Responsibility vs Anonymity

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Today, much is made of the many changes occurring in medicine: DRGs, PPOs, PPNs, HMOs, malpractice, defensive medicine, and many others. Everyone is quick to place the blame—the lawyers, the government, the economic situation, or some other bête noire. I would suggest that we physicians and the medical system we have created are partly responsible for the situation in which we find ourselves and that we have the ability to shape the future.

In 1957, Michael Balint,[1] a Hungarian-born psychiatrist, described a phenomenon he labeled "the collusion of anonymity." At this time he was investigating the physician-patient interaction. He saw the collusion of anonymity as a phenomenon occurring often when a physician begins to consult with specialists. Balint states:

> In any situation of this kind, this is to say, when the patient offers a puzzling problem to his medical attendant, who, in turn, is backed by a galaxy of specialists, certain events are almost unavoidable. Foremost among them is the collusion of anonymity. Vital decisions are taken without anybody feeling fully responsible for them.

After reading Balint's description of this phenomenon, I began to look for examples in my own clinical experiences. Soon I realized that my experiences with those patients whose problems and whose care were upsetting or disturbing to me usually provided examples of the collusion of anonymity. I offer the experience I had with a pregnant woman, near term, who came to the obstetric emergency room complaining of breast pain. It quickly became clear that, in fact, the diagnosis was metastatic breast cancer. Surgical and oncologic consultants were contacted. After a two-week wait for a medical decision, a surgical procedure, or some definitive plan to be formulated and enacted, the patient during rounds one morning complained of hemiparesis and paresthesia. She was also areflexic below the waist. Over the next several hours consultants from seven different services were involved in the management decisions; however, no one completely accepted responsibility for the care of this patient. It was left to me, a fourth-year medical student, to explain what was happening to both the patient and the various health care providers who were involved over the next 18 hours, as a cesarean section, computed tomographic scan, myleogram, and emergency radiation therapy for spinal metastasis were performed.

Drs. Mold and Stein recently described in *The New England Journal of Medicine*[2] a cascade effect in the clinical care of patients. This cascade is described as

> . . . generally consisting of an initiating facts or factors, followed by a series of events that seem to be a direct result of previous events, often catalyzed by some characteristic of the system—usually anxiety. Physicians who are anxious about a patient's problem may be tempted to do something—anything—decisive in order to diminish their own anxiety . . .. When physicians feel incapable of managing their anxiety because they feel they do not know enough, they often turn to a consultant who, they hope, will gain control of the situation.

Anxiety, often the driving force or catalyst of the cascade, is diminished simply by a retreat into anonymity by involving a consultant, even if the consultant is not able to gain control of the situation.

The cascade effect described by Mold and Stein is only one of the many manifestations of the collusion of anonymity. Once one is sensitive to the phenomenon, it is not difficult to see it operating in medical education, in the medical community with regard to the "malpractice crisis," and in the nation, as for example with the space shuttle tragedy.

Having identified a problem, it is only right to propose a solution. Balint, unfortunately, does not have a simple answer. I believe the solution lies in personal responsibility.

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Most simply, responsibility in medical practice entails an acceptance of the relational model of patient-physician interaction. In an article entitled, "A Different Way of Doctoring," Dr. Lynn Carmichael[3] describes the components of the relational model as "affinity, evidence of a bond between the doctor and patient, intimacy, particularly as expressed by physical contact, reciprocity, or a sharing and giving and taking between the doctor and the patient, and continuity of care . . . an expectation that the physician will be there in the future when needed." Practically, responsibility in medical practice requires that each person has one physician clearly identified as his or her own physician. It further requires that that physician accept the "primacy of the person" as described by Fried[4] (ie, an individual's rights in health care). The first of these is the patient's right to a full and understandable explanation of what the problem seems to be (the right to lucidity). The second is the expectation of fidelity; in giving lucid information, the physician is noncoercive and understands what her or his own biases are. The third right is to autonomy; that is, patients, not physicians alone, make decisions. Specialists or consultants must then accept the importance of the relationship between patients and "their" physicians, and neither usurp the responsibility of the primary physician nor allow the primary physician to abdicate responsibility.

In summary, I believe that the medical profession needs to understand the danger posed by the collusion of anonymity. The system needs refocusing to emphasize responsibility to the fundamental goal of medicine, which is not solely curing disease, but the restoration of personhood. Persisting in a system that encourages or allows abdication of responsibility and assumption of anonymity will only promote the increasing narcissism of the profession and the further erosion of the real abilities that we have.

References

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