

EVERYDAY ETHICS

The Patient-Physician Relationship in the Context of Physician-Targeted Violence From the Perspective of a Medical Student

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ABSTRACT

The tragedy that transpired at a hospital in Tulsa, OK, in June of 2022 highlights the issue of physician-targeted violence in the United States.^{1,2} The shooting in Tulsa had occurred after a patient, dissatisfied with their back pain despite it only being 2 weeks after spinal surgery, attacked one of the few Black orthopedic surgeons in America, Dr Preston Phillips.¹ Dr Phillips' murder is not an isolated incident. In 2015, Dr Michael Davidson, a cardiothoracic surgeon at Brigham and Women's Hospital in Boston, MA, was shot and murdered by the son of a patient that the surgeon had operated on the previous year.³ Dr Davidson had spent a significant portion of time answering questions from the disgruntled son who would eventually murder him. The 2 tragedies, separated by over 7 years, center around physician-targeted violence. Both surgeons had operated on a patient and were murdered as a result. Both cases beg the question: what went wrong, and how could they have been avoided?

These 2 cases represent examples of a greater trend of increasing violence toward physicians exacerbated by the COVID-19 pandemic.^{4,5} Figures from the US Bureau of Labor Statistics estimate that the rate injuries from attacks against medical professionals grew by 67% from 2011 to 2018.⁶ US hospitals reported an increase in assaults and threats mirroring the global trend during the COVID-19 pandemic.⁷ Violence against physicians is symptomatic of a large issue: the deteriorating patient-physician relationship and the illusion of what the physician is. At the core of health care is the patient-physician relationship.⁸

Four models of the physician relationship have been described.^{8,9} The paternalistic relationship has the physician creating decisions on behalf of the patient. The interpretive relationship requires a physician to figure out a patient's goals and values and subsequently offer options to achieve them. An informative relationship has the physician providing information and allowing patients to decide for themselves. Finally, in a deliberative relationship, the physician

and patient collaborate as equals and work together to achieve a goal.

Historically, the paternalistic model predominated, in which the physician's main duty was seen to protect patients even at the expense of their autonomy.¹⁰ This has contributed to the expectations that physicians are miracle workers and if they fall short, they should be blamed. In line with a paternalistic model, physicians often avoid talking about poor prognoses to be protective or kind; however, research shows that patients end up feeling isolated with their concerns, and the inability to discuss poor outcomes adds to the illusion of perfectionism.^{11,12} The paternalistic model has contributed to the deterioration of the patient-physician relationship by disrupting communication for the sake of the patient.

Part of the problem has been the portrayal of physicians by the media.¹³ Physicians are seen as wanting to maximize profits, seemingly pushing medications unnecessarily.¹⁴ Historical events have contributed to that perception. In the past, the medical field acted against the best interest of already marginalized patients through experiments like the Tuskegee Syphilis Study conducted from 1932 to 1972, which withheld vital treatment from Black men diagnosed with syphilis.¹⁵ Actions to correct the matter only took place after it had come to light, resulting in regulations requiring researchers to obtain voluntary informed consent and the Institutional Review Board's approval.¹⁶ Historical events have created a gap between specific marginalized populations and physicians.

Although institutional change is necessary to bridge the mistrust that exists within marginalized communities, individual physicians and medical students can take steps to help address the issue. Physicians can start at the bedside by showing that they want the best for patients, and breaking down mistrust begins at the medical education level.¹⁷ Understanding the historical origins and source of the mistrust would provide context to physicians in navigating interactions with patients. Physicians use a historical lens to understand the decisions of patients and allow that

knowledge to guide their responses. Decreasing the amount of discrimination experienced by patients would minimize the mistrust felt by patients and work to support the idea of physicians as true patient advocates. Physicians can begin to decrease the amount of discrimination through removing stigmatizing language in patients' medical records that end up influencing future interactions.¹⁸ Similar to how one negative experience can paint a patient's view of future interactions, a positive one can create a favorable view of the medical field. Over time, the accumulation of positive interactions would go a long way to mend the general patient-physician relationship.

Trust remains low in the general population, partially a result of the affordability of health care and the lack of transparency in decisions made.¹⁹ This perception of the physician has contributed to an "us versus them" mentality between the patient and physician. No longer are physicians seen as always doing the best for the patient.^{13,14} Decisions are analyzed through the lens of potential ulterior motives. Likewise, patients who end up distrusting their physicians are labeled as "noncompliant" even if they have legitimate reasons not to trust them. The relationship has been strained in both directions.²⁰ The way the health care system is built up does not help the issue. Physicians have limited time with each patient.²¹ The lack of time has fed into the discontent felt by many patients. And so, when the health care system fails to meet the needs of the patient, it is the physician who is blamed.

Fixing the issue remains a complex and convoluted process that requires moving away from a paternalistic model toward a more deliberative relationship that encourages partnership between physician and patients. First, change needs to occur at the level of medical education. Students should not be discouraged to broach conversations surrounding failure.²² A degree of perfectionism is required to make it to medical school, but it is important to allow medical students to fail. Fostering an environment where students can learn from their mistakes would go a long way toward removing the veil of perfectionism. Students and medical professionals should be encouraged to approach tough conversations about prognoses earlier rather than later. Physicians often feel inadequate in their training conducting these conversations, and starting from medical school would work to alleviate that.²³ Research shows these conversations do not harm patients and potentially strengthen the relationship between physicians and patients.^{12,24} Through discussions, patients will eventually realize that physicians, although trying their best, are not miracle workers. When failure arises, there should be steps to prevent it from occurring again; however, normalizing failure would allow patients to understand that it is a possibility.

Relationships go two ways. Patients need to realize the limitations that exist in medicine. The success of a procedure or diagnosis depends on numerous factors. Fostering a deliberative relationship model and allowing discussions of failure would work to allow patients to recognize that. Ultimately, physicians have limitations. Medicine is a science, not a miracle, even though it may seem like it at times. The issue can only be resolved as patients realize that physicians are on their side, and that requires a mindset shift with the public. As America once again deals with another tragedy, the medical field needs to work to address the discontentment. Creating an environment that strengthens the patient-physician relationship is essential to ensure that these tragic events do not happen again.

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