as witnesses to the various effects of those decisions. For example, the big debate in 2009-2010 is that of the reform of health insurance and access to health care. This is a debate in which the voice of the physician is crucial. I believe that every physician knows that the choices made in practice are influenced to some degree by the availability of financing to support those choices. This is true, even though physicians are certainly not disinterested parties in this debate because their own livelihood and their own sense of self are on the line. Physicians’ Role: Physicians must recognize that much of the reason they went into medicine was because they were interested in helping people one-by-one. They were drawn to a truly service-oriented profession that was highly personal. Nonetheless, physicians exist in a world that is about more than just one-on-one decisions. Instead, the world is about group-by-group decisions, and a physician’s participation can perhaps best be manifested by testifying to the effects of those group decisions about what the government will or will not do or about what the government will or will not fund. The physician can serve as a witness to the effects of those group decisions on the many individuals that they serve. Physicians can help keep everyone grounded in the reality of the effect of political decisions. (Reviewer-).

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Keywords: Bioethics, Politics

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Because of the highly diverse world in which we live and function, we must understand that “science” or “scientific facts” do not drive science and technology policies in and of themselves.

Although many people believe that science policy should be based only on “science” or “scientific facts,” the formation of science policy is also affected by ethical and political considerations. Reaching a consensus during the development of policies within institutions, professional societies, or legislative assemblies is challenging, at best. **Hospital Policies:** The process of developing hospital policies is often challenged by conflicts or power struggles between administrators, doctors, nurses, and allied health professionals; moral disagreements; and patient versus hospital interests. Policymakers must be responsive to complaints about marginalization, authoritarianism, and underrepresentation. In some situations, patient representatives, family representatives, and/or local community leaders may need to be included in the policymaking process. The more diverse the membership on a policymaking commission, the more difficult it may be to arrive at a consensus. A variety of religious and cultural traditions as well as competing political philosophies may promote conflict over basic moral premises and make finding the “common ground” very difficult. **Scientific Fact vs Moral Issues:** Although many believe that scientific issues remain politically and morally neutral as public policy is being developed, scientific facts will not end policy disputes and ethical conflicts between political parties, various citizen and religious groups, and scientific communities. At some point in the process, some may accuse the committee of corrupting the science with politics. The politicization of policymaking can be seen in the neglect of scientific evidence, the ignoring of research findings, and the removal of qualified individuals from the advisory board. Because of diverse interests and worldviews in the United States, science policy cannot be developed in an apolitical setting. Even reaching a resolution to highly contested topics is a political process. The bottom line is that in our pluralistic society, science, nature, and the laws of physics cannot in and of themselves dictate social policies. Value judgments cannot be squeezed out of science policies. We should expect that social policymaking, as it relates to bioethics issues, will include both substantive convictions that are not reducible to scientific evidence along with scientific facts. For any given policy under development, the process will involve only a small subset of available, qualified participants who are selected by an inherently political process of its own. In addition, committee members may disagree about what can be called reliable, accurate, and credible knowledge.

**Conclusions:** Because of the highly diverse world in which we live and function, we must understand that “science” or “scientific facts” do not drive science and technology policies in and of themselves.

**Reviewer’s Comments:** Science never has, and never will be, completely divorced from politics. Politics (among other factors) inevitably impacts which scientific questions are asked, what funding is available, and which findings get published. Understanding the relationship between science and politics can help physicians, as consumers of science, to be more critical, and thus more discerning, readers of the scientific literature. (Reviewer-Michael Green, MD, MS).

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Keywords: Bioethics, Political vs Scientific Policies

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Most political policies are based on the best interest of entire groups, not individuals. However, some rulings have been made regarding the health care of individuals in persistent vegetative states.

**Background:** Most political policies are based on the best interest of entire groups, not individuals. However, for patients in a persistent vegetative state (PVS), rulings have sometimes been made based on the specific health care of individuals. **Karen Quinlan:** In 1976, Karen Quinlan was in a PVS. When her parents asked that the ventilator be removed, physicians refused because they feared the legal liability, although they had no problem with the ethics of such actions. The New Jersey Supreme Court granted the physicians legal immunity in this case. As a result of this case, states passed “living will” legislation to provide legal immunity to physicians who honored patients’ health care wishes when they became incompetent. **Nancy Cruzan:** In 1990, the U.S. Supreme Court made a constitutional law based on the case of Nancy Cruzan, a young woman in a PVS who required a feeding tube to stay alive. The Missouri Supreme Court had said that those who spoke for Nancy must produce “clear and convincing” evidence that she wanted the tube feeding discontinued. After this Supreme Court ruling, people were encouraged to legally designate someone to make health care decisions for them should they become incompetent. **Terri Schiavo:** After a cardiac arrest in 1990, Terri Schiavo lived in a PVS and required tube feeding to keep her alive. Her husband petitioned the court to discontinue tube feeding, on the grounds that Terri would not have wanted to continue to receive this intervention under such circumstances. The judge agreed, deciding in the husband’s favor, and an appeals court came to the same conclusion. However, the woman’s parents challenged the findings, claiming that Terri would want to continue treatment and based on their conviction that life should be preserved regardless of its quality. Based on the findings of 5 physicians who were directed by the court to examine Schiavo, an appeals court affirmed the original decision. The parents went to the state legislature in an effort to have the feeding tube reinserted. The legislature passed “Terri’s Law” giving Governor Jeb Bush the authority to have the tube reinserted, which he did. In 2004, the Florida Supreme Court ruled that Terri’s Law was unconstitutional. In January 2005, Governor Bush petitioned the U.S. Supreme Court to hear an appeal, but they refused. The feeding tube was removed on March 18, 2005. Two days later, the U.S. Congress met to consider emergency legislation for Schiavo. On March 21, 2005, the Senate and House passed a bill to allow the parents’ appeal to be heard by the U.S. District Court for the Middle District of Florida. In the end, the judge denied the parents’ request for the tube’s reinsertion.

**Reviewer’s Comments:** For >30 years, there has been a substantial consensus regarding the withholding and withdrawing of life-sustaining medical treatments. The Schiavo case, while tragic, offered nothing new to these established precedents; it did, however, show how political considerations are sometimes inserted into private bedside interactions between doctors, patients, and families. (Reviewer-Michael Green, MD, MS).

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Keywords: Bioethics, Politics

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Clearly Distinguish Political Advocacy From Scholarly Efforts

What Happens When Politics Discovers Bioethics?

Kahn JP:

Hastings Center Report 2006; 36 (May-June): 10

As bioethics is pulled into heated political debates, bioethicists need to help ensure that policy and politics remain 2 separate entities.

In this editorial on policy and politics, Jeffery Kahn states that the policy debates in which bioethicists traditionally have participated are now evolving into heated political debates. The input of bioethicists has changed now that so many of the debates have placed bioethics into the Culture Wars. As the field of bioethics matured, it developed a reputation for “clearheaded analysis,” and those who became bioethicists wanted to make a difference in the policy issues at hand. Kahn wonders if this reputation will be maintained as bioethicists find themselves participating in heated political debates. The academic practice of bioethics may not translate clearly into the field of politics. For example, the “shades of gray” reasoning taught to bioethicists may become corrupted into black and white opinions by the media, thus soiling the scholarly reputation of bioethicists. Kahn states that probably the biggest danger of entering political debates is that bioethicists may be labeled with certain political commitments and leanings rather than with scholarly credibility. Although Kahn does not believe that bioethicists should hide from political issues of the day, bioethicists need to clearly distinguish their academic work from their political activism to the best of their abilities. Bioethics as politics should be clearly distinguished from bioethics as scholarship: political advocacy should not be confused with scholarly efforts. If bioethicists are successful in keeping advocacy and scholarship separate, they should continue to be appointed to government commissions based on their scholarly expertise rather than on their political bias. In these positions, bioethicists can help ensure that policy and politics remain 2 separate entities.

Reviewer's Comments: Kahn advocates for bioethicists to separate their political from scholarly roles. To do so requires a level of self-awareness regarding the political aspects of one’s scholarly endeavors. Without such clarity, it is difficult, if not impossible, to make such a separation. (Reviewer-Michael Green, MD, MS).

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Keywords: Bioethics, Politics

Print Tag: Refer to original journal article
In doctor-patient interactions, conflict is not necessarily a problem because most people work it out. The problem is when a conflict reaches an impasse and one of the parties withdraws from the relationship.

Most clinicians have interactions with patients that do not go well. Sometimes patients frustrate us. Sometimes patients drive us crazy. And sometimes, we have conflicts with our patients. Often, these patients get labeled as being “difficult patients.” **Doctor-Patient Conflict:** Conflict in the doctor-patient relationship is quite common. A recent study looked at primary care physicians and their interactions with patients, and it demonstrated that about 40% of these interactions resulted in conflict. So, almost 1 of every 2 interactions is associated with some level of conflict. However, just because doctor-patient conflict is common does not mean that it is a problem. Most people who practice medicine have a reasonable set of skills to work through the conflict. These solvable types of conflict are not the interactions we think about when someone refers to a “difficult patient” or “difficult family.” **The Impasse:** A problem occurs when conflict develops into an impasse, which is when both parties (doctor and patient) have taken an intractable position on something about which they disagree. For example, it could be something as simple as a patient with the common cold believing they should get a prescription for antibiotics, while the physician believes strongly that antibiotics are not in the patient’s best interest. **The Escalation:** When 2 people get into an impasse, the conflict starts to escalate because people become more committed to their position and become less flexible about either hearing the other party or being able to modify their position. The problem is not the conflict per se, given that conflict is so common and most of it is worked out between people. The problem is when the conflict reaches an impasse and the doctor and/or the patient starts to withdraw from the relationship. When people start to withdraw from the relationship, they become more rigid. This results in less of a hope of moving the conflict forward toward a resolution. **Reference:** Weingarten MA, Guttman N, et al. An anatomy of conflicts in primary care encounters: A multi-method study. *Fam Pract* 2010: 27 (February): 93-100. (Reviewer-).
Some problems brought before an ethics committee are related to true ethical dilemmas, but more often than not, actual problems are about fundamental conflicts or bad communications between people.

(Card 1 of 2) As most ethics committee members can tell you, many issues are framed as ethical dilemmas when in reality they are more like a fundamental conflict or communication problem between medical staff, patients, and/or family members. Sometimes there truly is an ethical dilemma, but more often than not, it is a problem between people, and the conflict is not over ethics per se. Typically, the conflict is more about the fact that the individuals involved are not able to talk to each other in a way that allows them to move forward. It seems that people call the ethics committee when there are elements of an ethical dilemma attached to the conflict. For example, it may be a question of whether to withdraw life support from a patient, where one side thinks it is time, the other side disagrees, and the 2 sides reach an impasse. Then they call the ethics committee because they need help. I believe one of the valuable things that ethics committees contribute is the ability to listen to each party and determine just what kind of help is needed. Is there truly an ethical impasse here, where value systems are clashing and no acceptable solution is apparent? Are people just having a difficult time communicating their feelings, fears, and concerns? Are they having a difficult time listening to the other party, making it impossible for them to understand what is driving the other person’s behavior? A common role for an ethics committee is to help sort out answers to these questions and then come together to help people find a solution to their conflicts. (Reviewer-).
Some issues brought to an ethics committee may have only a small ethical component. In such cases, what is needed most is a safe forum in which 2 parties can safely exchange views and resolve a conflict.

(Card 2 of 2) Ethics committees commonly are asked to help solve problems that are not true ethical dilemmas. Instead, their intervention may help 2 parties sort through feelings and conflicts to come to an understanding of each other’s views and, hopefully, to resolve the problem. An example of a common case is as follows. **Case Scenario:** An elderly gentleman (aged 83 years) who had a history of hypertension and diabetes presented to the emergency department with a massive stroke and was in the ICU on a ventilator. The stroke was catastrophic. The patient’s wife was deceased, and there was no living will or declared health care power of attorney, so the patient’s exact wishes were not known at the time. He had 3 adult children. **Conflicts:** Because the likelihood of recovery was very, very low, 2 of the adult children believed that their father had lived a good life and that it was okay to withdraw life support and let him die. However, the third child, who had moved away from the family and came back to visit his father in the hospital, began to raise a brouhaha, saying, “We can’t give up on Dad. We need to do everything possible, and all the aggressive medical therapy that is available should be given to him.” This created a conflict within the family, and it also created a conflict among the medical staff. In addition, this generated a conflict between the staff and the family because staff members believed the outcome was most likely going to be poor and that aggressive medical care was akin to torturing this fellow and delaying the inevitable. **Involving the Ethics Committee:** Was this truly an ethical dilemma? There may have been a small ethical component, but what was most needed was a safe forum in which family members could exchange views and reach a decision. During discussions with the ethics committee, many feelings were revealed regarding the question of the father’s treatment. The children were first concerned about their responsibility to their father. They also shared their feelings about the lives they had had with their father. For example, the son who was being disruptive felt like he had let his father down in his life and felt like he really needed to step up and “fight” for his father at the end of his father’s life. This particular piece of information helped the family to look at this son as someone who was trying his best to help his father rather than as an out-of-control disruptive individual who was demanding inappropriate medical care. Here was a case where the ethics committee’s involvement helped solve a family conflict rather than addressing a true ethical dilemma. (Reviewer-).
Because the solution to most conflicts will come through relationships, ethics consultants must set the stage for respectful, collegial, and compassionate relationships in the face of very intense conflicts.

The actual process of an ethics consultation may be foreign to many people. When someone requests an ethics consult, the consultant first comes and evaluates the situation. The Relationship: When I am involved in an ethics conflict as a member of an ethics committee, an important part of my job is to build a relationship of some sort with every person involved (the patient, the family, the nurse, the physician, etc). This is an important part of my job because, even when there are clearly contrasting ethical views and opinions in a true ethical dilemma, we somehow must find the solution. That solution will come through relationships. One of the things that we can do as ethics consultants is to set the stage for respectful, collegial, and compassionate relationships in the face of very intense conflicts. The Facts: Drawing from the old axiom that good facts make good ethics, the second task for an ethics consultant is to get the story from everyone involved and to do his or her best to discover actual facts for the given situation. Getting Help: If an ethics consultant finds that he/she needs help, then colleagues may need to be contacted and brought up to speed. Do you have a group model of doing ethics consults? Do you do it by yourself or with 1 or 2 other people? Because these situations are intense and complicated, doing consults alone may be risky. Having the help of your colleagues may be beneficial, even if they are just available for bouncing ideas back and forth. Bringing People Together: If the conflict persists, then the next step is to bring people together in a format to move the conflict forward as opposed to setting up a situation that may actually exacerbate the conflict. Some of these conflicts are intense, and the stakes are very high. Conflicts often revolve around life and death decisions, and people have strong feelings about the topic. Therefore, creating an environment that is respectful and that allows people to speak their mind and feel heard and understood is a very important part of setting the stage for the medical staff, the patient, and the family to work out their differences and move toward a resolution. (Reviewer-).
(Card 1 of 3) During an intense ethical conflict, an ethics consultant must help create a respectful environment in which people may voice their perspectives and feel understood. The goal is to help people communicate with one another so that they may work out their differences and move toward a resolution. **The ARCH Principle:** When all involved parties are brought together to discuss a conflict, first ask everyone to introduce themselves and say why they are there and their role in the impasse. The second thing is to follow the ARCH principle, which is a mnemonic for “Acceptance,” “Respect,” “Curiosity,” and “Honesty.” Because the emotion of these conflicts can be very distracting, use this principle to guide your interactions as a consultant.

**Acceptance:** In the ARCH principle, acceptance means that you accept every person “where they are, as they are.” You are not trying to change them. Acceptance does not mean agreement. For example, you do not have to agree with either position of withdrawing life support or pursuing aggressive care. However, when you accept people “where they are, as they are,” you accept that they have good reasons for what they want to do, which allows you to listen to them. If someone becomes unreasonable, it can be difficult to calm yourself and listen. Nonetheless, you must try to stay connected to these people. **Respect:** The second part of the ARCH principle is respect. The way you speak to someone is very important as part of the process of building a relationship, even if they are unreasonable. Respect can move a relationship toward being more reasonable and consolatory. Respect is seen in simple things like referring to someone as Mr or Mrs, allowing people to finish their sentences, and the tone of your voice. **Curiosity:** The third part of the ARCH principle is curiosity. What do curious people do? They ask questions. When there is an intense ethical dilemma, people often behave in a way that is controlling because they want you to hear their position and to “side with them.” As a result, they speak and behave in a way that is controlling. When you are curious as opposed to controlling, you ask questions. For example, even if you think a person is unreasonable, you do not say, “You know, I do not like the tone of your voice right now. I do not think your opinion is valid.” Instead, you say things like, “I am having a hard time understanding this. Can you help me understand your position? Can you help me understand why your dad might want that done now?” (Reviewer-).
During a meeting to help resolve an ethical conflict, most people who display controlling behaviors are not actually trying to be controlling. Instead, they are trying to gain a sense of control. (Card 2 of 3) While working with people who have an ethical conflict, the consultant may use the ARCH principle as a guide for interacting with the involved parties to help them communicate clearly and move toward a resolution. The “C” in ARCH stands for curiosity -- asking questions of people in a way that helps them further clarify their feelings or beliefs. However, in some meetings, you may forget and behave in a controlling manner rather than in a curious manner. **Controlling vs Curious:** For example, presenting a unilateral position is controlling -- saying, “I will only do this. I will never do that. I will not change until you change.” Typically, these people are not actually trying to be controlling. Instead, they are trying to gain a sense of control, which is a very different thing. However, the expression of their behavior is experienced by others as being controlling. Sometimes, someone becomes highly emotional in a meeting and starts standing up and shouting. If he or she becomes scary and intimidating, maybe even threatening in some ways, then you know the situation is rapidly escalating. A controlling response by you as the consultant would be something like, “Mr Jones sit down. We do not talk like that in this hospital.” However, using the ARCH principle, a curious response by you would be, “Mr Jones, I can tell by the way you are speaking now how deeply you care about your father. Can we talk for a few minutes more about your worries for your father?” **Threatening Behavior:** Remember, there is a difference between escalating behavior and a true threat. Safety is paramount. If we do not feel safe, then we cannot function. If you are in a room with someone whose threatening behavior is escalating and who may potentially attack you, then you need to get to a safe place. In those extreme situations, do not worry about being curious or controlling. Instead, worry about the safety of everyone in the room. The thing to do is say, “I think for right now we need to put a hold on our meeting. We are going to go out of this room and talk in the hall for a while and try to collect our thoughts. Then we will reconvene in 30 minutes.” The key is to get out of the room. However, sometimes people are clearly becoming agitated or upset in a meeting, but they are not behaving in a threatening manner. If you are controlling, you might say, “Sit down or I’m going to call security.” In this case, you are issuing an ultimatum, which will make the person feel out of control and potentially provide a trigger for the escalation of that person’s behavior. (Reviewer-).
During an ethical conflict, the consultant must make honest statements geared toward keeping the conversation going between involved parties. As long as the conversation keeps going, there is hope of finding a resolution.

(Card 3 of 3) During ethical conflicts, an ethics consultant must help create a respectful environment in which people may come together to voice their perspectives and feel understood. **The ARCH Principle:** It is important for you, as the ethics consultant, to follow the ARCH principle when dealing with people in these emotionally intense situations. ARCH is a pneumonic for “Acceptance,” “Respect,” “Curiosity,” and “Honesty.” Acceptance means to accept people “where they are, as they are” -- choosing to believe that their motives are good. Respect is reflected in the way you speak to the involved parties, including your tone of voice and choice of words. Respect is very important for building a good working relationship. Curiosity is about asking questions to help the involved parties more clearly communicate their perspectives and clarify their beliefs. **Honesty:** The fourth part of the ARCH principle is honesty. Honesty is using yourself in an honest way in the interaction to move the process forward. The key here is using honesty to move the process forward. For example, a most unhelpful thing would be to say, “You know Mr Jones, I think you are behaving like a jerk right now.” While this may be an honest statement, it is not going to move the process forward. However, restating this by saying something like, “You know, Mr Jones, I can tell that you are frustrated by this. I too am frustrated and I am worried about whether we are going to be able to find a solution.” This is an honest statement, but it is said in a way that is geared toward keeping the conversation going. As long as you are keeping the conversation going, you have hope of finding a resolution. (Reviewer-).
Trusting Relationships Lead to Collaboration

The Importance of Relationships in Shaping Collaborative Problem-Solving Processes.

George F. Blackall, PsyD

George F. Blackall, PsyD - Special Presentation

If you go into a meeting trying to convince others that your point of view is the only correct position, then the other people in the room will likely respond by being more fixed in their opposing positions.

A good ethics consultant uses the ARCH principle (acceptance, respect, curiosity, and honesty) to set the environment for people being open to listening to each other and to other points of view. Once this is achieved, then the question becomes, "How do you talk to someone when you have very different points of view?" What if the situation is such that there is complete disagreement between what the doctor and the health care team members believe versus what the family members believe? You may have established a relationship through ARCH, but you still have to move toward a resolution. Is it a reasonable or appropriate goal for the health care team to try to convince the family to change their minds? **Collaboration, Not Coercion:** Without first developing a trusting relationship, problem solving is going to be very difficult. It takes time and energy to build these relationships in the face of conflicts. The relationship is the foundation of the problem-solving process because you are trying to develop trust and a style of working with people with whom you outright disagree. With trusting relationships, the problem-solving process becomes collaborative rather than conflicted or controlling. So then, what should the next goal be? If your goal is to get the others to see the world your way, then you will be trying to control them. It is okay for you to have your views, but as part of this process, you must be open to why the others have their views and what is driving their views. For example, if you go into a meeting with your goal being the immediate withdrawal of life support because you believe the patient is suffering, then it is going to be a difficult meeting because the other people in the room who disagree with you may believe that you are being coercive. This makes the others feel frightened and out of control. When this happens, people respond by being more fixed in their position -- they dig their heels in deeper. (Reviewer-).

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Keywords: Ethics Committees, Conflict Management

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During ethical dilemmas, patients and families are thrust into a role for which they do not feel a sense of competence, so they forget some of their preexisting competencies, such as the ability to work with people.

Unfortunately, in medicine, the doctor-patient relationship can become conflicted. However, with some work, this relationship can be turned back into a collaborative relationship. To help guide this process of change, we have the Five Universal Principles for Collaborative Doctor-Patient Relationships. One of the key principles is that of “Competence.” Competence can be seen as a person having a sense of (or actual) mastery over his or her life. For example, an eighth grader may have a sense of competence over the ability to throw a baseball or to add simple numbers. When people feel competent, they feel in control. During ethical dilemmas, patients and families are thrust into a role they did not choose and for which they do not feel a sense of competence. They do not feel competent as a patient, they do not understand medicine, and they are frightened. As a result, they can forget some of their preexisting competencies, like intelligence, humor, and the ability to work with people. When we start with highlighting people’s competencies, it gives us a better chance of helping them be open to our methods. For example, an 85-year-old man is in the ICU after having a catastrophic stroke. After being told of his very poor prognosis, 2 of his adult children want to consider withdrawing life support because the end is inevitable, the father may be suffering, and the father has had a good life. However, a third son believes aggressive life support measures should be provided to his father. He believes that he is the only advocate for his father’s life at this time, considering how his siblings completely disagree. As the impasse is discussed, the third son’s behavior begins to escalate. The question is, how do you highlight the competencies in someone whose behaviors are becoming difficult? One possibility may be to remind him of his competencies by saying, “Mr Jones, it is clear to me that you want to be a good son to your father right now. It is also clear to me that, in the course of your life, you have been very successful in solving difficult problems. This is a difficult problem. I wonder how we can use those skills that you already have in this current situation.” By reminding them of skills they have, you highlight people’s competencies in an effort to get them thinking about how to creatively apply those competencies to the current dilemma. Remember that a statement of competency is not a compliment. Compliments are transient. When you highlight someone’s competencies, you are speaking to their core about something that is important to them. (Reviewer-).
Doctor-patient conflicts can be resolved when we get creative, remain open to people, and stay connected. Resolution is possible whenever we continue to build relationships in the face of these intense conflicts.

Most physicians must deal with doctor-patient conflicts in their practices. Some also must deal with finding resolutions to ethical dilemmas. **General Tips:** Because these dilemmas can be very difficult, the stakes are often very high. One of the key things that can be very helpful is to start with the assumption that, generally speaking, people’s motives are good. Everyone really is trying to do the right thing. As physicians, our task is to find a way to keep the conversation going until there is a shift in the process. That shift might be that the patient’s medical state declares itself. That shift might be that people have genuine conversations about their fears and their feelings about what is happening -- these conversations can help people find creative approaches and solutions to their problems. When we get creative, remain open to people, and stay connected, then these issues can be resolved. I am often asked to describe the magic formula for resolving these issues and dilemmas. However, there is no magic formula. Nonetheless, when good people come together with a genuine interest and the skills to build relationships in the face of these intense conflicts, there is always a way out. To help us learn about developing these resolution skills, resources are readily available. **Resources:** The following book provides details about learning to deal with conflict and presents a number of cases to help illustrate important concepts: Blackall GF, Simms S, Green MJ. *Breaking The Cycle: How to Turn Conflict Into Collaboration When You And Your Patients Disagree.* 1st ed. Philadelphia, PA: American College of Physicians; 2009. In addition, the following Web site has links and other resources on it: www.doctorpatientcommunication.org. (Reviewer-).
Physicians with the most frequent number of encounters with difficult patients tend to be significantly younger and to be women. They also are 12 times more likely to report burnout than are those with low levels of difficult encounters.

**Background:** The problem of “difficult patient” encounters is common, with almost 1 in 6 patients being identified as “difficult” by their doctors. Attributes of patients that lead to this label include having mental disorders, presenting with >5 somatic symptoms, exhibiting high use of health services, having a list of complaints, and/or having threatening or abrasive personalities. However, common attributes of physicians who have encounters with difficult patients are less well known.

**Objective:** To compare selected characteristics of primary care physicians who have high numbers of encounters with difficult patients with attributes of those who do not.

**Design:** Nested analysis.

**Methods:** Using survey methodology, levels of stress, burnout, job satisfaction, time pressure, intent to leave the practice, and medical errors were compared among 422 general internists and family physicians located in 5 regions of the United States.

**Results:** The most frequently identified type of encounter that doctors identified as “difficult” was when patients insisting on being prescribed an unnecessary drug (36.7%). Frequent difficult encounters also resulted from patient dissatisfaction with care (16.1%) and unrealistic patient expectations of care (13.7%). Physicians classified as having the least problems with difficult encounters were almost unanimous in their reports of having no perceived difficulty with patients. Conversely, physicians classified as having the worst problems with difficult encounters were almost unanimous in their reports of working with many difficult patients. These physicians were significantly younger (aged 41 years), were more likely to be women, were 12.0 times more likely to report burnout, and were 3.8 times less likely to be highly satisfied with their jobs than were physicians with low levels of difficult encounters.

**Conclusions:** Because encounters with difficult patients may be common for some physicians, additional training for handling these situations is recommended. These difficult encounters are associated with job dissatisfaction and physician burnout.

**Reviewer's Comments:** While physicians often identify challenging patients as “difficult,” such labels are seldom constructive. By definition, challenging encounters involve a relationship between at least 2 people, only 1 of whom is the patient. Doctors can help prevent and manage difficult encounters by shifting their focus away from challenging behaviors and instead attending to the patient’s strengths, skills, and competencies. Doing so involves changing the physicians’ responses to these encounters rather than trying to change the patient. (Reviewer-Michael Green, MD, MS).
During the patient interview, physicians can improve patient satisfaction and compliance by expressing empathy for the patient's situation, by being courteous, friendly, and reassuring, and by encouraging questions.

Background: During the patient interview, physicians give a number of verbal and nonverbal cues to their patients that may be linked with patient satisfaction and health-related outcomes.

Objective: To determine which verbal and nonverbal cues are given by the physician to the patient that can be linked with favorable patient satisfaction and health-related outcomes.

Design: Literature review of 14 studies regarding office interactions that were published between 1975 and 2000.

Methods: These studies evaluated the physician’s vocal intonations, proximity/touch of the doctor to the patient, and the positioning of movements of the head, face, trunk, and extremities. In addition, physicians’ verbal behaviors for gathering information from the patient, developing relationships, and decision making were evaluated. The effect that these verbal and nonverbal behaviors had on patient outcomes (patient recall, satisfaction with the office visit, compliance, symptom resolution, health status, and mortality rate) were also evaluated.

Results/Conclusions: Verbal behaviors linked to improved patient satisfaction, compliance, and comprehension included expressing empathy for patients’ situations, courtesy, friendliness, reassurance, support, encouraging patients’ questions, giving good explanations, and offering positive reinforcement/good feelings toward patients’ actions, possessions, or self. Another beneficial verbal behavior was that of laughing or joking for tension release. The following behaviors enhanced information exchange: listening, health education, summarizing patient statements, talking on the patient’s level, addressing patient problems of daily living/social function, and psychosocial counseling. Shared decision making between the doctor and patient was associated with improved health outcomes. Helpful nonverbal behaviors for physicians included leaning forward and directly facing the patient during the interview. Leaning backward and frequent touching of patient during the interview were behaviors associated with decreased levels of patient satisfaction. Further studies are needed to address the effects of physicians’ facial expressions, voice intonations, touch, and gestures on patient satisfaction and outcomes.

Reviewer’s Comments: Since doctors are almost always alone with patients during their interactions, physicians are often unaware of their verbal and nonverbal communication skills and shortcomings. This study provides useful guidance regarding specific learnable skills that can improve important patient outcomes. The challenge is for doctors to know which skills are needed, something that requires one to obtain critical feedback about communication skills in a timely fashion. One solution is to periodically video or audiotape one’s interactions with patients and then to review them with a trusted colleague. Though potentially awkward, doing so can be an eye-opening experience that can lead to important quality improvement in communication with patients. (Reviewer-Michael Green, MD, MS).

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Keywords: Patient Relations, Verbal Cues, Nonverbal Cues

Print Tag: Refer to original journal article
Watch Your Words -- Conflict Common With Patients


Weingarten MA, Guttman N, et al:

Fam Pract 2010; 27 (February): 93-100

Approximately 40% of doctor-patient encounters result in conflict. In Israel, physicians found it most difficult to show empathy to patients during resource-related conflicts.

Background: Doctor-patient conflicts are common and can disrupt effective communication and care. In Israel, where this study takes place, conflicts often arise between doctors and patients around the issue of health care rationing.

Objective: To determine various causes and associated outcomes of doctor-patient conflicts so that educational interventions may be developed for physicians.

Design: Multi-method, multistage study of general practitioners in Israel.

Methods: Physician focus groups (56 physicians in 7 focus groups) were organized to gather data on physicians’ perspectives regarding doctor-patient conflicts. These data were used to build a model for analyzing responses to conflict. In addition, videotaped sessions of 251 doctor-patient interactions were used to gather data on actual doctor-patient communications. These sessions allowed development of 40 different categories of conflict.

Results: Of 291 videotaped doctor-patient interactions, 113 (40%) contained elements of conflict. The 3 main causes of these conflicts included (1) concerns about medical management of the presenting problem, (2) concerns regarding management of background health issues, and (3) concerns regarding bureaucratic issues, such as authorizations. Physicians tended to show less empathy toward the patient when the conflict was caused by disagreements about health care rationing and resources. Physicians tended to dominate conversations in all doctor-patient encounters, regardless of the nature of the conflict. Female doctors were less likely to be involved in a conflicted interaction with a male patient. Previous studies have established that the doctor-patient medical encounter involves 5 stages: opening and agenda setting, history taking, physical examination, counseling, and closing. Generally, history taking and counseling make up the largest segment of these encounters. However, in conflicted encounters, counseling was the largest part of the visit. In addition, during conflicted medical encounters, discussion around the conflict-related topic took a disproportionate amount of time.

Conclusions: Approximately 40% of doctor-patient encounters result in conflict. During conflicted medical encounters, a disproportionate amount of time is devoted to the conflict-related topic, thereby limiting therapeutic elements of the interaction. Physicians appear to find it most difficult to show empathy to patients during resource-related conflicts.

Reviewer's Comments: Conflicts between doctors and patients are both common and distracting. An effective way to address conflicts is to attend to the relationship. While potentially more time-consuming in the short term, it establishes trust and results in a more therapeutic (and less conflicted) interaction in the long term. (Reviewer-Michael Green, MD, MS).

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Keywords: Patient Relations, Conflicts, Causes, Outcomes

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