



A Physician's Role: An Examination of the Patient-Physician Relationship

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Abstract

According to the ethical ideals presented in the American Medical Association's Code of Ethics (2016), the role of a physician within the patient-physician relationship is defined as that of a protector. It is not dictated, though, how a physician must perform this role. In order to determine how to best fulfill their role as protectors, physicians enter into a negotiation with their understanding of ethical ideals and the culture of their medical specialty. The purpose of this negotiation is to establish the physician's boundary of protection. The physician is not a static entity, so their boundary of protection is not static. Instead, it is dynamic to allow for re-negotiation.

Keywords: patient-physician relationship, protect, boundary, ethics, negotiate

In the summer of 2017, I observed a cardiologist as he met with patients in the Cardiac Intensive Care Unit. For the couple of weeks prior to observing this cardiologist, I had been working to understand how physicians portray their understanding of medicine through their performance in the patient-physician relationship. I had not witnessed anything that I felt truly encompassed this process, though. As Dr. Dunlap and I made rounds, we saw a patient who was in the hospital after a serious heart attack. The patient continuously asked Dr. Dunlap what he could have done to prevent the heart attack.

—Patient: “Is there something that I could have done to prevent this, Dr. Dunlap? Do these types of things just happen? Or is there a reason?”

—Doctor: “Heart attacks do just happen to some people no matter what preventative measures they take. You were lucky this heart attack wasn’t lethal, but it happened. Now we need to focus on how to prevent another one from happening. That is my concern, not what you could have done to prevent this one.” (M. Dunlap, personal communication, June 26, 2017)

I wrote the interaction in my notebook and put large stars around it; it had caught my attention. After leaving the hospital that night, I reread Dr. Dunlap’s encounter with this patient. I knew there was a reason that this particular conversation caught my attention, but it was not until that night that I realized why. I had listened to the same conversation between my mother and the doctor who performed my father’s autopsy.¹ Now, I understood what that doctor had been trying to accomplish; I understood what Dr. Dunlap had been trying to accomplish. My mother had pleaded with the pathologist, asking him what she and my father could have done to prevent my father’s massive heart attack. The doctor sat in front of my mother and said to her, “your husband was dead before he hit the floor. The only way he could have been saved is if he had been on the operating table in that moment. He felt no pain. It was an enlarged heart—a heart defect he probably had for a long time.” After my mother accepted this, he continued to explain that my mother’s concern should not be how the past could have been different, but how the future could be. He said, “those little girls sitting right there are my biggest concerns. They will grow up knowing they are at risk. If all of this had to happen, that is a blessing.” From that point on, yearly physicals for my sister and I consisted of complete blood panels, EKGs, and echocardiograms. This doctor encouraged my mother to focus on what she could control.

In the same way, Dr. Dunlap encouraged his patient to focus on how he could prevent a second heart attack rather than what preventative measures he could have taken in the past. After making this connection, I realized that both of these physicians were acting as protectors. All physicians are obligated to act as protectors,² but not all act in the same way. All physicians—prescribed to the role

1. At the time of my father’s death, I was six years old. There was no reason to expect that this experience would apply to my future interests as an anthropologist.

2. This role is described by the obligation of physicians to the Hippocratic Oath and the AMA’s Code of Ethics.

as protector—enter a conversation with their own understanding of medicine to establish the boundaries of their protection and their responsibilities as protectors. As I looked back at my fieldnotes, I saw countless instances in which physicians were negotiating their role as a protector. I started asking questions about how the culture of medicine influences a physician’s performance as a protector, how environment shapes the way in which physicians can protect, and how physicians determine the limits of their protection.

Patient-Physician Relationship: A Literature Review

As I began to search for answers to these questions in my fieldnotes and continued observation of physicians, I entered into a conversation with the substantial body of literature in sociology, philosophy, and anthropology regarding the patient-physician relationship in the United States. Sociologists focus primarily on the social factors that determine the efficacy of this relationship, and philosophers focus on the ethical codes present in the relationship (Ferguson, 2002; Shelp, 2013). Anthropologists, by contrast, have focused on times when the patient-physician relationship fails, leading to greater suffering among patients—particularly those from marginalized backgrounds (Fadiman, 2012). Much of this research, however, has been patient-centric; that is, these studies examine the characteristics, actions, and viewpoints of the patients and how these alter their relationship with healthcare providers. Physicians’ actions are rarely analyzed. There could be any number of reasons for this absence. Like other objects of biomedical knowledge (e.g. the patient’s body, the injury, the risk), scholars may objectify medical providers, viewing them as bodies of static, unchanging scientific knowledge (Janzen, 2001). Because physicians hold tremendous social status and power, patients and scholars alike may be less willing to examine and question their actions and decisions. In the field of anthropology, more broadly, this reflects a trend in which researchers have been hesitant to “study up,” or study populations that possess high social status (Nader, 1972). More and more, though, anthropologists and scholars of other disciplines are noting the benefits of “studying up” (Kivell et al., 2017), seeing such studies as vital to understanding relationships and processes impacting the general population. In this case, “studying up”³ is necessary to understand the entirety of the patient-physician relationship.

The American Medical Association (2016) characterizes the patient-physician relationship as a fundamentally “moral activity,” established through trust and rapport, “which gives rise to physicians’ ethical responsibility to place patients’ welfare above the physicians’ own self-interest or obligations to others, to use sound medical judgment on patients’ behalf, and to advocate for their patients’ welfare.” By taking the Hippocratic Oath,⁴ physicians are required to practice

3. I place “studying up” in quotation to indicate its influence on anthropological literature and research. Much attention and thought have been given to the process and difficulties of “studying up.”

4. The Hippocratic Oath is an oath taken by individuals entering into the medical profession. It is of Greek origin and requires physicians to swear to uphold ethical standards. Today, many doctors do not swear to the original Hippocratic Oath, but the majority of physicians take a similar oath when they graduate from medical school.

medicine according to their best ethical judgment. Scholars have drawn from the field of philosophy to explore and identify the ethical norms that characterize the patient-physician relationship (Shelp, 2013). These ethical practices lead this relationship to provide different healing qualities such as hope, trust, and faith (Shelp, 2013). When providers do not fulfill their role within the relationship, these traits are absent, and the patient suffers (Scott et al. 2008). By focusing solely on the patient's response to different characteristics of the patient-physician relationship, scholars have neglected how a physician actually interacts with these ethical practices to make decisions in his or her everyday practices to best meet the needs of a particular patient. Physicians, practicing under the Hippocratic Oath, are obligated to interact within the bounds of their ethical obligations to the patients (American Medical Association, 2016). If this is true, then the ways in which physicians understand their ethical code dictates how they understand their role in the patient-physician relationship. It is necessary to understand how physicians negotiate with the ethical code of medicine, their own moral compass, and their understanding of medicine to determine their actions.

One of the common themes across social science literature is the ways in which ethnicity, race, and language affect the quality of the patient-physician relationship. Patients who come from marginalized groups often characterize their relationships with primarily white physicians as less empathetic and less communicative (Ferguson & Candib, 2002). Patients feel less involved in decision-making and there is greater resistance toward treatment (Ferguson & Candib, 2002). These findings combined with the unspoken belief that physicians are unchanging bodies of knowledge have led to an increased emphasis on "cultural competency"⁵ training in medical schools in order to effect better patient outcomes. Culture is defined as a static entity and stands parallel to the idea of a static physician (Taylor 2003a). Anthropologists have shown, though, that culture is not a static entity. It is "not a 'thing,' somewhere 'out there,' that books are 'about,'" but rather is a "process of making meanings, making social relations, and making the world that we inhabit" (Taylor, 2003b). If this is true, physicians cannot be static entities either. Physicians exist within a culture—a societal culture and a culture of medicine—and undergo a process of using those cultures to develop a specific understanding of medicine. This process is extended to interacting with patients. Physicians are not static but rather are dynamic individuals capable of adjusting during different patient encounters to fulfill their role in the patient-physician relationship. In the scenarios I described above, these physicians were interacting with a single patient during a single encounter. They did not behave the same way in encounters with other patients.⁶ Instead, they manipulated their own understanding of medicine to determine how they should best act during a particular patient encounter to fulfill their duties to the patient.

5. I take this term from Janelle Taylor's description of current medical education. By placing this idea in quotations, I am questioning the reality of medical students' understanding of culture as an abstract idea.

6. I cannot comment on the fluidity of the physician who spoke with my mother, but by generalizing from my observations of physicians during this study, I am confident in that statement.

Studies of the patient's experience in the patient-physician relationship are important, but they are insufficient without a fundamental understanding of the role of the physician in the relationship. Furthermore, simply knowing the physician's role is not adequate. There must also be consideration given to the decisions a physician must make within this role. While research on the abstract ethical concepts characterizing the patient-physician relationship is also valuable, it does not illuminate how physicians actually engage with these values in determining how to best play their role in the relationship. "Studying up" is necessary to understand how physicians negotiate their role within the boundaries of the expectations of the patient-physician relationship, their ethical code, and their own understanding of medicine. My research aims to illustrate not only the role of a physician, but the range of action a physician has within this role. I hope to develop a concept of how physicians interact with their understanding of medicine to make ethical decisions in their daily practice.

Physicians as Protectors

The American Medical Association⁷ clearly defines the field of medicine through its Code of Ethics. Based on the Hippocratic Oath, it establishes the field of medicine as an altruistic field and places the physician firmly in his or her role as a protector (American Medical Association, 2016). Each section of the Code of Ethics outlines the ways in which a physician shall protect patients. For example, physicians should "practice a method of healing founded on scientific basis," should "not reveal the confidences entrusted to him in the course of medical attendance," and "should safeguard the public . . . against physicians deficient in moral character or professional competence" (American Medical Association, 2016). All actions of a physician must be "justified ethically by focusing" on ideas such as "patient autonomy and physician nonmaleficence" (Kendler et al., 2013). These ethical considerations cement physicians in their role as protectors, but they do not necessarily dictate how these physicians act to fulfill their role. In the United States, many physicians practice within the culture of biomedicine.⁸ Arthur Kleinman contends that biomedicine maintains a "single-minded approach to illness and care" (Kleinman, 1995). Here, I argue here that physicians are not static entities, but, rather, they are fluid actors. They do not single-mindedly approach care, but, instead, engage with the ethical values of medicine, their own understanding of medicine, and the environment in which they practice to actualize their role—as a protector—in the patient-physician relationship in a variety of ways.

In the sections that follow, I provide the context for my ethnographic study of physicians' role in the patient-provider relationship. I describe the physicians I observed. Then I present three cases studies that illustrate the

7. The AMA is the governing body of medicine in the United States.

8. The term "biomedicine" is defined as the practice of medicine based on the application of the principles of the natural sciences and especially biology and biochemistry. The culture of biomedicine stands opposed to that of naturalistic medicine, for example.

fluidity of the physician in his or her role as protector and the ways in which he or she establishes the boundaries of his or her protection. Finally, I conclude by commenting on the culture of medicine.

Methodology and Context:

Methodology

I took my first Medical Anthropology class⁹ during the fall of 2015. It was in these first classes that my professor first introduced me to the concrete idea of the patient-physician relationship. Pursuing a career in medicine,¹⁰ I observed the patient-physician relationship during my shadowing experiences, but I had been more focused on learning about the science of medicine rather than noting how physicians developed relationships with their patients. During class discussions, though, I became intrigued by the idea that individuals were actors in their role as physicians. They had to account for their own culture, their own understanding of medicine, and their oath to remain ethical when deciding how they would act in their role as a physician. I began to realize that I had seen this negotiation of a physician many times but had been naive to what was occurring. Because I was able to continue to take part in shadowing opportunities, I was able to start paying attention to and asking questions about the internal negotiations of the physicians I observed. From these initial observations, I started to ask myself questions about what the physician's role was in the patient-physician relationship and how physicians acted within this role. I developed this study in order to answer those questions.

I conducted the study over a six-week period during the summer of 2017. During this time, I obtained ethnographic data through observation of patient-provider interactions and unstructured interviews with medical professionals in a variety of clinical environments at Hospital Z. Hospital Z provides undergraduate pre-medicine students with the opportunity to shadow physicians in a variety of different clinics within the hospital. This opportunity provided me the space in which to complete my research. Prior to completing research in the hospital, I completed the Collaborative Institutional Training Initiative human subject training certification course and received approval from the Institutional Review Board of the University of Kansas and Hospital Z administration¹¹ to conduct ethnographic research.

Over the course of the six weeks, I observed and interacted with attending physicians, residents, and medical students in different clinics throughout the hospital. Hospital administration assigned me to the clinics in which I would

9. I took the class Introduction into Medical Anthropology with Dr. Kathryn Rhine. I took this course after enjoying the introductory biological anthropology course.

10. When I took my first medical anthropology class, I was in the second year of my undergraduate education. At this point, I was still deciding between pursuing a Ph.D. in Molecular Biology or a medical degree. I took this course to explore the medical field and gauge my interest in medicine. It was this class, in part, that helped to solidify my desire to be a physician.

11. I did not submit my study to the IRB of Hospital Z. Because I was not collecting protected patient information, the administration at Hospital Z considered the approval of the University of Kansas IRB to be sufficient.

observe.¹² These clinics included the hospital's geriatric health clinic, rehabilitation clinic, operating room and emergency department, cardiology clinic, intensive care unit, and catheterization laboratory, plastic surgery clinic, dermatology clinic, weight-loss clinic, and in-patient floors.¹³ Observation occurred within spaces in which the patient-provider relationship is learned, formed, and discussed. These spaces include patient exam rooms, hallways, classrooms, and meeting rooms within the hospital. I was allowed access to all spaces to which the medical professionals I observed had access.

I observed the conversations and non-verbal communication held between patients and providers, attending physicians and residents, and multiple physicians. I considered questions such as: what are providers saying, what are they doing, and what body language they are using? When they walk into a patient's room where do the providers first look? How are the spaces in which I am observing this relationship organized? No identifying information about patients was documented to protect patient privacy and observe HIPAA (Health Information Portability and Accountability Act of 1996) regulations. I do have to recognize that some of these conversations may have been censored because I was present, making it difficult to collect data on less ideal patient interactions.

After initial data collection through observation, I performed unstructured interviews. These interviews were performed with individuals with whom I was able to speak multiple times throughout the duration of the research project. The purpose of the conversations was known both by the interviewees and me, but there was no specific guide to the conversation. Establishing rapport with the medical providers through unstructured interviews was essential to the success of this research. Semi-structured interviews were used to collect final data. These interviews provided me with greater insight into what I had previously observed as well as the providers' viewpoints. Pseudonyms are used.

Context

The Hospital. Hospital Z is located in downtown Kansas City and is one of many hospitals throughout the Kansas City-Metro area that are part of the Hospital Group System. It is a faith-based care hospital system with over 600 physicians representing over 60 medical specialties. The hospital is a teaching hospital for students at a local medical school. The current downtown hospital has over 600 in-patient beds in various units, such as the emergency department, intensive care, and rehabilitation. On the hospital campus, there are also outpatient clinics. These specialty outpatient clinics include cardiology, geriatrics, plastic surgery, weight loss, and dermatology. The outpatient clinics are physically

12. The assignment to specific clinics within the hospital was completely random. I did not give preference to particular clinics or select the clinics in which I wished to observe. The internship program directors assigned me the following clinical rotations: Geriatrics, Surgery, Emergency Medicine, Internal Medicine, Cardiology, and Dermatology and Plastic Surgery.

13. The program was designed to allow observation in a variety of different clinics. Although assigned to six different clinical rotations, each rotation had a specific schedule with time assigned to observe a variety of physicians in a variety of clinical spaces.

connected to the main hospital building by hallways and walkways.

The Physicians. The majority of the physicians observed and interviewed were Caucasian¹⁴ male medical doctors (M.D.s).¹⁵ I interviewed six Caucasian female physicians and one female nurse practitioner. The interviewed physicians ranged in age from thirty-two to sixty-six. All of the physicians in this study received their medical degrees from United States medical schools and were currently practicing as a physician in the Alphabet Hospital Group Health System. Each physician trained in a different medical specialty and had a unique understanding of medicine and his or her role as a protector of patients. Each physician employed different methodologies to achieve this role. Although only three case studies of physicians will be presented here, I observed and interviewed many more physicians.

The Physician as an Actor

Physicians, I argue, are fluid actors who have the ability to adapt during interactions with patients to provide that patient with a unique type of protection. Although they are guided by an ethical code, have predetermined duties, and practice in rigid environments, physicians interact and negotiate with their own understanding of medicine and what it means to be a protector. The case studies that follow exemplify this idea.

Dr. Jacob Harvey, M.D.

Dr. Jacob Harvey is a sixty-six-year-old physician who specializes in Geriatric medicine. He practices in the geriatric care clinic providing care to a specific population of patients, aged seventy-five or older. He was trained in internal medicine and completed a fellowship in geriatric medicine. Geriatric medicine has a unique culture. The term “geriatric specialist” is, in a way, a misnomer. It is true that physicians practicing geriatric medicine are trained to care for a specific population, but they must maintain a wide breadth of knowledge about the health of this population. Unlike a cardiologist or other specialist, a geriatric care physician must recall information about all body systems rather than a single one. Dr. Harvey must understand his entire patient. This becomes an important part of how Dr. Harvey acts as a protector of his patients.

Geriatric patients represent a unique subset of patients within the hospital.¹⁶ Dr. Harvey explained caring for this patient population, saying:

14. Due to the clinical rotations to which I was assigned, I was unable to observe or interview physicians from marginalized background to understand their interaction with the cultures of medicine. This will be important for future research.

15. This is as opposed to a Doctor of Osteopathic Medicine (D.O.) who may interact with medicine in a unique way as he or she practices within a unique culture of medicine.

16. In the general population, individuals ages 75 and older are not necessarily unique. In the context of the hospital, though, they are because they require a special type of care.

For geriatric patients, the long term just isn't there. I'm not worried about their potential for cholesterol build up in thirty years because the truth is they just won't be here. Instead, I want to have conversations with them about how they can continue to be independent. Their independence is so important. I want them to get what they need from me so that they can do what they want to do in life. It is about finding a balance between making the last years quality, while also minimizing discomfort. (J. Harvey, personal communication, June 7, 2017)

Because the patients in this population are at least seventy-five years old, preventative care—to the extent in which it may be emphasized in pediatric or primary care medicine—is not a priority for Dr. Harvey. Instead, his primary goal is to ensure that his patients are receiving care that supports their independence while also managing any chronic diseases. The space in which Dr. Harvey functions is designed to support the culture of biomedicine—a culture focused on protecting patient autonomy. The following is a description of the geriatric clinic:

The Geriatric Care clinic is found in the medical office building attached to the main hospital, but only a single hallway attaches the medical office building and main hospital. As one walks down this hallway, a clear distinction can be made between the main hospital and the medical office building. The hallways of the medical office building are much narrower and dimmer than those of the main hospital. The floor is carpeted, and the walls are covered with warm-toned paint and artwork. Office doors line the hallway. Each is labeled with the clinic name and/or the names of physicians practicing in that clinic. One enters the Geriatric clinic in the patient waiting area. On the wall opposite the entrance, there is a reception desk and a door, which leads to another hallway. Down this hallway are both the examination rooms and physician offices. Examination rooms are labeled with letters, while the physician offices are labeled with the name of the physician. Exam rooms contain countertops filled with educational materials, a sink, and cabinets with supplies, an examination table, a computer, a rolling stool, and two chairs.

Here, it is clear that the focus is on the education of the patient and patient autonomy, or the ability of a patient to make his or her own decisions regarding his or her health care. The layout and environment of these clinical spaces allow for private meetings between physicians, patients, and the patients' families. Physicians are able to consult with patients, provide patients with information,¹⁷ and allow patients to take their time making decisions regarding treatments. This space directly supports the goals of Western biomedicine. The culture of biomedicine has evolved in response to ideas of bioethics as laid out by the AMA (2016). Biomedical culture “has come to rely on the fundamental assumption [that] the unit of care (and the unit of value) is the autonomous self-directing

17. In these spaces, physicians educate patients both verbally and with written material (i.e. pamphlets).

patient” (Beever & Morar, 2016). Physicians are expected to respect the autonomy of the patient and foster an environment in which this autonomy is central to the physician’s desires. Dr. Harvey acts in conjunction with this culture. In addition, his medical training emphasizes understanding the entirety of a patient. By working within this understanding of medicine, his focus is not on how he can prevent potential illness, but, instead is on how he can preserve his patient’s autonomy. He desires only to subject patients to treatment necessary for their current health rather than treatments that may degrade their quality of life without significant benefit to their health.

This same conceptualization of medicine has led Dr. Harvey to recognize that not all of his patients need or desire the same treatments. Many times, he seemingly gave complete autonomy to his patients to direct their treatment plan. After presenting his recommendation and the reasoning for that recommendation, Dr. Harvey allowed the patient to make decisions without any more of his input. This is exemplified in the following interaction:

—Patient: “I know you are going to tell me to take those pills, but I’m just not going to do it. The more medications you take, the more you are going to need.”

—Doctor: “We’ve gone over this before. You are at risk for heart disease because of your high cholesterol levels. I recommend that you start taking Statins to help lower them, but it is your choice. You know my stance, but it is your decision.”
(J. Harvey, personal communication, June 5, 2017)

By using language such as “we ought to do this” and “if I were you, I would do this,” Dr. Harvey was providing his recommendation in a way that allowed the patients to believe that they, rather than Dr. Harvey, were directing their care. He presents information in a neutral way. It appears that Dr. Harvey is protecting his patient’s autonomy and fulfilling the expectation of biomedical culture to place decisions in the hands of the patients. He hopes to ensure that patients are able to make educated decisions about their health and then allows those patients to make them on their own. This negotiation with the patient, though, reinforces Dr. Harvey’s position of power. The patient cannot dismantle his medical reasoning. He has the knowledge that the patient¹⁸ lacks to make medical decisions. In reality, a patient is not making the medical decisions but instead choosing if he or she will follow the doctor’s decision or not. Dr. Harvey will not waver from his position of power, because he never loses the ability to make the medical decision. He protects his own position of power while presenting his recommendation in a way which appears to give the patient full autonomy. In order to have full autonomy, though, a patient would have had to receive no advice from a physician. This dichotomy presents a tension within the patient-physician relationship. The obligation to protect the autonomy of the patient and the desire of a physician

18. It cannot be assumed that all patients lack knowledge of medical science. For the general patient, however, the physician will be more educated in these matters than the patient.

to retain his or her power¹⁹ opposed each other. Dr. Harvey negotiated with his patient in a way that maintained both.

In some instances, the obligation of the physician to protect the autonomy of the patient and the desire of a physician to retain his or her power will function together. For example, when a breast cancer survivor scheduled an appointment because she was concerned about an inflamed area on her arm, Dr. Harvey extended his power as a physician to fulfill the patient's request. The following interaction took place:

—Patient: “So, I’m here because I found something that just doesn’t feel right. I went back and forth on if I should come in to see you. I think I’m exaggerating what I am feeling, but if my cancer is back, I just need to know.”

—Doctor: “I’m glad you came in to see me. I understand feeling over cautious and it is a good thing that you are. I think that this is just a cyst, but how about we do an ultrasound to be sure.”

Patient: “Does that mean you actually think it is something more.”

—Doctor: “Absolutely not. I wouldn’t normally order this, but in your case, I do not want you waiting for six months to see if it goes away or not. You’d spend the whole time worried. Let’s just put you at ease. I am your doctor, and this is my job. We’ll get the test done and I’ll be sure to call you personally with the results.” (J. Harvey, personal communication, June 8, 2017)

By ordering more tests than he deemed necessary, Dr. Harvey was attempting to provide his patient with ease of mind. He knew that if he told her to wait six months to see if the area became larger, that this patient would spend the entire time worrying about relapse.²⁰ It is common for patients of western biomedical practices to turn to diagnostic testing to lessen fears of illness or disease. Patients depend on diagnostic test results rather than a physician's experience and expertise to determine if they are healthy or ill. A positive test result elicits fear of the impending prognosis, while a negative test result instantly works to ease a patient's worrying. Because biomedicine relies so heavily on technology, technologies, such as diagnostic tests, have become the ultimate dividing lines between being healthy or ill.

To help lower medical costs, the AMA cautions against the overuse of diagnostic testing. According to AMA guidelines (2016), it would be acceptable in the situation above for Dr. Harvey to simply tell the patient that he was confident the patient had a cyst and to recheck the spot in six months. Dr. Harvey, though, defines his role as a protector of both physical and mental health. He recognized the constant worrying of this patient as problematic. He negotiated with the ethical code and his own understanding of his role in medicine to come to a decision about how he would act. He, acting in a position of power, is able

19. Because Dr. Harvey practices in a space that does not directly provide a physician with power, part of his negotiation with the patient must involve maintaining the power that he does have. Physicians in spaces similar to the ICU may not have to do this.

20. Dr. Harvey explained later that this would be the normal course of action.

to order these tests with minimal explanation as to why the test is needed. The patient, expressing her role as an autonomous individual, is asking for the extra diagnostic tests. Dr. Harvey is manipulating the understanding of diagnostic tests within biomedical culture. By exploiting the patient's understanding of what it means to be healthy and ill and his power as a physician, Dr. Harvey is able to act in a way which reinforces the idea of him as a protector. Dr. Harvey explains his reasoning for ordering the extra diagnostic testing in order to emphasize to the patient that she is a special case. By using language such as "I wouldn't normally do this," he hopes to create a relationship in which the patient understands that he is fully committed to his role as the patient's protector.

The physician's role as a protector has been cemented in the culture of biomedicine.²¹ Patients expect their physicians to fulfill this commitment. Sometimes, though, physicians do not meet the expectations of their patients. On at least one occasion, a patient expected Dr. Harvey to call after she was hospitalized from a fall. At her next appointment, she made it clear that she was disappointed that he neglected to check in on her. After her appointment, Dr. Harvey explained the following:

Could you tell that she was upset with me? I told you before that patients think, 'you are my doctor and I am your patient,' but what they don't realize is there are all these other patients that are mine. It is an intimate relationship for them. I try to do my best, but sometimes it gets really hard. (J. Harvey, personal communication, June 8, 2017)

Physicians must find a balance in their role. They act as a protector to each patient but must identify the extent to which they act in that role; they must determine the boundary of their relationship. When the boundary established by the patient and the one established by the physician do not fall at the same place, there can be a disconnect that creates tension in the patient-physician relationship.

In each of the three cases presented above, Dr. Harvey determined a boundary of protection. The boundaries were not rigid or the same for each patient. Instead, some extended further than others. For one patient, Dr. Harvey emphasized the fact that he was that patient's doctor. He used language that made it seem as if she were the only patient he had, but, with a different patient, he spoke about how he could not fulfill her expectations because he had many other patients about whom to worry. And in another case, Dr. Harvey tightened the boundary by allowing the patient to choose to accept his recommendation or not. The boundaries were continuously negotiated through each encounter that he had with his patients. Past encounters influenced how he chose to behave during current meetings and the current meetings dictate how he behaves during future appointments. His assumptions about how a patient would respond to

21. Furthermore, because biomedicine is widely accepted as part of Western culture, the role of a physician as a protector is firmly rooted in Western culture as a whole.

his behavior decided where his boundary with that patient laid.²² Dr. Harvey constantly negotiated with his understanding of his medical specialty, the spaces in which he functioned, the culture of biomedicine, and the patient's expectations in determining the boundary of his protection.

Dr. Martin Dunlap, M.D.

Dr. Martin Dunlap is a forty-eight-year-old physician specializing in cardiovascular disease. He works as a hospitalist, consulting with patients throughout the hospital. He trained in internal medicine²³ and completed a fellowship in cardiovascular disease. Cardiovascular disease is a specialty concerned strictly with the cardiovascular system. Because Dr. Dunlap works as a hospitalist, he is consulted to care for patients staying in the hospital on the inpatient floors. He may be called for a consult on a patient who had an acute cardiac event or for a patient who experienced an acute event in another organ system, but that event impacted the health of the heart. Dr. Dunlap functions within a culture of medicine focused on treatment and prevention of future acute cardiovascular events rather than diagnosis.

Cardiologists who practice as hospitalists, such as Dr. Dunlap, have different experiences than geriatric physicians and other primary care providers. Unlike clinicians with hospital privileges who may follow a patient's progress both in the hospital and in their outpatient clinic, Dr. Dunlap only sees patients for the duration of their hospital stay. Compared to clinic physicians, Dr. Dunlap interacts with his patients for a relatively short amount of time. During this time, Dr. Dunlap and other hospitalists must establish a trusting relationship with the patient and assert their role as a protector. Dr. Harvey and other primary care physicians are able to rely on their past encounters to determine how to best fulfill their role as protector. Because hospitalists such as Dr. Dunlap have no or few past encounters with their patients, they must rely on other physicians' encounters to establish boundaries with this patient. This requires Dr. Dunlap to have great confidence in his relationship with other clinicians. Dr. Dunlap's ability to protect is interwoven with other physicians. When he is first assigned a patient for a cardiovascular consultation, Dr. Dunlap will review the patient's chart to determine what primary care or other long-term doctors a patient is seeing. He will ask questions such as "have you seen this doctor?" If a patient sees a physician with whom Dr. Dunlap has a relationship, he will positively acknowledge this to the patient. For example, when Dr. Dunlap first met one patient, he immediately told the patient the following:

22. It would be interesting to expand on this research to ask if physicians recognize the negotiations that they have with their understanding of medicine and patients. In some instances, the physicians appeared to recognize this. They made commentary about why they acted in a certain way with a patient. I do not believe Dr. Harvey recognized his negotiation of boundaries. During conversation with him, he mentioned, "people make assumptions about the geriatric population." He went on to say that he works not to make assumptions. This is interesting, though, because his negotiation of boundary is based on assumptions that he makes about his patients.

23. Dr. Harvey also trained in internal medicine during residency. For many specialties, this is a necessary step in order eventually to complete a fellowship in the desired specialty.

—Doctor: “So I know that you have been seeing Dr. Shah and I know his team has been following you for a while. They are a good group. I want to run my ideas by them first, but this is what I think I am going to do. . . .” (M. Dunlap, personal communication, June 26, 2017)

Dr. Dunlap accomplished two things through the acknowledgement of other doctors. First, he is attempting to demonstrate to the patient that he is acting in a cautious manner. He does not know the patient’s history in depth, so consulting with doctors who do allows him to ensure that he did not miss significant information in the patient’s chart. By identifying specific doctors that the patient has seen, the patient can feel confident that Dr. Dunlap reviewed his or her file extensively and knows any medical history that may be important to his or her current medical case. But more importantly, Dr. Dunlap recognizes that the boundary of his own specialty allows his relationship and protection over a patient to extend throughout only the present. His specialty establishes a boundary that requires the circumscription of other physicians. He must include other physicians in his care of patients so that his boundary of protection is expanded.

Second, he is acknowledging his understanding of his protective role for the patient. Dr. Dunlap’s role is to care for a patient’s cardiovascular health during the acute event that hospitalized him or her. After that acute event has subsided, Dr. Dunlap will not act as the patient’s primary cardiologist. He is a short-term doctor and provides short-term protection. Because of this, Dr. Dunlap must negotiate with the patient a boundary of care; he must delineate where his care stops and the care of a long-term physician begins. Dr. Dunlap reinforces patients’ relationships with their other physicians in order to do this. By mentioning other doctors, Dr. Dunlap provides a subtle reminder to the patient that he is not their long-term care provider. “I do this,” Dr. Dunlap explained, “to make sure patients know that I am working with their doctors who know them and their history better than I do” (M. Dunlap, personal communication, June 27, 2017). He is protecting the patients’ relationship with their long-term physicians. Dr. Dunlap is finding the balance between establishing trust with the patient and creating a boundary between acute and chronic care.

Throughout encounters with patients, Dr. Dunlap continuously used “we” language. This “we” language is ambiguous (Rhine, 2015). The patient may hear it and assume that Dr. Dunlap is placing himself and the patient on the same decision-making level. In reality, Dr. Dunlap is placing himself on a team of the patient’s other doctors. By leaving the pronoun ambiguous, though, the patient is allowed to seem themselves on the team of doctors. The patient feels a sense of autonomy. Ambiguous pronouns such as “we” allow Dr. Dunlap to make claims that are not only his but an entire team’s claims. Dr. Dunlap is placing himself on a team with the patient and the patient’s other doctors. On this team, he positions his wishes as third while the wishes of the patient and the other doctors are positioned as first and second. This reinforces his boundary of protection. He is present for

specific input on the condition of the heart of the patient, but the others on the team are the real decision makers because they are the ones who will be responsible for the extended care of the patient.

For similar reasons, much of Dr. Dunlap's time with patients is spent explaining treatment options. His explanations are thorough and complete. The following gives Dr. Dunlap's reasoning for doing this:

I like to make sure that I explain all the possible options to my patients. A lot of them I am seeing for the first time, so I need to make sure that they know that I am knowledgeable and make them feel like they are autonomous in the decision and I am not just telling them what to do. I mean I would have a hard time letting someone I've only just met tell me exactly what to do about life-altering options with huge risks without all the information. I am careful to go over all the risk and benefits and the balance. I explain the details, everything I can. Things that I would never recommend, but at least it is on the table. Then when I tell them what I would do. They know that I have thought through it. (M. Dunlap, personal communication, June 27, 2017)

For Dr. Dunlap, medicine is not simply the doctors telling the patient what to do. Instead, it is about presenting full explanations of drugs and potential treatment options. Dr. Dunlap is only consulted after others have performed initial diagnostic testing. He was not present for the conversation about diagnosis, so his boundary of protection only extends to allow him to determine possible treatment options.

The only reason Dr. Dunlap is brought into the conversation is because another physician asked him to be there. Just as before, his practice of medicine is dependent on his relationship with the physicians around him. Dr. Dunlap has been asked to consult with patients in order to provide them with possible treatment options. In order to maintain his relationship with other physicians, Dr. Dunlap chooses to discuss every detail of all potential treatment options, risk factors of those options, and future preventative measures with his patients. This proves to the other physicians that he is thorough and careful in his practice. The entire time he is doing this, he is still in dialogue with the other physicians. Dr. Dunlap hopes this performance works to reinforce a positive relationship with the other physicians.

Dr. Dunlap's protection of patients is relatively short term. Because of this, his practice of medicine is reliant on other clinicians. If he does not maintain his relationship with other doctors, his boundary of protection will be non-existent; he will not have patients to protect. He must use strategies that protect patient autonomy while giving up some of his own. His boundary of patient protection is relatively small and dependent on others. There is an irony in this. He partakes in a performance of passing his own autonomy to other doctors and the patient in order to maintain his ability to protect patients. He gives up some of his autonomy so that he can maintain some of it. Dr. Dunlap continually negotiated

his relationship with other doctors in order to maintain his boundary of protection as an acute care physician.

Dr. Dina Derby, M.D.

Dr. Dina Derby is a fifty-three-year-old internist. She works as a hospitalist and focuses on internal medicine specifically for those in critical care or with pulmonary disease. She received her training in internal medicine and completed a fellowship in critical care. As an internist, Dr. Derby is responsible for coordinating the care of a patient who is in the hospital for an acute event. She requests consultations with other hospital specialists, if needed, and works to verify that the treatment plans of all of the specialists work together.

Like Dr. Dunlap, Dr. Derby is also a hospitalist who is assigned new patients on a daily basis. Dr. Derby's main concern is to determine the patients' needs and make the patients most comfortable while they are staying in the hospital. For many, staying in the hospital can be an overwhelming experience. One man was not happy to be in the hospital and was not cooperating with nurses or the doctors. Dr. Derby was called in to speak with the man.

—Patient: “They all really pissed me off. I told them I didn’t want to do that, and they tried to get me to do it anyway.”

—Doctor: “I know. I apologize for that. We will wait until your daughter gets here. Does that make you feel better?”

—Patient: “Yes I want to wait for my daughter. She helps me.”

—Doctor: “Tell me a little bit about your daughter. Is she from around here?” (D. Derby, personal communication, July 10, 2017)

Dr. Derby was able to realize that this patient's family, specifically his daughter, made him feel the most comfortable. He was accustomed to his daughter being at medical appointments, so being in the hospital without her made him anxious. Dr. Derby's ability to recognize this was integral to the success of his treatment. Dr. Derby made sure that doctors and nurses knew that if they needed to run a test or ask questions, it needed to be done when the patient's daughter was there. Patients have other protectors besides their doctors. In negotiating her protective boundary, Dr. Derby had to account for the other protectors that a patient may have had. She must adopt the other protectors' viewpoints in order to provide the best care for a patient. Dr. Derby was able to protect the patient from an experience with which he was not comfortable. She was able to empathize with the way he was feeling and adapt her medical practice to match those feelings.

This was a common theme for Dr. Derby. In order to teach the medical residents and students working with her, she had all of them try different liquid diets that some patients are required to have. On this diet, patients can only have liquids of a certain consistency. To have water on these diets, for example, thickening powder must be mixed in with the water to make it the consistency of honey or nectar. She explained her reasoning for doing this:

Now, why am I having you taste all of this? I want you to understand what you are doing to patients when you give different orders. If you don't understand it yourself, then you are going to put patients through some not very fun things. It's important that we have empathy and understand what we are forcing upon them when we restrict their diet like this. You can't just do something blindly. I just want you all to be sure to think about the risk/benefit balance and quality of care you provide. (D. Derby, personal communication, July 10, 2017)

Dr. Derby was emphasizing the importance of empathizing with patients. She explained how one must put oneself in a patient's position to understand his or her experience. Working to create the best experience for her patients is central to her decision-making process. She is there to care for the patient. She touches the patient on the arm and uses language such as "this is what we are here for" to emphasize to the patient that he or she is the first priority. The use of the ambiguous "we" ensures that a patient's other protectors are included in the care process.

In one instance, Dr. Derby gave a toothbrush to a patient after realizing the previous day that the patient did not have one. Before leaving the room, she pulled the toothbrush out of her white coat pocket and said, "You can't go another night without one of these" and left the toothbrush on the patient's nightstand. This, a simple empathetic gesture, changed the patient's experience. Dr. Derby stepped outside of her "normal role"²⁴ as a protector; she reached outside of her "normal" boundaries to provide the highest quality care to the patient. She entered into a motherly type role with her patients. This was striking as Dr. Derby was one of the few female physicians interviewed. In the United States, women are frequently described as "motherly."²⁵ They are expected to be more caring, protective, and empathetic than their male counterparts. In comparison to the male physicians observed, Dr. Derby most embodied the motherly figure. This is direct evidence that the cultural ideas of the society in which physicians practice influences how they act in their role.

Dr. Derby extended her boundary of protection only to where it met that of a patient's other protectors. She allowed full autonomy of the other specialists working to determine treatment plans for a patient and only intervened to ensure that their care plans were in sync. She included a patient's non-clinical protectors, such as family members, in the circle of protectors. Dr. Derby acted as a protector only in areas where there was no protector or in areas where the boundaries of protectors overlapped. Her boundaries were in constant flux as she determined where protection was needed or where the boundaries of protection of two individuals needed to be negotiated.

24. I use quotation marks here to emphasize that, in reality, there is no "normal" role for a physician as a protector. Each of the physicians examined have performed in the role as protector, so to assign a "normal" way of doing this would be impossible. I contrast Dr. Derby's act of giving the patient a toothbrush to the idea of a "normal" role for a physician in order to show that the patient did not expect this of Dr. Derby.

25. I use quotation marks here to emphasize by using the "term" motherly to describe the qualities of being empathetic and care; one is making generalizations about the nature of all mothers that may not be accurate.

Conclusion

Physicians practice under the Code of Ethics described by the American Medical Association (2016). They are obligated to uphold specific ethical ideals. It is these ideals that establish the role of a physician in the patient-physician relationship as that of protector. Although there is a prescribed role for physicians, there is no dictation of how an individual physician must fulfill that role. Instead, physicians negotiate with the ethical code and the culture of their specific medical specialty to create their own understanding of medicine. It is this understanding of medicine that influences what decisions a physician makes within his or her role as protector.

Most importantly, though, physicians do not simply interact with their understanding of medicine to make random decisions regarding their performance of protection. Rather, a physician's unique understanding of medicine guides the formation of his or her boundaries of protection. It is these boundaries that dictate how physicians act within their role as a protector. These boundaries are fluid and dependent on the specific patient with which the physician is interacting. Physicians are not single-mindedly approaching healthcare, but, instead, they are interacting with their understanding of ethics, medicine, their environment, and the boundaries of their role when making care decisions.

Both external and internal entities view medicine as a "culture of no culture" or institutions or group of individuals that tend to "foster static and essentialist conceptions of 'culture'" (Taylor, 2003a). My findings stand in direct contrast to this idea. Physicians are, in fact, not static, but dynamic individuals who are in constant negotiation with their own culture of medicine. It is this negotiation that leads to the establishment of a protective boundary. Physicians decide, based on prior interaction with patients, their relationships with other physicians, and their ethical obligations to patients, where those boundaries lie. It is the examination of this negotiation that shows that physicians should not be defined as static individuals fostering a "culture of no culture" (Taylor, 2003a). Instead, physicians should be seen as part of a fluid and dynamic interplay of cultural and ethical understandings.

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