Doctor-Patient Relationships: When Is It Ethically Acceptable to End Them?

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Bioethics case study on doctor–patient relationship and ending a physician–patient relationship.

The doctor–patient relationship is the fundamental aspect of all medicine. People seek medical treatment or advice when they are sick and in need of help. Medicine is complicated and only becoming more complicated. So when a patient seeks advice from a healthcare professional, they are putting themselves in a vulnerable position.

How will they know that the medicine they are given will work? How do they know that surgery may not be the best option? How will they know what to expect next with their disease?

All of these questions rely on the doctor–patient relationship to be strong—and, more importantly, rooted in trust. Patients need to trust their providers, because without trust, medicine cannot work as intended. This makes keeping and maintaining trust extremely important.

Even from the beginning of organized Western medicine, the Hippocratic Oath recognized this and required practitioners to promise that whenever they went into a patient's home, they would enter for the benefit of the sick. And that what they saw or heard in the lives of their patients—whether in connection with professional practice or not—would be kept confidential.

But this does not mean that providers are entirely subject to their patients. Providers need to be able to act with their best medical judgment, and sometimes that requires

telling patients things they may not want to hear, no matter how true they are. Providers take an oath to give to their patients. So, when is it ethically acceptable to eliminate that relationship?

There are two major causes of ending a physician–patient relationship.

The first is when the patient makes threats to the provider or the provider's team. If there is a threat of violence against a healthcare worker, it is often seen as ethically permissible to stop providing for that patient. Healthcare workers should not have to risk violence to themselves or their families in the course of providing care.

The second is when trust is lost—or was never present at all. I remember working with a pediatrician and asking him, hypothetically, how he would respond to a patient who refused vaccines for their children. He said to me directly: "I would ask them to find another doctor."

I was a little struck by that, and when I asked why, he said: "Because it implies that the patient does not trust me. I believe in vaccines and in the benefits they provide. If my patient does not trust me on these, how can they trust me on even more challenging matters?

"And if they don't trust me, I cannot be a good doctor to them. I would recommend they find another doctor they can have that relationship with. So I would dismiss them, but I would also refer them to another provider—because that patient deserves to have a trusting relationship with their doctor. And if they are refusing vaccines, then they likely won't establish that relationship with me."

I found that deeply meaningful. It was ending a patient relationship, but only because of a lack of trust—making it impossible to provide proper care for that patient.

Healthcare workers should be able to trust that they can provide for their patients safely, but also with the kind of trust that is a necessary component of health going forward.