Medical Paternalism

Dr Iain Crofton Briggs
The Lodge
Lodge Road
Ilketshall St John
Beccles, NR 348 JH

Curriculum vitae

Iain Crofton Briggs born in England, and graduated from the London Hospital, London University, with a BSc in 1979, and MBBS in 1982. After persuing a number of jobs in Norwich and Birmingham, particularly in paediatrics, he completed a General Practice Vocational Training Scheme. He then came out to South Africa where he was MO at Mosvold Hospital, Ingwavuma, from 1988 to 1992, with particular interest in primary health care and community development. At present he is busy completing MPRAX Med course at Medunsa, but returned to England where he is now a principal in general practice, which is an ideal situation for holistic doctor-patient relationships.

Summary

The costly consequences for a patient, whom I had not prepared well enough for her hospitalisation, rudely brought me to my senses. What sort of doctor do I want to be? Our training, our medical system, our patients and society as a whole make us take on a parental role which does not always serve our patients. I considered the ethical aspects of paternalism, of autonomy, of consent and the use of placebo, and decided: for the good of my patient and their autonomy, I must help them to take more responsibility for their own health and not allow circumstances to push me into a paternalistic behaviour.

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Introduction

Like most young schoolboys attending a medical school interview, my head was full of ideals of working with and helping people. (I remember answering when offered articles in accountancy, that I wanted to work with people and not with "inanimate figures".) They duly believed me and I went to medical school. But in my clinical years this ideal sagged under the weight of acquiring clinical skills. The name of the game was clever diagnosis, and the patients became the "inanimate figures". On the wards I still had my high ideals, but when I started to build up a rapport with a patient with Crohn's disease I was told not to get involved. The ward round is a classic example of non-involvement: patients are referred to, not as people but as diagnoses and, worse still, differentially diagnosed from the foot of the bed as though they were inanimate.

So I changed under the pressure to conform to the role models of my teachers. (Not only are role models a strong influence, but the desire to pass finals is even stronger!) I strove for the academic ideal of becoming a super diagnostician and felt inadequate if I could not attain this standard. I am sure my experience is not unusual and I think it is inappropriate for anyone wanting to enter general practice. The reductionist approach to medicine makes diagnosis and treatment its goal, whereas the general practitioner has to keep his/her sights on the person rather than the illness. A non-medical friend once asked me how I could possibly become a specialist when their interest is proportional to the patient's misfortune: the rarer the disease, the greater the specialists fascination – but often the greater the patient's suffering!

Even in a specialist setting of a hospital, I discovered that I was ill prepared for important aspects of my work. In my first house job I was on duty every post-op night, and had to break bad news of cancer to relatives after lists of Bronchoscopies and Oesophagoscopies. This was shattering: relating to people hadn't been in the syllabus. It was not lack of interest: I had taken an intercalated BSc in Psychology along the way, and still I was unprepared.

Several years later I had still not learnt to relate to people and was still locked, more and more unhappily, into the diagnostic ideal. Events affecting one patient rudely awakened me to the fact that this outlook could have unacceptable consequences, and it was high time I sorted out what sort of doctor I really wanted to be.

The Patient

A lady of 43 came to see me with watery PV discharge and heavy irregular bleeding for three months. She had a hard craggy mass arising from her cervix. I told her I was worried and I wanted her to go to Durban as soon as possible for a second opinion.

She did not realise that she would be admitted, so she had not prepared her school, of which she was the principal, for a month's absence, nor had she had time to visit dependant relatives who were left for two weeks wondering what had happened to her. She also went without sufficient clothes or money, and as a result of this was unable to pay the entrance fee of R46,00, without which she was billed for all her expenses, costing several thousand. To rectify this mistake took extraordinary efforts by people with resources far in excess of those available to most patients.

The ward round is a classic example of non-involvement

When I learned of all these problems through a mutual friend, I realised I had acted paternalistically in that I had not shared my knowledge with her, nor understood her as a person, nor taken account of her circumstances. I realised that I needed to work out an alternative stance which would prevent such errors and be morally acceptable to me as a person; a stance which would be *mine*, not just a product of my conditioning.

What sort of doctor I really wanted to be...

Developing a New Viewpoint

I turned to the relevant literature but soon found that Paternalism is not the most straight forward of ethical concepts. So what is it, and is it ever acceptable or even necessary?

Paternalism has been defined in a number of ways.[1,2,3,4] It is the interference with a person's freedom of action or freedom of information, for that person's own good. Authors differ about whether *coercion* forms part of the definition. Furthermore, Komrad[5] considers paternalism to be inversely related to autonomy: "When autonomy recedes, paternalism advances; and vice versa. Paternalism

cares for an individual's interest in place of autonomy, either by force or by necessity."

Autonomy is not straight-forward either. Miller[4] gives four senses in which the term autonomy can be used.

1. Autonomy is free action;
2. Autonomy is being true to oneself;
3. Autonomy is effective deliberation;
4. Autonomy is moral reflection.

A decision can be autonomous in some senses and not in others. Miller cites a man who develops severe headaches, stiff neck and fever, who is diagnosed as having meningococcal meningitis, but refuses treatment and prefers to die. He is acting autonomously in the sense of free action, but not in the other three senses, so treating him would actually respect his autonomy in the senses of 2,3 and 4. As Miller says, this paradox makes autonomy a complex issue. Christie and Hoffmaster[4] resolve some of the confusion by dividing autonomy into two types:

Moral/Evaluative: freedom, the right to make decisions and be informed.

Psychological/Descriptive: The possession of cognitive, psychological and emotional ability to make a rational decision.

I believe moral autonomy is a person's right, which should be respected. My patient (above) had the right to know the information I withheld from her.

I think this view is compatible both with liberal-democratic thinking and also with Biblical Christian ethics. God wants us to be autonomous, "You shall know the truth and the truth will set you free."[6] Jesus came to set us free[7] and that we might have life abundant.[8] Freedom is an essential part of His relationship with us. He gave us the freedom to choose, to choose Him or reject Him. Should we, as doctors, not also aim towards assisting our patients towards freedom?

Our attitude to them is also very important: Jesus calls us to humble ourselves and be like servants, for God is not a respecter of persons,[9] and all people are equal in His sight. Above all Jesus cares for everyone, whatever their race, upbringing – or sins – He just loves them.

Prescribing a placebo can only damage the doctor-patient relationship

Psychological autonomy, however, is often imperfect; then some degree of paternalism becomes more acceptable, but only to the extent necessary to enable the patient to move towards fuller autonomy, so it is self limiting.

So what are the imperfections of autonomy? "Ideal" autonomy (expressed in such phrases as "rational economic man", "consenting adults", "rational choosers") are at best approximations – one has only to consider the effects of advertising! And in the context of medicine, O'Neill[10] reminds us that it is important not to overestimate a patient's autonomy: "medical concern would be strangely inadequate if it did not extend to those with incomplete autonomy." He gives as examples of reduced volitional or cognitive capacity: infancy and early childhood, unconsciousness, senility, some kinds of illness and mental disturbance or retardation.

The patient's fears have a major influence on his decisions

However, we must not underestimate autonomy either, we must never fail to treat the patient as a person and avoid needless (and therefore unacceptable) paternalism.

Providing the information that respect for autonomy demands, entails some problems.

The knowledge gap: Mill[4] points out that no one knows a person – his values, desires beliefs, preferences etc as well as himself. So how well does

the GP know the patient? In individual cases, what does he need to know?

There is usually some imbalance in the other direction too: between the doctor's knowledge and the patient's which can constitute a conscious, or more often unconscious, reason for paternalism: the doctor has been trained in a particular way of thinking, and his language is also a problem: not so much my lack of Zulu (enormous though that problem is) but the technical terminology which it is easy to use without considering whether it is understandable by the patient. We use this to keep our distance. Patients, too, pick up medical jargon, often from the lay press, which can lead to serious misunderstanding, since the patient and the doctor may understand the same term quite differently.

So the doctor should try to "package" the information which the patient needs in non-technical language which will not be misunderstood. The problem is that this takes time- in the short term; but it will often save time in the long term (as this patient's history explains).

But can a patient really weigh up all the pro's and con's. (Now there is a temptation to paternalism!) Surely the doctor's task is to present them as fairly as possible in the light of the knowledge available, so sharing the decision-making with the patient. Mill[4] who advocates that patients know best says, "individual judgement is only legitimate, where the judgement is grounded on actual, and especially on present, personal experience; not where it is formed antecedently to experience, and not suffered to be reversed even after experience has condemned it."

The effect of illness. Illness does impair our ability to act autonomously. Pellingro[5] calls it "an ontological assault aggravated by the loss of freedoms we identify as peculiarly human". Talcott Parsons[4] writes about "a state of dependency and vulnerability which makes the sick role an involuntary state of diminished autonomy". Christie and Hoffmaster[4] quote examples from Jackson and Younger where illness affects psychological and emotional states. The first is a patient on the ventilator who changed his decision whether or not to be ventilated according to whether his family were present: maybe he himself was not ambivalent, but just responding to pressure from his relatives, who may have been (One does not know the whole situation). The other patient refused chemotherapy, but when his dehydration and calcium had been corrected, his nausea and vomiting improved and his mood brightened, he agreed to chemotherapy.

Does the patient in crisis prefer a paternalistic doctor to see him through?

Patients often perceive they are not being heard

Illness can therefore affect people's freedom to make rational decisions; ie, their autonomy. Balint[4] discusses illness as a new-life situation to which the patient must adapt, which consumes energies far beyond what are needed for the physiological defence process. This readjustment is complex and multi-dimensional. He states, "It is a severe shock to realise, no matter whether suddenly or gradually, that because of illness our body (or mind) is, for the moment, not capable and perhaps will never again be fully capable of reassuring us that our hopes are still possible of fulfilment in some unspecified future.[1]

Consent

The above discussion affects the way I now think about consent. How have I packaged the information? Am I biased? Do I have my own agenda? Morally I must give the patient the right to act autonomously: I must take time to share my knowledge and assist the patient to understand the relative probabilities – though not

listing every last complication or side-effect lest this influence autonomy negatively. Moreover, does the doctor or the patient really know all the possible consequences of the decision? These are constantly changing and dynamic and therefore frightening, though, honesty makes them less frightening. I have also learnt how important it is to find out the patients' perceptions and fears, as these will have a major influence on their decisions. Morally, we should yield the decision making to the patient as far as possible, especially as there is often more uncertainty than we care to admit.

The use of Placebo's

I would like to grasp this hot potato by saying that because of the above considerations I do not believe that the prescribing of a placebo is morally acceptable. It can only damage the doctor-patient relationship by introducing an element of dishonesty. If the patient finds out, the relationship may be irreparably damaged.

Why do we act Paternalistically?

The doctor as drug[11] is recognised as an important benefit of the relationship. However, as one aims at increasing patient autonomy the efficacy of the drug is weakened. The high cultural regard for doctors gives them a parental position of authority in society. Some patients like and need this. S LeBaron et al[12] show that the patient in crisis prefers a paternalistic doctor to comfort them and see them through – they need a refuge.[13] Inglefinger[14] states that if treatment is to succeed, the patient needs a physician whom he invests with authority and competence. Whilst recognising that this effect is important, I also believe we abuse it if we do not also aim to help the patient towards self reliance.

Le Syndrome du Bon-Dieu: This syndrome is described by J Kriel[15] as a malady which affects many doctors today, creating in them a need to act paternally.

Doctors have a life of acclamation from the time they start training. I can remember being told on my first day that we were among the top 0,2% in the country having made it into medical school. What a great way to educate a class of servants to the community! Worse is to come after qualifying, with nurses and patients being respectful, submissive, admiring and even adoring. Anything derogatory is unlikely to reach the doctor's ears. The doctor is on top of the professional pyramid – the boss, the decision man. He has the answers and begins to believe that he has them not only in the field of medicine, but in social and other fields where his opinion may be sought: so there are constant boosts to his ego until he comes to think of himself as the good god, or in French: le bon-Dieu.

Outside this false life of acclamation he functions less well: his family (who see him as a mere mortal) does not boost his ego in the same way, so he may withdraw more into his work, as he cannot relate to normal people on a basis of equality. He thus acquires further kudos for dedication and a vicious circle is set up. He is alienated not only from his family and social life but from his patients too, for he no longer relates as one human being to another. He cannot hear what the patient is trying to say because he already has the answers, so it is not surprising that patients perceive that they are not being heard.

The Apostolic Function: Balint[16] cites another reason why doctors act paternalistically: he calls it the Apostolic function or Mission. He says every doctor has his own ideas of how patients ought to behave, "almost

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as if every doctor had a revealed knowledge of what was right and what was wrong for patients to expect and to endure, and further, as if he had a sacred duty to convert to his faith all the ignorant and unbelieving among his patients."

This is where I find myself tempted to act paternalistically. If I believe something strongly I do feel pressure to enlighten my patient (for his own good). I know smoking is bad for him so I embark on a crusade to get him to stop.

Balint also writes about how the doctor's own personality affects the doctor-patient relationship and his handling of patients, and he cites three main problems: Lack of objectivity, lack of psychological skill, and disclosure of the doctor's own ideas. The last may be endemic in general practice, but is it always bad? Probably not always. Even a father-confessor role can be useful: it is possible and legitimate to encourage patients to change their life styles, but this must be done by offering knowledge, objectively and without apostolic zeal (otherwise paternalism creeps in).

The doctor must know him/herself

If he does he can at least recognise when he is acting as an apostle or as God. If not, he is the last person to perceive the effect his personality is having on his attitude towards his patients. The recognition of paternalism can (and must) be the beginning of learning to use it only when valuable, and of examining one's own objectivity. The doctor can ask himself, for example: "is my view based on anecdotal experience or well researched facts?" "How much are my own motives involved?" "Who is the reassurance for? For the patient or for myself? And who is the treatment for?"

The other aspect Balint[19] cites is the needs of the doctor, for example to feel wanted, to be seen as good, kind, knowledgeable and helpful. If the doctor fails to recognise this, his actions may be governed by his own needs and not by the patient's best interests, which obviously constitutes unacceptable paternalism. Again the doctor must know himself.

The key to this for me, is to understand both the patient and oneself as people in their context, then one can begin to help towards personal development. The other thing I have learnt is that just the process of making the effort to understand the patient on this level can be all that is needed to effect the required change. I suppose this is because patients meet someone who values them as persons and so boosts their self-esteem and self-worth.

Conclusion

This paper is not meant to be an authoritative dissertation but rather, an agenda for discussion. It is one person's attempt to grapple with the complexities of the subject and find a balance. It is not to set hard rules, because as persons we are all different, and no two situations are identical.

I consider we have an unenviable task ahead of us. We are conditioned by our training and the hierarchical system; moreover, our patients and society have, at least until recently, looked to us for a parental role. For the good of our patients and their autonomy we must demedicalise society and allow the people we serve to take more responsibility for their own health and lives.

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