Cambridge Quarterly of Healthcare Ethics (2024), 33: 2, 271–274
doi:10.1017/S0963180122000275

CAMBRIDGE UNIVERSITY PRESS

DEPARTMENTS AND COLUMNS

Applying the Peter Parker Principle to Healthcare

James E. Stahl[1]* and William A. Nelson[2]

[1]The Dartmouth Institute of Health Policy and Clinical Practice, Geisel School of Medicine at Dartmouth, Section of General Internal Medicine, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire 03766, USA
[2]Ethics and Human Values Program, The Dartmouth Institute of Health Policy and Clinical Practice, Department of Medical Education, Elizabeth DeCamp McInerny Professorship, Geisel School of Medicine at Dartmouth, Hanover, New Hampshire 03755, USA
*Corresponding author. Email: james.e.stahl@hitchcock.org

The role of power in healthcare can raise many ethical challenges. Power is ownership, whether given, ceded, or taken of another person's autonomy. When a person has power over someone else, they can control or strongly influence the decision-making freedom of that person. From the principalist perspective[1,2] of healthcare ethics, denying a person their freedom to choose should only occur when justifying conditions related to beneficence and nonmaleficence are sufficiently satisfied. In healthcare, it is rare to be able to identify situations where paternalism is justified. However, experience suggests that abusive power in healthcare is used too frequently without justifying criteria.

We propose that the ethical foundations of professional behavior in healthcare are related to the Peter Parker Principle. The Peter Parker (aka Spiderman for noncomic-book readers) Principle comes from one of the very first issues of the comic, when Peter's Uncle Ben, as he lies dying, reminds Peter that "with great power comes great responsibility." While few of us have superhuman abilities, we frequently are in positions of power that are usually manifested through a combination of force, position, finance, and/or information. Any of these possibilities can give us control over another person's autonomy. We believe this happens all too often unilaterally and without consent.

In this perspective, we explore some of the power dynamics that exist in healthcare, how these power relationships influence decision-makers, and how their decisions may diverge from the ideal that an ethically grounded relationship asks. The issue of power dynamics is constantly present though rarely acknowledged. We believe that healthcare professionals in coproduction with patients, colleagues, trainees, and administrators are less likely to make ethical choices when the professionals are unaware of these dynamics and the consequences or contexts of their actions.

The following is a brief reflection of common power dynamics and its impact on the delivery of healthcare.

Doctor–Patient Relationships

Perhaps the relationship most familiar to people when discussing power discrepancies in healthcare is the doctor–patient relationship. Here is a classic situation of asymmetric agency[3] where the doctor has special knowledge, information, and perceived authority that the patient typically does not possess. Asymmetric agency can also raise its head in many nonhealthcare situations—the lawyer and client, the broker and homebuyer, the admission officer and student applying to college, or, for that matter, medical students applying to residencies.[4]

This asymmetry manifests even in the words we choose. The doctor's word choice can powerfully influence patients' decision-making as illustrated in Daniel Kahneman and Amos Tversky's work on the power of framing.[5] This becomes a constant challenge as there is no such thing as truly neutral statements, though this may be aspirational.[6] For example, in clinician–patient decision-making, even when the doctor is "sticking to the facts" regarding the potential benefits and risks of an intervention, the

doctor is still framing the information. The field of shared decision-making is essentially an endeavor to improve informed consent by rebalancing the traditional power dynamic between the doctor and the patient. In shared decision-making, stakeholders both cede and acquire decision-making autonomy.

Despite all the work and research spent on the ethical issues surrounding informed consent from the healthcare professionals' side, it is important not to forget that patients also bear responsibilities in this relationship. The patients are the experts on their own values, preferences, and personal history. They control how much information their doctor has access to and can shape the conversation to their own ends. An unfortunate example is doctor shopping among patients with substance abuse problems who are experts in their needs and rely on their deeper knowledge of their case than a doctor who is naïve to their situation. Continuity of care and actively cultivating trust and respect on both sides can foster the application of the Peter Parker Principle.

Doctor–Doctor Power Dynamics

Peer–Peer Relationships

Peer-to-peer ethics in healthcare, from the Hippocratic Oath to the Physician Charter on Professionalism,[7] have evolved into professional standards of behavior. For example, the Hippocratic Oath starts with a pledge of care, respect, and duty owed to one's peers. In theory, power asymmetry should be the least among peers, but even here the power dynamics of peer-to-peer relationships can raise their head.

All true, respectful relationships need to have an ethical grounding, including trust in the relationship. When I trust my friend, family member, or healthcare peer, I cede to them a certain amount of my autonomy regarding their decisions. I allow them to make decisions for me or on my behalf. Trust implies an expectation of some compensatory beneficence, nonmalevolence, or justice to me in return. With our clinical peers, if we consult them, we trust them to give us the best information they can provide without the need to verify their knowledge. If we take "call" for our peers, we trust they will care for our patients with the same level of professionalism and skill as we do. That said, doctors are human too and suffer flaws and misuse the power inherent in trust relationships. On its most basic level, trust is a form of the golden rule. It asks us to expect our professional peers to use the same level of skill and attention as we would expect to use ourselves.

Teacher–Student/Attending–Trainee/Junior Clinician

Probably less developed is the exploration of mutual duties and responsibilities of the teacher–student, attending–trainee relationship. Despite the pedagogic evolution of medical and surgical training over time, it remains primarily apprenticeships in structure, where the apprentice or trainee is very dependent on senior physician, and preceptor power. This power dynamic can make or break a trainee. The senior physician can enforce rules (or not) during clinical rotations, influence the junior trainee's advancement, and launch or cut off their careers through recommendations to potential current and future employers. Generally, this relationship is benign but there are also numerous cases where it has not been. We have no doubt most clinicians can speak to both.

We would propose that in any hierarchical situation, the person with higher professional standing needs to truly understand and take responsibility for the extent of their power. This responsibility grows more important the further apart the two individuals are in the healthcare hierarchy. The more junior the trainee is, the greater the latitude to learn, the more senior is the clinician, the greater the expectation of applying their power with attention, justice, and beneficence. The more senior the professional, the more they control the junior trainees' autonomy and the consequences thereof, such as, if the junior makes mistakes. This is the necessary onus of being a Peter Parker Principle teacher. Practically, this implies for the teacher or senior physician, clear communication, unambiguously articulated expectations, and sensitivity to the vulnerability of trainees.

Health System Leader–Healthcare Workers

Health system leadership, whether acquired through experience, moral authority or simply through an institutional position, can be even greater than peer-to-peer power. Such leadership comes with great responsibility and power to ensure that the organization's values are consistently aligned with its culture and practices. As it is with controlling positions, power can result in beneficial good for the staff and population served, as well as an ability to cause harm, purposely or inadvertently.

Power can be abused through actions ranging from the inadvertent poorly worded communication to purposeful favoritism to outright unlawful acts. In some European countries, leadership's power is occasionally shared with workers having explicit positions on governing boards. In the United States, we have some examples of healthcare insurance cooperatives, which involve mutual assistance with a common goal of shared governance. These mechanisms foster shared power and autonomy. That said, this shared power comes with its own responsibility, such as advocating for those you represent and communicating to multiple stakeholders to enhance transparency.

Clear communication and transparency are one of the tools we can use to mitigate the misuse of power. In healthcare organizations, we have an ethical obligation to have good communication between the leadership and the staff. This falls under the same principles that drive informed consent. If you are going to purposely or inadvertently coerce or potentially harm someone through a budgetary decision or a change in organizations rules, are you not obligated to at least try to obtain a form of consent, or at least acknowledgment and recognition from those affected? Clearly, the leader's obligations to communicate and to achieve at least transparency if not necessarily the consensus of the governed is constrained by the nature of the decision, the time frame the decision must be made, the cost of communication in time and effort, and the impact on those affected by the decision. Structurally, committees and oversight mechanisms may act as proxies for the consent of others, much in the way trust-building can help one-to-one relationships. The obligation of the leader increases, not decreases, with their hierarchical distance from the employee. The more difficult the decision and the more lives affected, the greater the need for transparency.

We are ethically obligated to design our organizational structures to enhance responsibility and staff connection. We have learned in the equity-focused discussions that social and organizational structures can facilitate and perpetuate behaviors, both good and bad.[8] Organizational hierarchy, itself unfortunately may be used to shield or dissipate responsibility rather than enhance it. Part of the current distress and mistrust in healthcare is a feeling of lack of connection between those on the front lines of care, who often must respond to decisions made without their input or knowledge, and those in the "c-suite." The use of euphemisms, such as "c-suite," by frontline staff to label the senior-level leadership is a manifestation of disconnection and distance. This lack of connection creates a sense of loss of control, engagement, and depersonalization. From the senior leadership side, the more disconnected a person is from the direct impact of their actions or decisions, the easier it is to contribute to staff misunderstanding and discord. For example, leadership decisions will need to be made that may not be universally accepted by all staff. In such situations, we believe that organization-wide justification is essential. Such transparency stems from the importance of communicating the justifying reasons leading to a decision. Even though the decision may not resonate with everyone, such transparency can help create trust and respect. Similarly, one can see how appreciated and beneficial it is when organizational leaders spend time with their frontline workers, getting to know them as people and the consequences of decisions made that affect them directly.

Are flatter organizational structures likely to behave more transparently from an ethical perspective? We believe that is possible, though obviously there are challenges and trade-offs that must be made regarding the amount of work needed and the available people with the necessary skills. That said, the objective should be to create the flattest possible organization that can still fulfill the organization's mission and values. The larger the organization, the more they need transparent mechanisms and processes.

Most of us do have some degree of power. If we are employers, we have power over our employees; if we are teachers, we have power over our students; if we are senior leaders in an organization's hierarchy,

we have power over those below us. Even in situations of apparent parity—with our friends or loved ones—we still have the power to affect the lives of others for better or for worse. We exist in a web of relationships, with each connecting fiber affecting another's life, and we should learn the lesson of our friendly neighborhood spiderman—that with power comes responsibility.

Conflict of Interest. The authors declare none.

Notes

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Cite this article: Stahl J. E and Nelson W. A (2024). Applying the Peter Parker Principle to Healthcare. *Cambridge Quarterly of Healthcare Ethics* 33: 271–274, doi:10.1017/S0963180122000275