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Commentary

A Doctor's First, and Last, Responsibility is to Care

Comment on "Denial of Treatment to Obese Patients—the Wrong Policy on Personal Responsibility for Health"

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Abstract

The obesity epidemic raises important and complex issues for clinicians and policy-makers, such as what clinical and public health measures will be most effective and most ethically-sound. While Nir Eyal's analysis of these issues is very helpful and while he correctly concludes that "conditioning the very aid that patients need in order to become healthier on success in becoming healthier" is wrong, further discussions of these issues must include unequivocal support for safeguarding the fundamental moral basis of the doctor-patient relationship. Regardless of any patients' failures to demonstrate effective responsibility for their own health, each patient needs and deserves a physician whose caring is never in doubt. Policy-makers need to ensure that our health systems always make this a top priority.

Keywords

Obesity, Doctor-Patient Relationship, Caring, Moral Responsibility

"In every house where I come I will enter only for the good of my patients."
Oath of Hippocrates

The obesity epidemic is a growing public health crisis that raises important, profound, and complex questions. The problems associated with the obesity epidemic include not only the serious health problems that obese patients suffer from, but also the rapidly-growing costs to society of caring for obese patients and the many medical complications that their obesity causes. Solutions to the epidemic that will be both effective and ethically-sound will not be easy.

Creating incentives ("carrots and sticks") for patients to improve their health makes eminent sense from a policy perspective. As Eyal (1) correctly points out, these incentives need to be as evidence-based as possible. But as he also correctly points out, some kinds of incentives can and should be rejected up front, including "the absurdity of conditioning the very aid that patients need in order to become healthier on success in becoming healthier". If we agree, as I do, imposing that kind of incentive is "absurd", we are still left with questions about what other "incentives" might be appropriate. As we explore those, complex issues about personal responsibility, stigma, and social justice must all be considered. Even the very idea of "incentives" is complex. Positive incentives in the form of rewards ("carrots") for doing or achieving something good often sound appealing, and negative incentives ("sticks") often less so. "Rewarding" people is usually intuitively more attractive than "punishing" them, but positive reward systems can leave those who fail to "earn" the reward demoralized, and thus worse off than if no reward system existed. Would that count as a form of "punishment"? I find that even trying to answer this question is very complicated.

But sometimes the more complex an issue is, the more important it is to step back and remind ourselves of things that are actually quite simple and fundamental. In medicine, there is nothing more fundamental than the nature of the doctor-patient relationship, and what a patient should expect when she/he enters the doctor's office.

When a patient comes to see a doctor, she/he needs to know that the doctor has one, and only one, overriding concern: how can I use my medical knowledge and skills to help you? In that office, during that visit, any "conditions" that the doctor imposes on that commitment to help, threaten the very nature of medicine as it has been practiced for millennia.

This does not mean that doctors should never impose conditions on the help they offer, but any such conditions should be in the service of an unconditional commitment to try to help, and conveyed in a way that deepens the patient's confidence that the doctor cares only for her or his welfare. And unless "carrots" and "sticks" can be shown to be compatible with deepening that confidence, I would ban that language, and that mindset, from the doctor's office.

Since I often find discussions of these issues unhelpfully abstract, let me give a concrete example. Caring for patients with alcoholism can be very difficult. All my medical training, lectures, seminars, journal articles, and books taught me that alcoholism is a "disease", that "blaming" patients for having a "disease" is not only unfair, but therapeutically counterproductive. And yet when I was with a patient who would not (could not?) stop drinking, I found it almost impossible to resist the temptation to blame the patient. Yes, alcoholism is a "disease", but I also believe that continuing to drink often (? almost always) includes at least

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some volitional component that is under the patient's control. If the patient does not take some personal responsibility for that, then cannot I as a doctor at some point refuse to care for him?

Early in my practice career, an important clinical mentor and role model, a physician deeply dedicated to caring for patients with problems with alcohol, taught me that sometimes unconditional caring for his patients led him to refuse to see them if they arrived for an appointment intoxicated. One morning a patient of mine arrived for her visit and I smelled alcohol on her breath. I told her that, and she adamantly denied she had been drinking. Adapting my mentor's practice, I told her that it was very painful for me to hear her say that, since I could so clearly smell the alcohol. Further, I told her that if she came to an appointment with me drunk, then there was no way that I could succeed in helping her the ways that I wanted to, including helping her manage her many medical issues, including her hypertension that was worsened, if not entirely caused by, her drinking. I told her that there was no point in continuing the appointment, but if she came back the next day sober then I would squeeze her into my already-full schedule so we could work on the medical issues she needed my help with. She left angry, but returned the next day, denying again that she had been drinking, refusing to talk about alcohol, but saying she needed her prescriptions for blood pressure, which I refilled.

A year later, at a routine office visit, I asked her about her drinking. She told me that she had not had anything to drink for a year. I expressed surprise (and obviously to her, also some doubt). She then reminded me of that earlier visit, when I refused to see her because I had said I thought she had been drinking. She did not admit that I was right, but told me that she had been deeply moved by how much I cared, and that she had never had anything to drink since.

The point of this story is only partly about the "outcome". Outcomes matter, but the doctor-patient relationship is not only about outcomes. The relationship itself, whether the "outcome" of that relationship is better health or not, has intrinsic value. It is not only a means to the end of better health. In my current clinical practice, focused exclusively on palliative care, I am often powerless to affect the patient's outcome, at least in the sense of whether or not the patient will die. I am sometimes even powerless to make much of a difference in important aspects of the patient's suffering—pain and other physical symptoms can almost always be adequately controlled, but sometimes the "existential" suffering that comes from knowing that you will die soon is refractory to even the most skilled, emotional, psychological, or spiritual care. But even then, every patient needs and deserves a doctor who they know truly cares. The doctor-patient relationship itself is sometimes all we have to offer, and failing to offer that, no matter what else is going on, would be to fail in our most fundamental obligation to our patient.

Conclusion

Patients with obesity who continue to gain weight, patients with alcoholism who continue to drink, patients with lung cancer who continue to smoke—all of these raise difficult clinical, health system, and policy challenges. But every one of these patients needs and deserves a doctor, a doctor they know cares. And every policy-maker needs to ensure that our health system will always make that a top priority.

Ethical issues

Not applicable.

Competing interests

The author declares that he has no competing interests.

Author's contribution

LF is the single author of the manuscript.

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