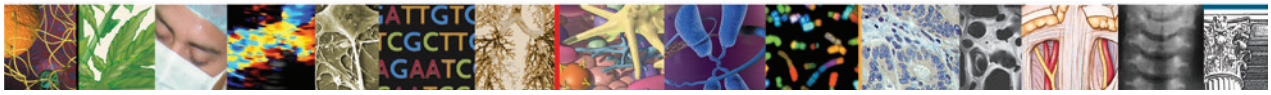

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Perspective

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FUNDAMENTALS OF HEALTH LAW

The Physician–Patient Relationship

Arthur R. Derse, M.D., J.D.

A frail, cachectic 85-year-old man with metastatic pancreatic cancer who has lost decisional capacity is receiving mechanical ventilation and vasopressors. He has not completed an advance care planning document, and his family does not know what he would want under these circumstances. The attending physician tells the family that cardiopulmonary resuscitation is extremely unlikely to be successful and might only prolong the dying process, but they insist that the patient retain "full code" status. The physician, unable to persuade them otherwise, considers next steps.

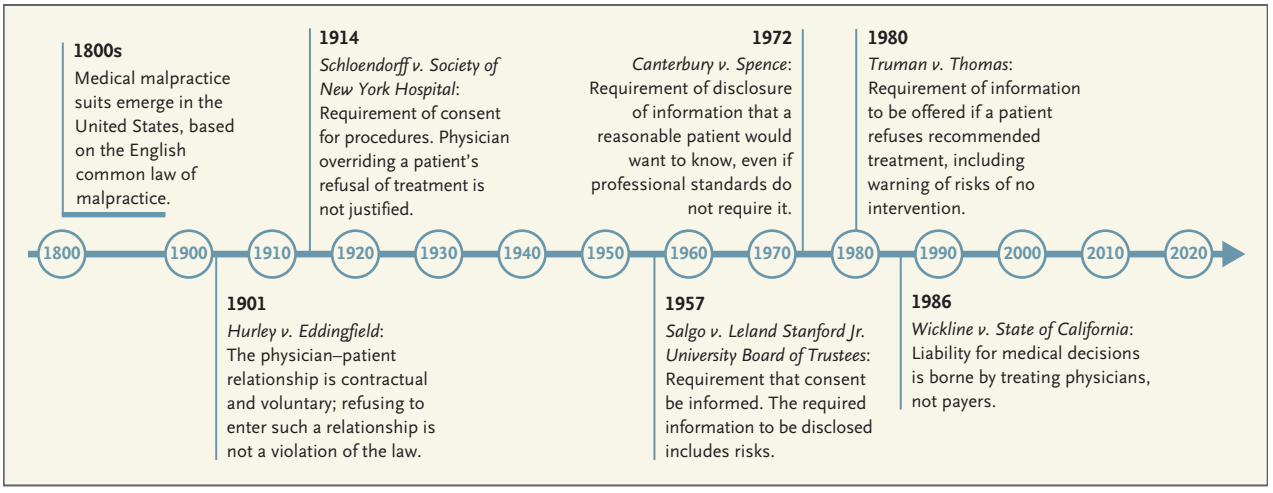
In this case, the treatment is extremely unlikely to benefit the patient, he can no longer speak for himself, and the family members have their own interests. And possibly, as has been the case at times during the Covid pandemic, vital resources may be constrained.

Today in the United States, the physician–patient relationship may be more fraught than ever, challenged as it is by greater emphasis on patient autonomy in the context of widespread misinformation and by external forces, constraints, and incentives not aimed at patient benefit. Nevertheless, physicians owe patients both longstanding duties, such as adhering to standards of care, and more recently added duties, such as obtaining informed consent.

In legal terms, the U.S. physician–patient relationship was defined around the turn of the 20th century as a contract under which a patient may negotiate with a physician for services (see timeline). In nonemergency situations, physicians had no obligation to a person seeking treatment unless they willingly undertook that care. Whereas many types of contracts create an obligation to produce a specific outcome, physicians promise to provide medical care to a patient without guaranteeing an outcome.

The legal aspects of the relationship, however, go beyond an arm's-length business contract. The relationship is not one of equals: the patient is often vulnerable because of illness or injury, and the physician has special knowledge and skills. The paradigm that some (though not all) courts have used is that of a fiduciary duty, according to which the physician must act for the patient's benefit rather than proceeding under a pure contract model, which might permit maximization of the physician's self-interest. Violations of this entrustment could bring civil penalties, including punitive damages. Courts have recognized fiduciary-like aspects of the relationship, including the duties of confidentiality and nonabandonment.[1]

A physician–patient relation-



Modern Legal Landmarks of the Physician–Patient Relationship.

ship is easily formed and difficult to terminate involuntarily, with legal remedies for abandonment under tort law. Once the relationship is formed, the physician must provide competent treatment, defined as adhering to the standard of care.

Patients' ability to make decisions about their own medical care (in accordance with the ethical principle of autonomy) was not a traditional tenet of the relationship. Physicians possessed expertise about what was best for patients, and there was no beneficial reason to ask patients to consider treatment options. Until the 20th century, physicians were not even obligated to tell patients the truth about their medical condition. The legal requirement for voluntary consent for treatment is just over a century old (1914), and the requirement to provide patients with information deemed essential to making an informed decision — information about a treatment's benefits and risks and about alternatives, including forgoing treatment — was not established until the 1950s.

The standard for the specific information to be disclosed was originally determined by the profession itself, though many states adopted the general standard that physicians should disclose what a reasonable patient would want to know to make the decision at hand. A "shared decision making" model, first proposed in 1978 by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, went beyond the minimum elements of the legal standard to endorse physicians' making recommendations that take into account what a given patient finds relevant and important to the decision — an aspiration for ethical physician–patient communication.[2] In *Truman v. Thomas* (1980), the law recognized patients' right to information about the consequences of refusing treatment. Failure to provide adequate informed consent has since become a substantial domain for litigation.

As medical technology advanced, societal changes contributed to a rebalancing of the physician–patient relationship, with increased patient autonomy legally supported in such areas as end-of-life decision making and, in some jurisdictions, medical aid in dying. (Such patient autonomy also applied to reproductive health care for more than half a century, until the volte-face of the Supreme Court's *Dobbs* decision, with its uncertain repercussions for a range of decisions long made by patients with physicians.) Though expansion of patient participation in decision making has been salutary when there are reasonable medical options to be considered, the physician–patient relationship has been especially challenged in instances when patients demand interventions that physicians deem medically inappropriate, nonbeneficial, or "futile."

The Covid-19 pandemic stressed medical resources such as masks, ventilators, personnel, vaccines, and medications, rendering allocation issues especially pressing. Some emergency allocation proposals ("crisis standards of care") would have overridden the primacy of clinicians' duty to act in the best interest of individual patients. Some states provided clinicians immunity from liability for acting in good faith, in accord with emergency standards promulgated or supported by the government. Though such standards were implemented temporarily in only a few jurisdictions,

related discussions and actions highlighted the tension between the bedside physician's fiduciary duty and society's needs in a public health crisis. They also brought to the fore allocation-priority issues that had previously been largely limited to the realm of organ transplantation.

The wide availability of Covid-19 misinformation has led to demands from patients and families for unproven or ineffective interventions, such as ivermectin. When families have brought lawsuits to force such treatment, they have generally lost.[3,4] But these petitions reflect the mistrust that misinformation engenders, challenging the ideals of shared decision making and the limits of patient autonomy. Staffing shortages, increased incivility, and violence against health care workers have further undermined connection, communication, and trust.

In the case described above, the family demanded an intervention that was extremely unlikely to benefit the patient. In some jurisdictions, the law supports physician refusal of such requests based on professional judgment of ineffectiveness; in others, there may be a required process for making a determination (including parental or guardian approval for minors). Still other states have no applicable law other than the medically determined standard of care — what prudent medical professionals would do under the same circumstances. Providing a treatment contrary to a physician's considered judgment undermines that standard of care. It also engenders moral distress in physicians and medical teams and sets unrealistic expectations for patients and families. Yet demands for particular interventions despite the professional determination of extremely low (or no) likelihood of effectiveness are increasingly common. Families may suspect that the physician is acting to save money for the system, evincing a lack of trust in physicians to fulfill their responsibility to patients.

Indeed, a prominent barrier to effective physician–patient relationships has long been financial conflicts of interest, arising from physicians' ownership of health care facilities, for instance, or their receipt of financial incentives from industry. More recently, the increasing corporatization of the practice of medicine has created additional challenges. Corporations and insurers do not have the fiduciary responsibility for patients that physicians have, and adverse corporate and insurer practices do not relieve physicians of liability for violating their duty, though there may be avenues for holding corporations accountable.

Since a typical treatment team now comprises myriad health care professionals, these challenges are shared interprofessionally. Moreover, U.S. health care's corporatization, centralization, and granular assessment by administrators and payers have constrained physician judgment and sidetracked professionals with required documentation and productivity goals, reducing clinical time spent with patients and thereby undermining shared decision making. In recent years, private equity firms have been purchasing physician practices and pressuring them to maximize income with aggressive billing practices while including nondisparagement agreements in their contracts that interfere with physicians' obligations to report problems with the quality of care. Consolidation of health care systems, allegedly meant to improve efficiency, has resulted in increasing costs that are ultimately borne by patients.

Other emerging challenges with legal implications include governmental and organizational limits on physicians' counseling of patients in clinical encounters (e.g., regarding gun safety or reproductive choices), conscience-clause invocation by health care workers, and appropriate physician responses to abusive comments directed toward health care workers by patients or visitors.

Such challenges remind us that although the law delineates minimum enforceable standards of competence, much of the physician–patient relationship is not legally regulated. Engendering trust and communicating well and empathetically are therefore vital. Francis Peabody's admonition that "the secret of the care of the patient is in caring for the patient" has no legal correlate — though competent treatment is legally required, caring for the patient is not. But caring is an ethical virtue of the good physician.

Caring for the patient, exercising professional judgment, and as Sir William Osler counseled, maintaining equanimity remain essential in navigating the legal parameters of the physician–patient relationship in a fraught environment.[5] The law provides guideposts, but ultimately, the relationship hinges on human connection, trust, and judgment. In the case described above, these qualities might have resulted in guidance to the patient during an early advance care planning discussion, communication of his wishes to his family, implementation of his values within the parameters of indicated treatment, avoidance of nonbeneficial interventions that prolong the dying

An audio interview with Dr. Derse is available at NEJM.org

process, provision of appropriate palliative care, and fulfillment of the physician's duties to the patient.

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The series editors are Erin C. Fuse Brown, J.D., M.P.H., Aaron S. Kesselheim, M.D., J.D., M.P.H., Debra Malina, Ph.D., Genevra Pittman, M.P.H., and Stephen Morrissey, Ph.D.

From the Center for Bioethics and Medical Humanities, the Department of Emergency Medicine, and the Kern Institute for the Transformation of Medical Education, Medical College of Wisconsin, Milwaukee.

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Hospital Standards of Care for People with Substance Use Disorder

Honora Englander, M.D., and Corey S. Davis, J.D., M.S.P.H.

More than 100,000 Americans died from drug overdoses in 2021 — a staggering death toll that would have been unthinkable only a few years ago. Approximately 75% of overdoses involved opioids, and most involved multiple drugs, including stimulants and alcohol. Substance use disorder (SUD)–related hospitalizations, readmissions, and health care costs are increasing and are associated with high mortality from drug-related and other causes. In one study of hospitalized adults with opioid use disorder (OUD) in Oregon, 7.8% of patients died within 1 year after discharge — mortality similar to that associated with acute myocardial infarction.[1]

Hospitalization represents a key opportunity for engaging and supporting patients with SUD. One in nine hospitalized adults has SUD, and most are not receiving addiction treatment at admission. A rapidly expanding evidence base describes the benefits of hospital-based addiction care, including improved trust in physicians, increased engagement in postdischarge SUD treatment, and reductions in SUD severity, stigma, and mortality. Furthermore, hospital-based addiction care increases the likelihood that other hospital care will be trauma-informed and meet the comprehensive health needs of people with serious illness and SUD.[2]

Most efforts in hospital-based addiction care to date have been led by motivated clinicians who have made a case that such efforts could improve both financial and quality outcomes.[3] Absent clear funding or financial incentives, however, adoption of best practices varies widely, with most hospitals not offering evidence-based addiction care. Harms of not addressing addiction in hospitals include untreated withdrawal and pain, frequent patient-directed discharges, and moral distress for patients and staff.[2] Moreover, hospitals are the training grounds for most health care professionals. Failing to train the next generation in evidence-based SUD care represents a missed opportunity to improve outcomes and dispel the false notion that SUD is a moral failing rather than a treatable health condition with biologic, social, emotional, and cultural underpinnings.

Evidence-based medications for opioid and alcohol use disorders are effective but widely underused, with only a fraction of patients who are likely to benefit actually receiving them. Decades of evidence shows that treatment with an opioid agonist such as methadone or buprenorphine substantially reduces morbidity and mortality among patients with OUD. Widespread access to medication for OUD (MOUD) is ever more urgent, given the increasingly lethal illicit drug supply; yet most U.S. hospitals do not offer MOUD or effectively connect patients to OUD care after discharge. A nationwide study estimated that only 15% of patients who had OUD when they were admitted to Veterans Health Administration hospitals received any MOUD, and initiation of MOUD treatment plus linkage to post-discharge care was provided in less than 2% of cases.[4] Another study revealed that 46% of New