

Medical professionalism requires that the best interest of the patient must always come first

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As one of six key elements of high-quality care,¹ patient-centred care puts patients first. So too, for example, does the 2002 Physician Charter, endorsed by over 130 medical organisations worldwide.² The Charter's first principle, the 'primacy of patient welfare', has been the basis of medicine's contract with society since at least the time of Hippocrates. This principle also finds explicit support in New Zealand primary care, for example through the Patients First partnership. How could anyone seriously doubt that patients' interests are paramount in health care?

One reason for such doubt is that people do not always say what they mean. Even when speaking in support of patient-centred care, clinicians may tend to exclude patients as active partners by using clinician-centric terms such as 'medical error', 'provider continuity' and 'pay-for-performance'.³⁻⁵ Moreover, the individualistic focus of patient-centred care contradicts clinicians' engagement with both the epidemiological pedigree of evidence-based medicine (and its inference of individual effects from average group effects) and policy initiatives such as New Zealand's Primary Health Care Strategy. This Strategy has increased the tension that clinicians can face between personal and population health care delivery. Seduced into adopting the potentially adversarial role of a 'double agent',^{6,7} primary care clinicians have been expected to advocate for patients while implementing government health policy that confers much larger benefits to the community than to most individual patients.⁸

The alternative to putting patients first is not clinician self-interest or a communitarian ethic. What is needed instead is an inclusive and interactionist approach informed by a minimal principle of equality. This ethical principle requires 'equal consideration of equal interests' as advocated by philosophers such as David Hume and, more recently, Peter Singer. For the sake of clarity, I will explain this principle for the dyadic case of the clinician-patient relationship. On the basis of their personhood, patients and clinicians are moral equals. Their equal interests include being treated, and treating others, with dignity. Each of these parties has a moral right—and, within the limits of what individual circumstances can allow, a moral responsibility—to help satisfy these equal interests through giving and receiving care. One justification for this right is moral sentiment theory, which explains the entitlement to equality in terms of 'the faculty of empathy and the fact of interdependence'.⁹ Equal consideration of equal interests is also important because it can enhance the consequences of medical care.

The greater the lack of consideration of equal interests, the greater the capacity for an imbalance and misuse of power by clinicians—and indeed by patients, whose modern relationship with the clinician has increasingly developed through role convergence into an 'adult-adult' relationship. Such a relationship between the clinician and patient is characterised by mutuality of different but equally important sources of participatory power.¹⁰ However, in any clinician-patient relationship, subordination of clinician interests can harm clinicians and patients because the interests of both parties are integrally connected. For example, when clinicians feel tired, devalued and neglect their

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own health, patients may share the fallout. As Foucault¹¹ proposed, care of the self is required for ‘the proper practice of freedom in order to know oneself ... form oneself’—and so be able to care about others. Of course, sometimes the interests of the patient will trump those of the clinician, and vice versa. Stress may lead clinicians, for example, to ask patients to wait, or return for another visit. It can be seen, therefore, that equal consideration of interests does not necessarily require treating the patient and clinician the same.

Glyn Elwyn and I drew upon the principle of equality to frame our advocacy for a new, more egalitarian model of the patient–clinician relationship.¹² Characterised by reciprocated caring, this model is described by the metaphor of a ‘window mirror’,¹² wherein ideally the clinician and patient may see—and care for—both themselves and another person at the same time; and alternate the focus. The window mirror makes concurrently visible at least four directions of sight: clinician to patient, patient to self, clinician to self, and patient to clinician. These pathways intersect with each other, precluding the equal interests of either the patient or the clinician from coming first.

Recent support for the principle of equality comes from mounting evidence that a modern version of person-centred medicine has started to supersede patient-centred care. Defined as ‘a medicine of the person, for the person, by the person and with the person’,¹³ this model focuses centrally on people, including patients and clinicians, as moral agents. Through the construct of people-centred public health, it also responds—beyond clinical practice—to the interests of individuals in the context of their communities; and carries the imprimatur of over 30 international groups, including the World Health Organization, World Organization of Family Doctors and International Alliance of Patients’ Organizations.

Putting patients first helps neither clinicians nor their patients. Both of these parties, among others, are entitled to, and can benefit from, respect for a principle of equality that considers equal, interconnected interests in health care.

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