

What is a Good Patient? Insights from Philosophy of Medicine

Elise Garza Williams
Philosophy and Classics- Medical Humanities
The University of Texas at San Antonio
1 UTSA Circle
San Antonio, TX, 78249 USA

Faculty Advisor: Şerife Tekin

Abstract

Individuals suffering from illness often suggest that they want to be “good patients,” so that they fully recover or at least improve their condition, withstanding their illness. However, a scholarly debate on what it might mean to be a “good patient” is not sufficiently examined in the contemporary bioethics and medical humanities literature, even though a significant body of scholarly work has been concerned with what it means to be a “good doctor.” For example, the biopsychosocial model, a popular school of thought in contemporary medicine, defines illnesses not only as biological problems, but also as psychological, and social problems. It thus emphasizes the importance of paying attention to all three dimensions of the illness. Similarly, narrative medicine, another popular school of thought, focuses on strategies for developing a healthy relationship between physicians and patients through narrativity. While the patient is the central axis of both of these healthcare models, most of the emphasis has been on the characteristics of the ideal humanist physician, or the virtues and strategies they must develop to be a good doctor and understand patient’s narrative. There is no explicit discussion on how to be a “good patient.” This paper argues that without exploring what it means to be a “good patient” a complete and effective healthcare model cannot be established. To support this thesis, a view of “good patient” will be developed by using the fundamental commitments of the biopsychosocial model and Narrative medicine. According to this view, a “good patient” (i) is transparent with respect to their biological, psychological, and social states of affairs, and (ii) has reflective agency with the help of which they are empowered to play an active role in their own healing and recovery. This account of the “good patient” has positive implications for enhancing the principles of medical ethics that are upheld by healthcare professionals.

Keywords: Good Patient, Medical Humanities, Philosophy of Medicine

1. Introduction

Individuals suffering from illness often suggest that they want to be “good patients,” so that they fully recover or at least improve their condition, withstanding their illness. However, a scholarly debate on what it might mean to be a “good patient” is not sufficiently examined in the contemporary Bioethics and Medical Humanities literature, even though a significant body of scholarly work has been concerned with what it means to be a “good doctor.” For example, the biopsychosocial model, a popular school of thought in contemporary medicine, defines illnesses not only as biological problems, but also as psychological, and social problems. It thus emphasizes the importance of paying attention to all three dimensions of the illness. Similarly, narrative medicine, another popular school of thought, focuses on strategies for developing a healthy relationship between physicians and patients through narrativity. While the patient is the central axis of both of these healthcare models, most of the emphasis has been on the characteristics of the ideal humanist physician, or the virtues and strategies they must develop to be a good doctor and understand patient’s narrative. There is no explicit discussion on how to be a “good patient.” This paper argues that without exploring what it means to be a “good patient” a complete and effective healthcare model cannot be established. To

support this thesis, a view of “good patient” will be developed by using the fundamental commitments of the biopsychosocial model and narrative medicine. According to this view, a “good patient” (i) is transparent with respect to their biological, psychological, and social states of affairs, and (ii) has reflective agency with the help of which they are empowered to play an active role in their own healing and recovery. This account of the “good patient” has positive implications for enhancing the principles of medical ethics that are upheld by healthcare professionals.

2. Narrative and Biopsychosocial Approaches of Medicine: No Explicit Discussion of “Good Patient”

Developed by George Engel, the biopsychosocial model of medicine claims that diseases are simultaneously biological, psychological, and social.¹ All these aspects of illness are crucial to understand in order to develop an effective treatment plan for the individual. The biopsychosocial medical model was adopted as a response to the identity crisis in medicine; namely the question of whether biological or social sciences offer the best frameworks for medical treatment. George Engel explains that the physician’s heavy reliance on the quantitative data and laboratory testing to make a diagnosis is disadvantageous, and antiquated. The biomedical model “leaves no room within its framework for the social, psychological, and behavioral dimensions of illness.”² It is not flexible in its ability to define illness or develop a treatment plan because it does not adequately consider the factors outside the biological scheme that influence health.

The biopsychosocial model has evolved since its first introduction to subsume the complexities of mental disorders in the practice of psychiatry. For example, Jesse Butler argues that mental disorders are multi-dimensional as they include “an overlapping matrix of underlying mechanisms, cognitive functions, and social behaviors.”³ The biopsychosocial model is an avenue which considers the implications and various etiologies of mental disorders so that they may be better understood and thus, better treated. Failing to acknowledge mental disorders from a biopsychosocial perspective leads to the downfall of relying on one focus or perspective, such as observational behavior, to understanding mental disorders. The biopsychosocial model is a framework that does not restrict mental disorders to a single theory, thus, recognizes people and the mind as a complex phenomenon.”⁴

Both Engel⁵ and the later commentators, such as Butler⁶, propose that the biopsychosocial model should replace the medical model in treating diseases as they are convinced that this model fully encompasses these factors and allows physicians to practice in a way that reflects medicine not only as a science-based field, but as an art. The various duties of a good physician in the biopsychosocial model include recognizing why the patient was prompted to seek medical attention and how the biological, psychological, and social contexts of the patient factors into their decision to seek medical attention. A physician must also establish whether or not the patient is sick, why they are experiencing their symptoms, and in “which ways” is the patient sick. Then, the physician must develop a plan of action with the end-goal of having the patient return to their greatest possible health and function within the limitations of their illness.

While these discussions about the role of the doctor or other medical professionals in caring for the patient are pertinent to develop a humanistic care practice, they are incomplete without considering what kinds of characteristics or virtues a patient must acquire in order to be a “good patient.” The fundamental commitment of the biopsychosocial model is to see patients beyond their biology and consider them as active social and cognitive agents; thus, the account of the “good patient” developed below aligns well with this model.

Narrative medicine bears resemblances to the biopsychosocial model of medicine. Of the various models of medicine presented in healthcare, narrative medicine is becoming widely accepted and subject to enthusiastic discussions about its implementation. Rita Charon described narrative medicine as a foundation for healthcare delivery where physicians must express “empathy, reflection, professionalism, and trustworthiness” when interacting with their patients.⁷ Charon claims that narrative medicine improves the effectiveness of the physician’s practice because it improves her interactions with her colleagues, with her patients and even with herself. The biopsychosocial model and narrative medicine are similar in that they both focus on the experience of the patient, not only as a biological entity, but also a social and psychological being.⁸ Narrative medicine takes the biopsychosocial model one step further by placing extra importance on the narratives of patients and physicians thereby supplementing the biopsychosocial model. They have both become increasingly popular in medical education, in order to facilitate the education of competent and empathetic physicians as well as other healthcare professionals in various modes of healthcare delivery such as in healthcare education, research, and policy.

While Charon discusses the importance of patients’ narratives as a whole, Arthur W. Frank identifies and outlines three categories of patient narratives: the restitution narrative, the chaos narrative, and the quest narrative. The restitution narrative follows the storyline that while the narrator- patient, is ill today, there will be a day when they get

well. This narrative stems from the sick role as presented by Talcott Parsons; the role of a sick person is not an action but rather it is the relationship between behaviors that medical providers can expect from the sick person and the behavior that the sick person can expect from the medical provider.⁹ The chaos narrative is the opposite of the restitution narrative in that it only focuses on the chaos caused by illness in an unorganized, non-chronological manner. This narrative does not follow a particular storyline as it is best described as a barrage of unfortunate events due to illness without hope of getting better and with no redeemable qualities. The chaos narrative does not present the patient as an active agent in their healing, but rather expresses the sense that the patient is hopeless and has no control over their health outcome.¹⁰ The third and final narrative Arthur Frank discusses is the quest narrative, the story of illness as a journey to be experienced. Illness is something that interrupts the normal progress of the patient's life and causes difficulties that are nonetheless conquered by the patient who is now the hero in their story. The patient can view their illness as a teachable experience that can aid in their moral development. This patient narrative allows patients to be viewed as "responsible moral agents whose primary action is witness."¹¹

Narrative competency, or the ability to hear a story, comprehend, and accurately re-tell it, is required to effectively practice narrative medicine. Thus, a good physician is one who practices narrative medicine and reflects upon the meaning of her work and practices this skill by consuming other narrative works, told from the perspective of other physicians and patients. The kinds of narratives that Frank evaluates in his work would be important for the physician to engage with as they support the patient through their treatment. For example, a physician may be presented with a patient who is recovering from a stroke. The patient may be experiencing weakness, balance problems, and slurred speech as a result of her stroke. It is also important to take into account that the patient also works as a teacher, provides for her family, and is a single mother of three. In some respects the narrative of this patient is a quest narrative: There are genuine obstacles on her path of life and the story of her recovery is also a story of not only recovering from a stroke but also returning to work, providing for and caring for her family, and how it affected the education of her children. The doctor's ability to comprehend this narrative and retell it not only helps the doctor find meaning in their work but also the patient in feeling like she has a companion who genuinely cares for her recovery and return to normal functioning.

While the proponents of narrative medicine make important strides into the importance of understanding and responding to patients' narratives as a way to humanize medicine, their views lack a robust approach to what it might mean to be a "good patient" nor how an account of the "good patient" may strengthen the humanism in medicine. Frank's insightful evaluation of the kinds of narratives that patients create during their healing process and their strengthening of agency in this path are resourceful in developing the framework to what it might mean to be a "good patient." As discussed below, a "good patient" is also a responsible moral agent who plays an active role in their recovery.

3. Attributed Roles to Patients: Insights for "Good Patient"

There is some work in the philosophy of medicine literature that examines the roles of patients and health care professionals. These conversations provide some insights for developing an account of the "good patient."

3.1 Sick Role and Student Role

The biopsychosocial and narrative models of medicine have been evaluated with the argument that while both views offer excellent resources for developing a notion of the "good patient," neither model explicitly details this framework. The literature that focuses on patient duties does not go beyond fulfilling such duties and does not explicitly focus on what it might mean to be a good patient. While Engel, Pellegrino, and Charon do assign roles to patients, these roles will be reviewed with the goal of addressing their shortcomings.

Engel argues that if a physician establishes that the patient is sick, it is the patient's duty is to "adopt the sick role", which was articulated by Parsons, and "accept status of patienthood".¹² He also specifies the responsibilities that do and do not fall on the patient: the patient is responsible for "cooperating" in their healthcare and they are not responsible for deciding whether or not they should be medically treated or contributing to determining the goals for treatment. There are no further discussions as to what the "sick role" or "patienthood" entails and the extent to which a patient should cooperate is not specified.

Edmund Pellegrino, another medical humanist like Engel, uses the teacher-student relationship as an analogy to explain the physician-patient relationship. Pellegrino seeks to educate future physicians in a manner that mimics "ancient ideals" of the art of medicine by outlining the characteristics that are required to be a humanist physician.¹³

The humanist physician is one who is competent, compassionate, and well educated. Pellegrino argues that the emphasis placed on scientific studies in medical education is harmful and that there needs to be a greater emphasis placed on including classical and liberal literary studies into the curriculum. The humanist physician is compassionate and therefore able to empathize with their patient. The teacher-student relationship analogy is created to highlight the importance of empathy that a physician must employ in the physician-patient relationship, but it also carries a deeper implication. Pellegrino states that the two relationships are similar in that “one person is seeking help from another who is presumably wiser and has power over the petitioner.”¹⁴ The physician-patient relationship described is built on such dependency; the student is dependent on their teacher to be understanding and the patient is dependent on the physician to be compassionate. This example suggests the idea that the patient is beholden to the physician and is seeking assistance as they are not as wise.

In narrative medicine, most of the emphasis has been on the characteristics of the ideal humanist physician, the virtues they must develop to be good doctor (such as compassion), or the strategies they must adopt to understand patient’s narrative. The goals of narrative medicine are met by mending the gap between the patient and the physician. Charon offers several suggestions for physicians to adopt in order to improve this relationship, and ultimately the effectiveness of their patient interactions, but there is no word on suggestions for the patient.¹⁵ She delves into the details of the patient-physician relationship but only alludes to how the physician may better connect and interact with the patient and not the other way around. A key component of narrative medicine is the physician’s ability to absorb physician and patient narratives alike in order to become competent, empathetic, reflective in their work, which ultimately makes them more effective practitioners. Narrative medicine is also valuable in promoting the inclusion of patient narratives in clinical case reporting to enhance medical epistemology by improving our research methods and body of materials for further research.¹⁶ Charon highlights the importance of the patient narrative but does not allude to the duties or suggestions that a patient may adopt in order to have a more effective interaction with their physician.

The three types of patient narratives illustrated by Arthur W. Frank still lack a discussion of the responsibilities given to the patient as an agent of their own healing during the experience of illness. The “sick role” in the Restitution Narrative is to focus on getting well; which detracts entirely from the patients’ experience of illness. In the Chaos Narrative, for example, the typical response of healthcare providers is to adjust their focus to push for the patient not to “dwell” on the complexities of their illness, but rather, advise them to focus on recovery. This narrative leaves no room for the concept of the humanist physician as the physician is to dismiss the patient narrative and advertise the idea that the patients’ focus should be on getting well. While the focus of the chaos narrative is on the experience of illness as an unfortunate one, the outcome still results in a push to distract the patient from the experience of illness; it fails to allow the physicians to absorb the narrative as they push for the patient to ignore this narrative instead. Lastly, while the quest narrative does allow the patient the most responsibility of the three narrative types in their experience with illness, it still identifies the patient as a “witness” and not necessarily an active participant or agent in their healing.

An evaluation of the types of relationships that exist between patients and physicians detailed by Emanuel must be discussed; Emanuel takes the four main models of the physician-patient relationship to be the paternalistic model, informative model, interpretative model, and deliberative model.¹⁷ The paternalistic model is generally viewed as archaic; the physician’s interaction with the patient is similar to that of a guardian. The physician would only offer medical treatment options to the patient which best align with what she believes is the best and assumes that the patient would have “shared objective criteria”.¹⁸ The interpretative model allows the physician to collaborate and explore the patients’ values and goals with the patient in order to help them make decisions which best fulfill these. This model assumes that the patient is unclear of their own values or objective criteria and relies on the physician to act as a “counselor” to help define them. The deliberative model suggests that the role of the physician is one of a mentor; they curate options that they believe would best serve the patient and then come together to deliberate on what options the patient should choose. The informative model of the physician-patient relationship is favored in biomedical ethics as it places an increased emphasis on patient autonomy and removes power from paternalism. The goal of the relationship in the informative model is for the physician to inform the patient of diagnoses or available treatment options so that the patient may select options that best align with their values and goals. This model assumes that the patient is well aware of their objective criteria and has a clear understanding of what she values.¹⁹ The informative model of physician-patient relationship is favored by biomedical ethics and is especially important in developing an account of “good patient”; it empowers patients to engage in their own healing.

3.2 Patient Duties

Previous inquiries of patient duties or responsibilities explore these from perspectives that tend to promote the idea of betterment for society, but pay little attention to the patient narratives. One discussion of such roles is held by H M Evans. He states that “the broad therapeutic interests of patients collectively are the reason why publicly funded healthcare—in which context the ‘justice-based’ responsibilities of patients most obviously arise.”²⁰ While Evans does discuss the idea that patient roles in healthcare are overridden by discussions of duties for healthcare professionals, his stance is highly utilitarian and does not take into consideration the idea that patients are intersectional beings or complex individuals with overlapping social categorizations and identities with varying needs that should be collaboratively met and require varying amounts of healthcare.²¹ He also states that “the interests of my ‘competitor’ co-patients produce in me not merely the negative duties of avoiding either uncivil behavior or needless waste, but also, provocatively, *positive* duties to promote my own health and, in the case of illness, to recover as quickly as possible.”²² Evans views patients as competitors but also remarks that they need to each have a duty to help each other; this is understood by his commitment to the fact that publicly funded healthcare is funded by tax payers. This stance promotes the idea that healthcare is combative and suggests that people are taking resources from others by being ill and inflict damage with negative duties so they must partake in positive responsibilities for the betterment of society.

Another such discussion is offered by James Todd and Robert Veatch as they explore the “covenant” or agreement that physicians and patients may have to one another. James Todd raises the question of whether society is responsible for detailing what is considered “honorable behavior” for a physician as “citizens have the right to make individual decisions as to what to do with their health, and the role of the physician is now to make relevant information available so patients can make intelligent choices.”²³ He also expresses his doubts as to whether or not a serious effort will or has been made by lay people to make these expectations. Todd is focused on how the roles affect society as a whole and what duty patients have to abiding by them. Veatch responds to this question and states that while a serious effort has not been made, patients have to “learn that they have a legitimate, important role as active partners in establishing the contract [or covenant] between the professional and the rest of us.”²⁴ Social expectations are all encompassing and can shape the principles that govern physicians to best serve society, however, patient agency and transparency are more specific and can help promote patient narratives and create humanist physicians. These narratives represent patients as individuals with unique needs and adequate attention can only be achieved by considering specific patient narratives that are bespoke to the individual rather than a generalization made by society. Todd focuses on how the roles affect society and what duty patients have to abide by them. This utilitarian approach lends itself to principles of biomedical ethics, but it does not lend itself to narrative medicine as utilitarianism is nonspecific in nature. Veatch emphasizes the importance patients have in their healing and the power they possess when they collaborate with physicians. He also points out the idea that patients have an unrealized potential. This supports the idea that patient agency is necessary, can have an impact on healing, and is an important characteristic of a “good patient.”

Carolyn L. Wilson, who also articulates that there is an absence of discussions surrounding patient agency and the importance of patient participation in healing, states that “Patients have traditionally seen their duties to themselves as ‘promises’ to the self rather than a moral requirement to fulfil a certain obligation.”²⁵ This view of personal duties has caused a breakdown in the link between “the rights that patients justifiably possess and the duties that they have to themselves.”²⁶ After taking a close inspection of the attitudes toward patients and the dynamics of the physician-patient relationship in educational humanist texts for physicians, it is difficult to say that the reason that patients are lacking agency is their misunderstanding that they are to fulfil a moral requirement. Rather, the physician should help the patient feel empowered so they may exercise their sense of agency. Wilson goes on to say that “When patients focus upon their own responsibilities within the doctor-patient relationship, their own rights are ultimately enhanced and respected.”²⁷ Wilson expresses the idea that the humanist physician and “good patient” can have a more effective interaction and outcome through this description of a collaborative relationship.

While patients are the pillar of the healthcare system there is limited discussion on what it might mean to be a “good patient” patient in the philosophy of medicine and bioethics literature. Narrative medicine holds patient narratives to a high standard as a tool for creating physicians that have meaningful interactions with patients but offers no suggestion as to how patients may contribute to have meaningful interactions with their physicians. The biopsychosocial model of medicine exemplifies the reasons why we need to consider varying aspects of the patient’s lives in order for physicians to accurately make diagnosis and develop treatment plans but fails to outline how that information should be passed from the patient to their physician and reports that the responsibility of the patient is essentially to comply with their physician. Pellegrino parallels the patient-physician relationship to that of a student-teacher relationship and suggests that the fate of the patient is dependent on the physician as the fate of the student is

dependent on the information and grade given by the teacher. In the few instances where we are able to discern an example of what the role or duties of the patient are, the examples inflate the physician and describe the patient as subordinate who is beholden to their physician. The physician has the definitive say and control over the fate of the patient and the responsibility of the patient is to comply and obey orders. These meager instances of a mention of a patient role do not expand on their discussions of the role of the patient and removes the patients' agency in the situation. There is little semblance of respect or credit given to the patient as an intelligent individual capable of autonomy and little discussion on to how the patient can help to facilitate a good relationship with their physician and participate in decision making. I will argue that a "good patient" must (i) be transparent with respect to their biological, psychological, and social states of affairs while communicating with healthcare professionals, and (ii) have a reflective agency so that they can play an active role in their own recovery and healing.

4. Characteristics of a Good Patient

The discussion above provides valuable insights as a fodder to define what it means to be a "good patient." Briefly, a good patient" (i) is transparent and (ii) has reflective agency. A "good patient" is one who is transparent with respect to their biological, psychological, and social states of affairs while communicating with healthcare professionals. Transparency in this setting does not strictly refer to vulnerability, nor is vulnerability necessary to be transparent, but it is simply about being forthright about the medical problems that the patient is facing and the implication that this medical problem has had on other aspects of their lives. For example, a 42-year-old man visits his primary care provider and complains of snoring. He is sent to conduct a sleep- study and the physician assesses the case and concludes that the man may benefit from using a CPAP machine. What the patient was not forthcoming with is the fact that his snoring does not affect him, but it is actually affecting his relationship with his partner. His snoring had become so unbearable that they are no longer sleeping in the same room, however, the CPAP machine that the physician prescribed is just as loud and intrusive as his snoring. If the patient had been transparent and explicitly told the physician that his snoring has harmed his relationship with his partner and as a result he is feeling depressed, the doctor may have offered other suggestions, such as a weight-loss plan, to help reduce the snoring and boost his mood. Being upfront about the consequences of the medical problem conveys a sense of trust that should be reciprocated within the doctor- patient relationship.

In addition to transparency, a "good patient" has reflective agency or the ability to have an active role in their own healing through self- insight and an understanding of one's goals. The presentation of the sick role by Engel and Pellegrino's comparison of the doctor patient relationship to a that of a teacher- pupil highlights the power imbalance between physicians and patients. Respect for the patients' autonomy, a classic principle in biomedical ethics, cannot be adequately fulfilled in the context of the "sick role". If a patient does not have a sense of agency, they will not feel empowered to act as autonomous beings. How can we accurately say that physicians are respecting patient autonomy when they anticipate being the superior to a subordinate in their relationship? Larry Davidson makes the claim that when physicians begin viewing patients as "fellow sufferers" or as equals, not as a group separate from themselves, there can be a regard for agency.²⁸ Larry Davidson highlights the importance that having self-insight and a sense of agency has on healing. The active role of the patient should be considered as Davidson states that "while we have yet to discover a cure for serious mental illness, many people nonetheless recover from it."²⁹ This anecdote describes psychiatric medicine, but it is a phenomenon which can be applied in the context of clinical medicine. Davidson argues that because of this, we need to include the active role of the patient as a factor of recovery in theoretical medical models.

A "good patient" has developed a reflective agency which allows the patient to gain self- insight and aid in the process of creating their own patient narrative. The doctor patient relationship should be one of teamwork, not subordination; having self-insight is critical for healing. Self-insight is defined as the patient's understanding of her personal identity, her puzzling symptoms, interpersonal relationships, and the relationship between these. Having good self-insight means that patients can understand themselves better and have a better quality of life.³⁰ As a result, they are more capable of responding to their situation and they become better reflective agents and advocates for themselves. It is important to have self- insight to heal as it allows the patient to understand that she is an intersectional being and she is able to recognize that her medical problems have consequences resulting in other problems in her life. Self- insight also helps the patient clarify what they should be transparent in regard to and it contributes to the creation of a rich patient narrative which is helpful for physicians practicing narrative medicine.

By having a sense of agency, the patient is capable of being their own patient advocate which gives the physician the opportunity to respect their autonomy. After all, an appointment with a physician may be condensed down to a

fifteen-minute exchange, but the patient spends their entire lives with themselves; we need to acknowledge patients as capable, experts on their own health.

In addition, reflective agency promotes the physician- patient interaction in Emanuel's informative model. As stated above, a prerequisite to the informative model is that the patient already has a clear understanding of their values and objectives, thus, is a competent agent of their own self. Having reflective agency allows the patient to explore what they value in healing in order to have that clear understanding of their values and objectives. This allows the patient to best select the treatment options offered by the physician that best align with their values and goals and creates an effective and informative physician- patient interaction.

4.1 Implications of Good Patient Account on the Principles of Biomedical Ethics

The account of "good patient" has plausible and positive implications for enhancing the principles of medical ethics that are upheld by healthcare professionals. The relevance of these characteristics of a "good patient" can be further supported by a brief exploration of their implications on the fundamental principles of Biomedical ethics which are first elucidated by Beauchamp and Childress and have been widely discussed since then. These are, "respect for autonomy", "nonmaleficence", "beneficence", and "distributive justice."³¹ The account of the "good patient" enhances and enforces these principles.

The principle of respect for autonomy encompasses personal autonomy or "self- rule that is free from both controlling interference by others and from limitations, such as inadequate understanding, that prevent meaningful choice."³² This principle is rooted in obligations that suggest, "autonomous actions should not be subjected to controlling constraints by others" and that there is "respectful treatment in disclosing information and fostering autonomous decision making."³³ It is the healthcare providers' role to adequately inform the patient of different consequences and benefits of treatments or topics concerning the patients' health so that the rational patient can make an informed decision regarding these. The "good patient" who practices transparency will inform their physician of any underlying problems so that the physician may adequately inform the patient about options. Having reflective agency allows the "good patient" to reflect on the impact of their illness on their life and explore what their informed decisions may mean with regard to the biopsychosocial aspects of their life.

The principle of non- maleficence is the principle that "one ought not to inflict evil or harm."³⁴ While some medical procedures may inflict some degree harm to the patient, the intentions are not evil. The principle of beneficence is complimentary to the prior as it "asserts the duty to help others further their important and legitimate interests".³⁵ It is the healthcare provider's responsibility to prevent and remove evil or harm and to promote good.³⁶ If a patient can practice reflective agency and transparency, they are allowing the physician to have a better understanding of the patient narrative so that they can benefit the patient and avoid needless harm or overtreatment. By having transparency and reflective agency, the patient is able effectively communicate with their healthcare provider about what they are finding troubling so that the healthcare provider may bring about the greatest benefit and least amount of harm to the patient.

The Principle of Justice concerns how medical goods and care are distributed to patients; this principle is regarded by Beauchamp and Childress from a utilitarian perspective as the "name for the [...] obligation created by the principle of utility."³⁷ The principle of utility would suggest that "actions are right in proportion as they tend to promote happiness."³⁸ According to Beauchamp and Childress, each patient should be given an equal share according to need, effort, contribution, merit, and free- market exchanges.³⁹ The "good patient" possesses qualities that lead to more effective interactions with the physicians which improves the quality of care received, thus, the quality of care distributed to other patients as well. For example, a "good patient" in an emergency room setting is perfectly aware that other patients in the waiting room whose healthcare needs are medically more urgent deserve to be given the first available spot even though she has been waiting there for a long time. They fully understand and grasp the justice principle and are respectful of healthcare professionals who want to act accordingly.

5. Conclusion

This paper constructed a definition of what it means to be a "good patient" and contributed to the discussion surrounding the patient role in philosophy of medicine. Other notable works from philosophy of medicine were used to build the argument that we currently have little emphasis or discussion surrounding the patient's role in the physician- patient relationship and have focused our attention on the physician's role. An argument was constructed that states that the "good patient" is one who (i) is transparent with respect to their biological, psychological, and

social states of affairs, and (ii) has a reflective agency so that they can play an active role in their own healing and recovery.

6. Acknowledgements

The author wishes to express their appreciation of Dr. Şerife Tekin.

7. References

1. George L. Engel, "The Need for a New Medical Model: a Challenge for Biomedicine," *Science* 196, no. 4286 (August 1977): 132.
2. Engel, "The Need for a New Medical Model," *Science*, 130.
3. Jesse Butler, "Understanding the Nature of Mental States: Psychiatry, the Mind-Body Problem, and the Biopsychosocial Model of Medicine," In *The Bloomsbury Companion to Philosophy of Psychiatry*, ed. Şerife Tekin and Robin Bluhm (London: Bloomsbury Academic, 2019), 42.
4. Butler, "Understanding," 56.
5. Engel, "The Need for a New Medical Model," *Science*, 133.
6. Butler, "Understanding," 56.
7. Rita Charon, "Narrative Medicine," *JAMA: The Journal of the American Medical Association* 286, no. 15 (October 2001): 1897.
8. Engel, "The Need for a New Medical Model," *Science*, 132.
9. Talcott Parsons, *Action Theory and the Human Condition* (Free Press, 1978), 77.
10. Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (The University of Chicago Press, 2013), 97.
11. Frank, *Wounded Storyteller*, 134.
12. Engel, "The Need for a New Medical Model," *Science*, 133.
13. Edmund Pellegrino, "Educating the Humanist Physician: An Ancient Ideal Reconsidered," in *Humanitas: Readings in the Development of the Medical Humanities*, ed. Brian Dolan (San Francisco: University of California Medical Humanities Press, 2015), 151.
14. Pellegrino, "Educating," 154.
15. Charon, "Narrative Medicine," *Jama*, 1898- 1899.
16. Rachel A. Ankeny, "The Role of Patient Perspectives in Clinical Case Reporting," in *Knowing and Acting in Medicine*, ed. Robin Bluhm (London: Rowman and Littlefield International, 2016), 104.
17. Ezekiel J. Emanuel and Linda L. Emanuel, "Four Models of the Physician-Patient Relationship." *JAMA: The Journal of the American Medical Association* 267, no. 16, (April 1992): 2221.
18. Emanuel and Emanuel, "Four Models," *JAMA: The Journal of the American Medical Association*, 2221.
19. Emanuel and Emanuel, "Four Models," *JAMA: The Journal of the American Medical Association*, 2221.
20. H M. Evans, "Do patients have duties?," *Journal of Medical Ethics* 33, no. 12 (December 2007): 689.
21. Kimberle Crenshaw, "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine." *The University of Chicago legal forum*. 1989 (1989): 149.
22. Evans, "Do patients," *Journal of Medical Ethics*, 689.
23. James S. Todd and Robert M. Veatch, "Medical Ethics: A One-Way Covenant?," *The Hastings Center Report* 10, no. 6 (December 1980): 45, <https://www.jstor.org/stable/3560286>
24. Todd and Veatch, "Medical Ethics," *The Hastings Center Report*, 46.
25. Carolyn L. Wilson, "Seeking a Balance: Patient Responsibilities in Institutional Health Care," *Medical Law International* 3, no. 2-3 (March 1998): 193.
26. Wilson, "Seeking," *Medical Law International*, 193.
27. Wilson, "Seeking," *Medical Law International*, 193.
28. Larry Davidson, "Cure and Recovery," in *The Oxford Handbook of Philosophy and Psychiatry*, ed. K.W.M. Fulford, Martin Davies, Richard G.T. Gipps, George Graham, John Z. Sadler, Giovanni Stanghellini, and Tim Thornton (Oxford University Press, 2013), 12. <https://www-oxfordhandbooks-com.ezproxy.lib.utexas.edu/view/10.1093/oxfordhb/9780199579563.001.0001/oxfordhb-9780199579563-e-015>.
29. Davidson, "Cure," 2.
30. Şerife Tekin, "Self-Insight in the Time of Mood Disorders: After the Diagnosis, beyond the Treatment," *Philosophy, Psychiatry, & Psychology* 21, no. 2 (June 2014): 141
31. Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics 5th Ed.* (New York: Oxford University Press, 2001), 12.
32. Beauchamp and Childress, *Principles*, 58.
33. Beauchamp and Childress, *Principles*, 64.

34. Beauchamp and Childress, *Principles*, 114.
35. Beauchamp and Childress, *Principles*, 166.
36. Beauchamp and Childress, *Principles*, 115.
37. Beauchamp and Childress, *Principles*, 231.
38. John Stuart Mill, *Utilitarianism* (Cambridge: Hackett Publishing Company, 2002), 7.
39. Beauchamp and Childress, *Principles*, 228.