Director's Corner

We Have Both a Duty to Care and a Responsibility to Care: What Does that Look Like?

by Adina Kalet, MD, MPH

A good friend of mine is suffering. She recently underwent what is typically a relatively straightforward surgical procedure both she and her physician expected would correct a disabling problem and improve her quality of life. Instead, she developed a rare, perplexing, painful complication that significantly limits her mobility, interferes with getting a good night's sleep, and has not responded well to treatments. And she essentially has been abandoned by the surgeon who performed the procedure.

When, months later, it became clear that she was not going to recover as expected, the surgeon ultimately made a general referral to see a pain specialist and only referred her to physical therapy on the patient's request. He does see her in "follow-up" but focuses only on the immediate post-operative issues, not the new condition. When my friend reaches out to inform him of her progress and asks clarifying questions or for advice, the registered nurse on his team responds to her messages in a curt "just the facts," perfunctory manner. For a few months post-surgery, the office reached out to inquire about her progress through an imprecise and impersonal "app," though no one has expressed care or concern that her pain continues. In my book, this is abandonment and therefore unethical.

As physicians, we have both an obligation and responsibility to care for, with, and about our patients. Like other service providers, we have a "duty of care," which is a legal obligation requiring us to adhere to "standards of reasonable care while performing any acts that could foreseeably harm others." From this perspective, strictly speaking, my

friend's surgeon did his duty. And given the current fragmentation of health care into sub-specialties, he can argue that by ensuring post-operative wound healing, he is discharging his obligations. But this is not caring.

The Ethics of Care, developed by feminist scholars including Carol Gilligan and Joan Tronto among many others, holds that moral action goes beyond meeting standards – being objective and justice orientated – but centers on the relationships and connection with others, especially when they are vulnerable and require expertise. The Ethics of Care emphasizes the importance of attentiveness and responsiveness to the individual, and acknowledges the complexity of care taking. Rather than taking a narrow view on the obligation to refer my friend to a competent expert, I believe this physician had a responsibility to do the complex, skilled work of caring for her. He demonstrated no intention to do anything beyond his narrowly focused area of expertise.

When I told my friend's story to a mentor who is an experienced surgeon, he said, "*These are the patients you hold close, you give them your personal cell phone number, you respond and see them often until there is some resolution or even if there isn't one. You are in this relationship for the long haul.*" The wise and ethical physician makes the referrals, ensures the patient understands what needs to be done, has the difficult conversations, and "quarterbacks" the game until there is a resolution.

By any measure, my friend is a "good" patient. She takes medication as prescribed, engages in physical therapy with enthusiasm and commitment, listens carefully to the recommendations and advice of her physician, engages actively in decision making, and is extremely well informed. Luckily, she has a caring pain management specialist and access to friends and relatives who are in health care. I have advised her to move on and consider the surgeon who operated on her as she would any high paid tradesman rather than as her physician. This is terribly disappointing, but common.

To be clear, while this isn't likely "malpractice" it is, in my view, clinical incompetence. My friend's current predicament was not due to a mistake in judgement or poor surgical technique, but her physician did not take responsibility to relieve her suffering by actively, assertively, compassionately, and competently *caring for her*. To do this well, he would have needed a mature, internalized professional identity to help him make morally-informed choices in a therapeutic and caring relationship, especially when things got frustrating or went wrong. It would enable him to spend the time and make the effort to communicate with this patient directly, guide her to effective symptom relief and sincerely empathize with her situation. This is not easy - sophisticated clinical communication skills are required. These include being capable of actively listening, while accurately identifying and appropriately responding to emotions, all while conducting clinical reasoning and creative problem solving. These *are* learnable skills but require both a desire and practice to master. This physician is not trying hard enough.

All physicians need to take responsibility for caring for patients, *especially when* the going gets tough, vexing, perplexing, and challenging, like when a patient, who should have recovered, does not. In one way or another, managing chronic pain is the responsibility of all physicians. Central to effective pain control from the patient's point of view is being taken seriously, remaining hopeful and realistic, being listened to, and experiencing authentic empathy from a trustworthy physician or other health care professional. Anyone who has gone through childbirth understands that extreme pain - as long as it is going to be time-limited and will end with the birth of a healthy infant - can be "suffered" without medication, be well-tolerated, and can even be experienced as joyful when surrounded by trustworthy, caring, and competent health professionals. On the flip side, even mild to moderate pain can be unbearable when "suffered" alone or is a sign of loss of bodily integrity, increasing disability, or a terminal diagnosis. A mature and skillful physician has the potential to relieve suffering simply by staying in the relationship with the patient.

Modern medicine takes place within complex institutions and, even with the best intentions, the incentives can be perverse. If care and caring must happen within trustworthy relationships, then health care systems that divide the labor so that everyone works at the "top of their license," are dividing the patient. I worry that as a side effect of "team care," health care professionals are being encouraged, incentivized, or forced to destroy therapeutic relationships. This is why physicians must have a strong character and a moral compass-sense of agency, and masterful communication skills to remain "the patient's doctor" when there is rough going; staying put when it would be more comfortable to leave or send in someone else.

I have spent much of my career learning, teaching, and studying patient-physician communications. To motivate others to take this very seriously, I often point out that patients are more likely to sue a physician for "abandonment" of the type described here than for actual malpractice. I interpret this to mean that people will forgive mistakes, but not lack of care.

The patient described has reviewed this essay, and has given permission to share her story.

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