
Medical Progress and the Physician-Patient Relationship

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In the twentieth century, technological developments have radically changed the practice of medicine. It is generally agreed by medical ethicists that, while medicine's potential for improving life and health is greater than in past centuries, its potential for causing suffering and harm to both individual patients and to society has increased to an equal degree. The progress of medical technologies raises several important challenges to the role of physicians and medical institutions in society. In particular, modern medical technology poses significant ethical challenges to the paternalistic model of the physician-patient relationship which is grounded in the tradition of the Hippocratic Oath.

This essay does not seek to present a new model of the physician-patient relationship. Rather, it seeks to examine the challenges medical technology presents to the paternalistic model of medicine. In so doing, it first defines paternalism and examines its roots in the formative document of Western medical ethics, the Hippocratic Oath. The essay then discusses three challenges posed by technology to medical paternalism, including the model of patient autonomy as a response to the problems of medical paternalism. It concludes with an attempt to demonstrate that the issue of who should decide what is best for a patient is part of the larger issue of cultural and moral pluralism.

Medical Technology and Medical Paternalism

In their work, *For the Patient's Good*, Pellegrino and Thomasma include a thorough discussion of paternalism. According to their definition, the paternalistic physician is one who "assumes full responsibility and authority to determine the patient's best interest and to act so as to advance those interests—if need be, without the patient's participation" (Pellegrino and Thomasma 1988, 12–13). Medical paternalism is not dissimilar to social or racial paternalism in which one race or nation believes that it can force its ethics, values, and/or culture on others perceived as "less developed." Paternalism can be thought of in terms of patriarchy as well. The paternalistic model of the physician-patient relationship is hierarchical, with the physician and his/her values marginalizing or superseding the values of the patient.

In medicine, the model of paternalism is built on the authority of the expert. Inherent within the model is the belief that the doctor is the technical expert and that the expert always knows what is best for all patients (Pellegrino and Thomasma 1988, 24). The expert, however, does not know the best interests of the patient in all cases because such a determination cannot be made on technical medical grounds alone; it must consider the values of the patient, as well as those of the society and culture of which the patient is a member (Pellegrino and Thomasma 1988, 24). Of course, one cannot ignore the fact that technology is valued in Western culture. While, physicians are often, though not necessarily, informed by the same cultural values as are their patients, it is important to bear in mind that Western societies tend to be culturally and morally pluralistic. Therefore, the values expressed by the technical medical expert, as an individual and a professional, do not necessarily correspond to the values of the individual patient. Even if the value systems of the physician and patient do correspond, the physician, in his/her role as physician, may fail to recognize these corresponding values. Perhaps physicians believe that they cannot do their jobs properly if they identify too closely with their patients. While this may be the case in some treatment situations, such as that of a critically injured patient in an emergency, in general a failure to identify with the patient in all situations can lead to objectification of the patient.

Paternalism, moreover, fails to recognize the patient as a moral agent who has dreams, values, and life plans of his/her own which do not necessarily match those of the physician/technical expert. A physician may insist on a course of treatment (or non-treatment) which conflicts with the values of the patient. The physician's attempt to impose his/her position on the patient is, therefore, potentially destructive of the patient's well-being and demonstrates the deepest failing of the paternalistic model

in modern society. Pelligrino and Thomasma write:

Paternalism as a model of the physician-patient relationship is itself flawed. At the root of this limitation is the fact that authentic healing cannot take place in a paternalistic model since paternalism overrides the patient's choice. Personal choice is essential to the processes of reintegration which, in turn, is essential to healing (Pellegrino and Thomasma 1988, 25).

While paternalism persists as the predominant model of clinical relationship for both doctors and patients (Pellegrino and Thomasma 1988, 13), it has its basis in the foundational and historic conceptions of Western medical ethics.

The Hippocratic Legacy

The relationship between ethics and the practice of medicine dates to the ancient civilizations of Greece, Babylon, and Egypt. Within the Code of Hammurabi, for example, there are laws which punish physicians for malpractice (Carrick 1985, 94). In addition, the writings ascribed to the Greek physician Hippocrates have been deeply influential in the Western tradition of medical ethics. The Hippocratic Oath, for example, is viewed as the foundation for the model of medical ethical conduct, as well as the cornerstone of medical paternalism.

The Hippocratic Oath was written within a particular historical context, probably that of fourth-century BCE Greece. Unlike the Babylon of Hammurabi, in which laws regulated the practice of medicine, ancient Greek city states did not hold physicians accountable to the government (Carrick 1985, 94). A physician had to develop a personal reputation as a good healer in order to develop a clientele from which the physician could make a living. According to Paul Carrick, the Hippocratic Oath "emerged out of the precondition of a relatively high degree of personal and professional freedom;" it would have been obeyed on a voluntary basis (Carrick 1985, 94).

Within the Hippocratic Oath, the primary duty of the physician is to "protect the patient from harm and to rid him [or her] of disease" (Carrick 1985, 95). Indeed, those who pledge the Oath must refuse to administer a deadly drug (implying a proscription against practicing euthanasia), refuse to perform an abortion, pledge that they will not have sexual intercourse with a patient, and promise to keep in confidence any information learned from the patient. As Carrick points out, "the Oath is unique in formally defining...the proper conduct of the physician-patient relationship. It goes a long way toward putting this relationship on a *prima facie* moral and religious footing" (Carrick 95).

Wherein lies the problem of paternalism? The Hippocratic Oath establishes the physician as the sole judge of what is harmful or beneficial to the patient. As Robert M. Veatch notes:

The historical evidence indicates that in its original context, the Hippocratic Oath was based on a philosophical system that saw physicians as the possessors of information that could be too dangerous for lay people. The line that talks of protecting a person from harm has been interpreted as condoning paternalism (Veatch 1991, 65).

While the concept of protecting a person from harm, of course, is not "wrong" in itself, the Hippocratic Oath does not recognize the patient as a person who has his or her own morals, beliefs, and values. There is no statement within the Hippocratic Oath that indicates that the patient should be viewed as one capable of participating in the decision-making process. As a result of this omission, as well as the presence of paternalistic statements in the remainder of the Hippocratic canon, the Hippocratic Oath is viewed by some as condoning, even encouraging, paternalism. Veatch writes, "The Hippocratic Oath is blatantly paternalistic. It justifies a physician's behavior whenever it is designed to try to benefit the patient regardless of whether the patient approves of it or believes it would really be beneficial" (Veatch 1991, 65).

In the twentieth century, paternalistic physicians have used the Hippocratic principle of protecting the patient to justify withholding information needed for fully informed consent to a therapy or surgical procedure, breaking confidentiality, and refusing to tell a terminally ill patient his or her full diagnosis (Veatch 1991, 65). In the modern age, where "high tech" treatments and therapies have the potential to cause a great deal of physical and emotional suffering for the patient, it is inappropriate to allow the physician to be the sole arbiter of what treatments are beneficial. Veatch draws the conclusion that while paternalism may have been appropriate in the original historical context of the Oath where few people were educated, it can have disastrous effects when applied in a modern, technologically advanced context (Veatch 1991, 263). His view is echoed by that of Pellegrino and Thomasma who believe modern medicine has the potential for altering both individuals and society. Physicians cannot be permitted, therefore, to act on their discretion alone (Pellegrino and Thomasma 1988, 13).

Paternalism in the Modern Era

In the history of women's medical care, the case of DES, a synthetic estrogen, is a celebrated example of the problem of pairing technology and paternalism. From the 1940s to the early 1970s, physicians pre-

scribed DES to women in high doses to prevent miscarriages. While the evidence to support its ability to prevent miscarriages was doubtful, in 1971 DES was linked to clear-cell adenocarcinoma, a rare form of cancer (Dutton 1988, 67). Apparently, DES caused cancer in the daughters of women who took DES during their pregnancies (Dutton 1988, 67). The link was discovered by Dr. Albert Herbst and his colleagues Howard Ulfelder, Robert Scully, and David Poskanzer. The practical response to the study was slow. In fact, the sales of DES actually rose in the year after the study was published (Dutton 1988, 73-74).

In her discussion of DES, Diana Dutton asserts that medical paternalism played a role in delaying the revelation to the public of potential dangers of estrogen therapy. She refers to an editorial published in 1971 in the *Journal of the American Medical Association* in which a staff member of the AMA recommended that "an organized effort by the medical profession to inform all women who were given estrogen therapy [would be] of questionable advisability...the fact that a risk exists should be known to the physician and should guide him [or her] to act in a careful, responsible fashion" (Dutton 1988, 74). Dutton interprets the editorial to mean that doctors should be aware of the risks of DES, but that they need not inform their patients (Dutton 1988, 74). She goes on to point out that many doctors who prescribed DES routinely refused to search their records to find women who had taken the therapy and a few managed to "lose" the charts of women to whom the drug had been prescribed (Dutton 1988, 75).

If Dutton's accusation is true, one must consider why physicians would withhold such information from their patients. In addition to the ever-present fear of legal action, it is possible that physicians did not believe it was their responsibility to contact the patients to whom they had prescribed DES. The physicians trusted the research information that indicated DES was useful for preventing miscarriage. They did not see themselves as responsible for the later effects. There was as well the basic problem of communication between physician and patient. It is likely that many physicians refused to go through their records and claimed they lost charts because they did not want to take the time or hire the staff to contact women who had taken DES. Contacting patients requires the physician to explain the situation in clear understandable terms and to answer a battery of questions asked by the worried patient.

The dangers of DES did not reach the public through the efforts of the American Medical Association or the U.S. government. Instead, it was grass-roots movement of DES mothers, sympathetic health professionals, and consumer groups which eventually produced a pamphlet to alert DES mothers and to inform them on receiving proper medical care.

The Challenges Presented by Technology

The medical progress in this half century alone has been remarkable. When medical professionals confuse the advancement of technique, however, with the interest of the patient, there is potential for tremendous harm to patients. Thomasma and Pellegrino point out that technology has presented the practice of medicine with three major challenges to the paternalistic principle which guides the physician to judge and act in the best interest of the patient.

The first challenge is called the "technological imperative" dramatic advances in medical technology have tempted physicians to misidentify what is best for the patient with the newest available technique. Oftentimes the technological imperative leads physicians to equate the patient's best interest solely with the medically indicated course of action, rather than with the values the patient may profess (Pellegrino and Thomasma 1988, 92-93).

The cure of the disease is not connected with the general care of the patient as a person. Instead, the marriage of paternalism and the "technological imperative" leads to the objectification of the patient. The patient, in the technological age, is often treated as an object of study, even of experiment, rather than as a person with whom the physician is to interact as a peer. The patient can quickly become an "it" rather than a "thou."

Closely related to the technological imperative is a second challenge presented by technology—the ability to sustain life well past the patient's "plane of normal effective and cognitive existence" (Pellegrino and Thomasma 1988, 93). It must be asked whether it is in the best interest of patients to sustain their lives through feeding tubes and ventilators or by offering treatments, such as chemotherapy, that have debilitating side effects with little guarantee of recovery. Although the possibilities presented by technology equate the prolongation of life with the best treatment of the patient, the end result is often that of prolonging suffering.

The third challenge to medical paternalism is the demand for patient autonomy in medical decisions. In response to the possibilities and potential hazards of medical technology, patients' rights organizations have emerged to challenge with vehemence the continuing existence of medical paternalism (Pellegrino and Thomasma 1988, 93). They uphold the right of competent, adult patients to make their own decisions about medical care. In fact, they contend the patient's right to decide supercedes the judgment of the physician.

Patient Autonomy?

Is the model of patient autonomy an appropriate solution to the problems presented by the paternalistic model of the physician-patient rela-

tionship? The improvement and wide availability of public education and the growing moral pluralism of North America have contributed to an increased emphasis on autonomy (Pellegrino and Thomasma 1988, 12). Essentially, in contemporary North America, people are better educated and receive more information about the advancements in medical research and the potential problems those advances may cause than in previous generations.

The model of patient autonomy assumes the presence of a competent adult patient, or a representative of the patient, who understands the life plan of, and is able to make decisions for, an incompetent patient. Competence is therefore an important term in this model. Citing the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982), Drs. Brock and Lynn state that competence implies a patient who is "sufficiently mature to have fairly settled value commitments and priorities, have a normal capacity to understand the situation and the likely effects of proposed interventions, have goals and value commitments, and be able to make and communicate a choice arising from these considerations" (Brock and Lynn 1986, 202). If the patient is not competent, then decisions about his or her care can be made by a competent family member who is familiar with the life plan, values, and goals of the patient.

The focus of autonomy is the protection of the individual. A person protects his or her rights against dominance by another person's values. This implies a definition of morality which rests solely with the individual. As Veatch, an advocate of patient autonomy recognizes, autonomy emphasizes "the individual as a center generating moral demands rather than as a locus of moral obligation" (Veatch 1991, 68). While demands do not necessarily generate obligations, an individual making moral demands in a clinical relationship is a significant problem. Just as a physician who forces his or her viewpoint on the patient may expect a patient to carry through with the course of treatment, a patient who makes moral demands of his or her physician may expect the physician to carry through on those demands. It is a more than a matter of who generates the demands; it is also a matter of objectification. The model of patient autonomy leaves open the possibility that the physician can be viewed as an object, rather than as a moral being. In this model, what is moral or ethical is perceived as what is best for one individual at a particular time. Little consideration is given to the effects an individual's decision has on the patient's family or community.

The model of autonomy extends to the competent patient the right to refuse life-sustaining treatments, including ventilation, nutrition, and hydration. Drs. Brock and Lynn, advocates for patient autonomy, believe

that patients, even those who are not near death, have the right to refuse life-sustaining treatments. They also feel that no social or legal policies should hinder competent individuals from refusing treatments offered by advanced medical technology (Brock and Lynn 1986, 210). In the 1980s, there were numerous court battles concerning the rights of patients, or their family representatives, to refuse treatment. The courts have tended to uphold the concept of patient autonomy and the rights of competent patients (and suitable representatives of incompetent patients) to decide their courses of treatment.

The model of patient autonomy, however, as applied to the physician relationship presents ethical problems, as intimated above. In particular, it threatens to violate the values of the physician. Just as medical paternalism risks violating the ethics, values, and life plan of the patient, the model of patient autonomy does not necessarily recognize the moral agency of the physician. It is possible for a patient to make demands which violate the ethical code a physician has accepted for his or her practice of medicine. In my own clinical experience I observed cases in which the wishes of a patient or a patient's family conflicted with the physician's point of view and plan for treatment. In one such case, a twenty-year old woman suffered massive brain damage from a loss of oxygen. The patient's mother was deemed by the attending physicians as an appropriate representative of the patient. Because the patient was not diagnosed with brain death, her mother requested that the patient be kept on a respirator. The physicians refused. After the respirator was removed from the patient, the physicians informed the patient's mother that they would not treat the patient should she develop pneumonia or any other form of infection. This refusal of treatment on the part of the physicians conflicted with the wishes of the patient's representative. In requesting that her daughter continue to be respirated artificially and that her daughter be treated for any infections, the patient's mother questioned the ethical commitment of the physicians. If one views this case from that standpoint of patient autonomy, the decision of the patient's representative should have superceded that of the physicians. On the other hand, the physicians argued that they had an ethical obligation to do no harm to their patient. They believed that by continuing to treat the patient, they would be doing harm to the patient in that they would only be prolonging her life without any foreseeable ability to improve the quality of her life.

Another such case involved a twenty-six year old man who was HIV positive, but not yet suffering from an AIDS-related illness. The patient had a respiratory infection which could be cured, but his treatment required the temporary employment of a respirator. The patient asked his physician to remove him from a respirator, although the patient knew it

would result in his death. A physician who disagreed with the right of the patient to refuse treatment, especially when a cure for the patient's immediate illness is attainable, might have denied the patient's request and withdrawn from the relationship if the patient persisted.

Who Decides What Is Moral?

The advancement of medical technology has challenged the validity of the paternalistic model of the physician-patient relationship. The concern surrounding the rights of the patient in the context of modern medicine has given rise to the model of patient autonomy as advocated by both physicians and patients' rights organizations. The conflict between paternalism and autonomy is a constant source of ethical questions in medical practice. At the heart of the conflict may lie a question deeper than that of who should control the use of medical technology. The central question may be that of who should define what is moral.

The problem of moral atomism or pluralism is addressed by writers in the field of medical ethics. Pellegrino and Thomasma believe that a patient's decision for treatment should be considered in addition to the ethical codes of the institution in which a patient is to be treated, the relationships in which the patient participates, and the society and culture in which the patient exists (Pellegrino and Thomasma 1988, 24). While they seem to be taking a broader social view, Pellegrino and Thomasma can be criticized by advocates of autonomy for attempting to hold on to a semblance of paternalism by maintaining a place for the judgment of the physician in the decision-making process.

In contrast, for those who support patient autonomy (Veatch, Brock, Lynn, *et al.*) the decision of the individual defines what is best for that person within a pluralistic society (Brock and Lynn 1986, 210). Brock and Lynn believe, for example, that the death of a person which has resulted from that patient's decision to forgo treatment does not have a harmful effect on the person's community other than in a "symbolic and metaphorical sense" (Brock and Lynn 1986, 210). They do not acknowledge that an individual's definition of what is "best" might have tangible negative effects on the person's family, community, or broader society. In this sense, autonomy seems to contribute to the growing moral pluralism of society.

Paul Ramsey points to moral pluralism as the basis for ethical crises in the field of medicine when he writes:

If there are moral dilemmas in modern medicine, if—some would say—there is a moral crisis in the ethics of the medical profession, this is not because of recent triumphs in medical research or the great promise and

grave risks stemming from medical technology. The fundamental reason is rather the continuing moral crisis in modern culture generally, which reverberates throughout all professions. It can no longer be assumed in the human community that we are agreed on moral action guides, the practice of virtue, the premises and principles of the highest, most humane, most embracing ethics, or what a moral agent owes to anyone who bears human countenance (Ramsey 1976, 35).

While it is questionable whether an agreement upon what Ramsey calls "moral action guides" or the highest ethical principles has ever existed, his point is important. The ethical conflicts which exist in the physician-patient relationship, brought to light by the advancement of medical technology in this century, are symptomatic of the individual's relationships within society. Conflicts arise when what seems best for the individual stands against what seems best for another individual or for the community.

The questions remain: Who should decide when the ethical or value commitments of two parties differ? Who decides what is moral in a morally pluralistic society? Two examples of conflicts or potential conflicts between the ethics and values of physician and patient or patient's representative have already been given. In one of the cases, a hospital board of ethics acted as arbiter and judged that the physician was acting in the patient's best interest. Arbitration is a potential means for resolving ethical conflicts in a pluralistic setting. On the other hand, it could only heighten the conflict by bringing addition sets of values and ethics into the conflict. In reconsidering the two examples of physician-patient conflicts, one means by which the issue could be arbitrated is evident. In both situations, the physician and patient or patient's representative had to communicate with one another on a consultative level. A conflict arose between what each believed was the ethical course of action, but each had to explain his or her positions, his or her value commitments. The arbitration of ethical conflicts begins with communication in which the physician and patient discuss the issues of treatment with the view that each is a moral and autonomous being, rather than an object of whom one can make demands with an expectation of a positive response.

In conclusion, it is clear that paternalism, pluralism, and technology are all elements which coalesce in the ethical dilemmas of the physician-patient relationship. While technology poses challenges to the Hippocratic, paternalistic model, it has also contributed to an objectification of patients. Knowledge of medical technology has created a class of physicians with an expertise all their own and a language which is hardly intelligible to laypeople. The technological expertise of physicians can thereby reinforce the belief that they are on a level above that of the patient and

that therefore their decisions should supercede those of the patients. On the other hand, the pluralism of society, coupled with a broader knowledge of the problems of medical technology and medical ethics, has led some to argue that patients should decide what is best for themselves. Autonomy recognizes that society is morally pluralistic and asserts that individuals should make their own decisions about treatment. It seems that both paternalism and autonomy are extreme positions which seek an absolute definition of who should make critical decisions and of who should control the administration of medical technology in the clinical setting. Moreover, the ethical conflicts within a physician-patient relationship reflects the larger problem of deciding what is moral in a pluralistic cultural setting.

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