Contemporary physician-patient relations and compassion

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In medicine, there is always a tension in the decision-making process between the patient and the physician. The first step in the decision-making process is taken by the patient who decides to seek help, and he is free to do so. The moral freedom of choice is not unlimited. One is obliged to seek help if it can reasonably lead to recovery or reduction of the problem, assuming that reduction of the problem is necessary for life. After all, the patient must be considered primarily responsible for his health (principle of freedom and responsibility). He is free to choose to whom he wishes to turn for help and to choose between equivalent alternatives.

Once a patient has found a healthcare provider, e.g. a physician, to whom he wants to turn, there will be a disparity in the relationship between the two: one suffers from the problem and feels it, is existentially involved, while the other has the knowledge required to see if, and if so how, the problem can be addressed. In order to reach a reasonable agreement on the decision to be taken, information must first be exchanged: information about the symptoms experienced by the patient and what else is useful; on the part of the physician, information about differential diagnosis and treatment options. In this process of cooperation, both parties are under a moral obligation that will influence the choices made. The decisions ultimately taken will be made in the context of the *physician-patient relationship*. How this relationship should be shaped, or which elements in this relationship are considered morally good, has evolved throughout history. In Hippocratic medical ethics, the physician-patient relationship was based on the model of *beneficence* (Beauchamp 1990): the physician's main task was to alleviate the patient's illness and pain by doing *what was right* for him/her. Informing the patient about his options and allowing him to participate in decision-making was not important. The increasing appreciation of *autonomy* since the Renaissance also led to changes in the nature of the physician-patient relationship. Sgreccia gives an overview of how, at the beginning of the 19th century, informing friends and acquaintances of the patient became a possibility and how this development gradually led to the current situation in which the patient must not only be fully informed about the examination to be carried out, the results arising from it and the therapeutic options, but must also give his full consent. This last point is clearly expressed in the practical interpretation of *principlism* (Beauchamp and Childress 1979), in which the authors present four principles as the basis of bioethics, namely autonomy, beneficence, non-maleficence and justice. In practice, autonomy was given a very prominent place within these principles and thus gained great influence on the design of the physician-patient relationship.

How the physician-patient relationship can be shaped in practice has been described on the basis of empirical research in four models (Emanuel and Emanuel 1992):

1. The *paternalistic model*. In this model, the physician chooses which diagnostics and therapy are most appropriate in the patient's situation. The model assumes that there are objective criteria as to what is the best solution in certain situations and that the physician decides according to these criteria. When this model is evaluated according to the criteria of principlism, the emphasis is on beneficence and not on patient autonomy.
2. The *informative or scientific model.* In this model, all diagnostic and therapeutic options are presented to the patient as neutral facts. The patient must choose the best solution for his situation on the basis of his own values. The basic assumption is that the patient himself knows his own values well and that he does not need help to choose on the basis of these values. In this model, the physician is a technician who knows all the possibilities and informs the patient about them.
3. The *interpretative model.* In this model, the physician tries to find out what the patient considers important and tries to help him to make a choice with the help of neutral information. The physician is not only a provider of technical information, but also a counsellor who helps the patient to assess the information provided according to his own values.

4. The *deliberative model.* This model is similar to the interpretive model, but goes further. The physician acts as a friend or teacher and tries to help the patient to order and value his values. The aim is for the patient to get to know his (implicit) values better in the dialogue with the physician and to develop further by understanding these values better, ordering them better and thus making a more informed choice.

Newer models, such as the phenomological approach and hermeneutic approach, place more emphasis on the physician's relationship with the patient, reaching a solution together and learning more about yourself in these relationships (both from the patient and the physician).

The paternalistic model was dominant until the second half of the twentieth century, but was increasingly criticised thereafter. The book by the Dutch psychiatrist Van den Berg*, Medical Power and Medical Ethics [Medische macht en medische ethiek], exposed* overtreatment and the absence of patient consent (autonomy or self-determination) within this structure of the physician-patient relationship. Autonomy was one of the four main principles in the general ethical principles (principlism) presented by Beauchamp and Childress. (Beauchamp and Childress 1979) The conceptualisation of autonomy was strongly coloured by the ideas of John Stuart Mill, a liberal who emphasised that people can and may shape their own lives. Mill sees autonomy as the ability to make decisions for oneself, without interference from third parties. The *informative model fits in* well with this view of autonomy. Nevertheless, criticism soon arose against this interpretation of autonomy. The freedom associated with autonomy was called *negative freedom* because it emphasises the possibility of saying 'no' to proposals made by healthcare providers, such as physicians. It was argued from both secular and religious perspectives that this negative approach to freedom severely limits the possibility of doing *good* to a patient. (Pellegrino and Thomasma 1988) (Dworkin 1988) (Chamsi-Pasha and Albar 2016) The opposite of negative freedom is *positive freedom.* According to Dworkin, this involves acting in accordance with fundamental personal values. (Dworkin 1988) The secular critics of the autonomy model with negative freedom look for methods in phenomenological and hermeneutic approaches to the physician-patient relationship to jointly seek solutions to decisions in the physician-patient relationship that reinforce the essence of the patient, and ideally also that of the physician, while at the same time taking account of the possibilities of the physician and medicine. (Dworkin 1988) (Gadamer 1993) The *deliberative model* approach comes much closer to this. The intention of adherents of the newer models, in combination with autonomy as positive freedom, is to see the physician-patient relationship as a relationship between two people who are jointly seeking a solution, but who also have knowledge and respect for each other's *being*.

In addition to this development, supporters of *Care Ethics point out* that models emphasising negative freedom do not automatically invite the provider to show empathy towards the patient. Secular models, therefore, tend towards an emptiness that can be characterised as a "lack of empathy, compassion and closeness".

The appreciation of autonomy is very much in line with the Catholic perspective. In theological terms, it is about the "freedom granted to man by God", which must also be respected in the physician-patient relationship. Pope Pius XII states that the physician - and we may also include other health professionals - "has no separate or independent right in relation to the patient; in general he can only act if the patient expressly or tacitly (directly or indirectly) authorises him to do so" (Pius XII 1957). Pope John Paul II sees the work of physicians and nurses as that of a *Good Samaritan,* who not only has compassion on the sufferer, but actually helps him. (Saint John Paul II 1984) Pope Francis repeatedly emphasised the importance of compassion in the relationship between healthcare providers and the patient. (Francis 2021a) (Francis 2021b) (Francis 2022) This fits in with the Christian perspective in which there is a very emphatic call to show love: God is love, the example of Christus Medicus urges healthcare workers to treat the sick with love and compassion. The mentioned calls of St. Pope John Paul II and Pope Francis are entirely in line with this thinking.

One difference between Christians and secular movements is the *knowability of truth*. The secular models do not assume a knowable absolute truth, which makes it impossible to know "the" morally good solution in a given situation: the patient must therefore determine "his truth" himself, with or without the caregiver, which puts autonomy very much in the foreground: all possible choices that the patient and the physician arrive at can be "the truth". The Christian perspective, which assumes an absolute truth, implies that everyone, including the physician, can know what is morally good in a given situation, provided they prudently consider the medical possibilities, the patient's situation and God's intention for the patient's and the physician's life. Even if, from a Christian perspective, the patient must always freely consent to proposed diagnostics and treatments, what is said to be "objectively good" should also have a place in the physician-patient relationship.

From the Catholic, philosophical point of view, two other visions are interesting. Two Catholic authors published another, ideology-based model of the physician-patient relationship slightly earlier than Emanuel. In this model, they place strong emphasis on *beneficence* from the Hippocratic tradition, but without it becoming paternalistic again. The basis for this model is the mutual trust between the patient and the physician: the authors characterise this model as *beneficence in trust.* (Pellegrino and Thomasma 1988). The patient's autonomy must of course be respected, not as a negative freedom, but as a positive freedom (Pellegrino 1994), precisely because respect for autonomy is an aspect of beneficence. Furthermore, an attempt is made to give beneficence based on objective criteria a place in this model. Beauchamp argued quite soon after the publication of this model that it was a veiled form of paternalism. (Beauchamp 1990) Emanuel did not mention this model at all. (Emanuel and Emanuel 1992).

Cardinal E. Sgreccia developed a philosophical foundation of bioethics known as *ontologically based personalism*. In personalism, there is absolute respect for persons, but it differs when a person may be called a person. Some personalists consider a human being a person only when he or she is capable of maintaining relationships with others. Sgreccia founds personalism in *what people are* and not in *what they have or what activities they engage in.* In Bioethics it leads to a patient-oriented, holistic approach, in which the spiritual dimension of the person must not be lost sight of. This approach demands that the superiority of the human person be recognised and guaranteed on a social level. On the basis of this approach, in a society that regards health as a social good, Sgreccia arrives at the following moral foundations for the physician-patient relationship:

1. The good for the patient as the ultimate goal;
2. The consent of both the patient and the physician to the medical act;
3. Legal recognition of both these principles.

For the interpretation of the physician-patient relationship, Sgreccia also uses Pellegrino's model, but with the note that *"the good"* has three components that also need to be addressed in a balanced way: 1) *the biomedical good, that which is* the best solution in the biomedical field; 2) *the patient's idea of the good for himself;* 3) *the good as the possibility of xercising the ability to reason in order to make decisions*. (Sgreccia 2012)

Pellegrino's and Sgreccia's approaches resolve the knowability of the objective good. They give an impetus to resolve the "emptiness that emerges in secular models": by seeking the good for the patient, respecting him as a human being, and in dialogue and compassion with the patient, they try to avoid coldness, to strengthen the patient's *being* both biomedically and spiritually, without losing sight of the *objective good*. These approaches integrate and improve the previously mentioned models. Sgreccia's principles also make it clear that the physician is also a person who must be respected and must, therefore, agree to the diagnosis or treatment to be carried out. The compassion and closeness emphasised by Pope John Paul II and Pope Francis go a little further. Not only do they indicate how decisions should be made in the context of the physician-patient relationship, they also indicate how the physician's attitude towards the patient should be: near, with love.

In Islam, physicians are expected to be both competent in their profession and to approach the patient as a person. Ideally, the physician should be kind, humble, trustworthy, compassionate and have integrity (Chamsi-Pasha and Albar 2016). In addition, informing and maintaining a good relationship with the patient's family members plays an important role. Decision making is based on dialogue and joint search for a solution. (Mohiuddin and Islam 2016)

In conclusion, the physician-patient relationship has developed from a relationship in which the physician decides everything, through a situation in which the patient has the opportunity to refuse, to a situation in which both parties jointly seek a solution that strengthens *the patient's* and, if possible, the *physician's*, *being*. In the secular models an emptiness is experienced, because empathy, compassion, love do not have a natural place. This emptiness can be filled by Christian approaches in which beneficence, love, expressed in proximity and compassion (Pope Francis), among other things, have a much more natural place. Christians have the task of not letting this opportunity be lost.

Notes

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