Singapore Med J 2002 Vol 43(3) : 148-151

Deconstructing Paternalism – What Serves the Patient Best?

N H S S Tan

(This Essay won the Singapore Medical Association Ethics Essay Award (Non-medical Undergraduate Category) in 2001.)

ABSTRACT

On the motion that "medical paternalism serves the patient best", this essay reviews current arguments on medical paternalism vs. patient autonomy. Citing medico-ethical texts and journals and selected real-life applications like electroconvulsive therapy (ECT) and the advanced medical directive (AMD), the essay argues that medical paternalism cannot serve the patient best insofar as current debates limit themselves to "who" wields the decision-making power. Such debates side-step "what" the patient's best interests are. The essay further argues through the case of Traditional Chinese Medicine (TCM), and acupuncture in particular, that the current dominant Western school of thought excludes other forms of "alternative" treatment through medical paternalism.

Singapore Med J 2002 Vol 43(3):148-151

Although probably not written by Hippocrates (c. 460 – c. 477 BC) himself, the Hippocratic Oath is one of the oldest, most binding code of conduct today. The oath expresses the aspirations of the physician, and sets the ethical precedent by spelling out the physician's responsibilities to the patient and the medical profession. Today, the Hippocratic Oath has been adopted and adapted world-wide; all physicians take the oath in some form or another. In Singapore, the doctor who undertakes the Singapore Medical Council's Physician's Pledge promises to "make the health of my patient my first consideration" and "maintain due respect for human life" (pars. 4, 9).

The primary concept behind the oath is the principle of beneficence, which is operationalised in the original oath as the resolve to serve "for the benefit of the sick according to (the physician's) ability and judgement" (cited in Mappes & DeGrazia, 1996; p.59). The principle of beneficence, indeed the over-emphasis of it, also led to medical paternalism or the physician's prerogative to act on his or her best judgement for the patient. R S Downie observed, "The pathology of beneficence is paternalism, or the tendency to decide for individuals what they ought to decide form themselves" (cited in 1996; p.5). More often than not, medical paternalism tends to focus more on the patient's care and outcomes rather than the patient's needs and rights.

In recent years, medical paternalism has come under fire through the concept of patient autonomy, or the patient's right to choose and refuse treatment. While the debate between autonomy and paternalism still remains unresolved, paternalists argue that "maximum patient benefit" can be achieved only when the doctor makes the final medical decision (Weiss, 1985; p.184). The pro-autonomy stance maintains that "benevolent paternalism is considered inappropriate in a modern world where the standard for the client-professional relationship is more like a meeting between equals than like a father-child relationship" (Tuckett, Boulton, Olson & Williams, cited in Nessa & Malterud, 1998; p.394).

This essay argues that medical paternalism cannot serve the patient best insofar as current debates sidestep the principle of beneficence in favour of decision-making power and medical paternalism under the current dominant Western school of thought excludes other forms of treatment.

Current debate surrounding paternalism has always been centred on the issues of autonomy and paternalism and reduced further into a power struggle between the doctor and patient. This polarisation of the decision-making power has distracted the medico-philosophical debate. Today's traditional medical values like "pain is bad" and longer life is more desirable than a shorter one" are increasingly challenged. Still, do patient and physician both share common understanding of what is best for the patient?

Paternalists would claim that physicians have a "medical tradition to serve the patient's well-being", with the prerogative to preserve life and thus have the patient's best interests at heart (Mappes and DeGrazia, 1996; p.52).

N H S S Tan
Second-year mass communication student at Ngee Ann Polytechnic

Correspondence to:
Noel Hidalgo
Tan Suwi Siang
Email: noelbynature@pacific.net.sg

Far from paternalism understood as a dogmatic decision made by the physician, James Childress in his book "Who Shall Decide?" further expounds paternalism into multi-faceted dimensions. Pure paternalism intervenes on account of the welfare of a person, while impure paternalism intervenes because more than one person's welfare is at stake. Restricted paternalism curbs a patient's inherent tendencies and extended paternalism encompasses minimising risk in situations through restrictions. Positive paternalism promotes the patient's good and negative paternalism seeks to prevent an existing harm. Soft paternalism appeals to the patient's values and hard paternalism applies another's value over the patient. Direct paternalism benefits the person who has been restricted and indirect paternalism benefits a person other than the one restricted. Whatever the case may be, the guiding principle of modern paternalism," says Gary Weiss, "remains that the physician decides what is best for the patient and tries to follow that course of action" (1985; p.184).

That the physician determines 'what is best' is questionable. The medical profession's back-to-basics Hippocratic prerogative is prone to strong medical paternalism, implying that the patient does not want or know his or her own personal good and conversely implying that the patient is to be given no choice other than the physician's. Consequently, there is immense potential for abuse by giving the physician the final say. Actively, a paternalist physician may declare a person mentally unsound – and thus incompetent – because the patient refuses treatment. Passively, the physician can confound informed consent and obfuscate treatment alternatives. In some cases information can be misrepresented entirely, as John Breeding (2000) argues in his report on electroshock, or electroconvulsive therapy (ECT). He states that patients who sign up for ECT have no real choice "because electroshock psychiatrists deny or minimise its harmful effects" (p. 65). Breeding reports a "lack of efficacy" in the ECT procedure with "no lasting beneficial effects of ECT" and the "(physical) and mental debilitation...for people who undergo this procedure".

There are, however, some justifications for paternalistic intervention, which generally entails situations where intervention outweighs the harm from non-intervention. The weak paternalistic approach is especially warranted to prevent a person from posing a danger to oneself, or when the patient in question is a minor or suffers from impaired judgement due to illness. For example, in Dr Y M Lai and Dr S M Ko's paper on the assessment of suicide risk, a paternalistic stand is seen where "accurate diagnosis and careful management of the acute psychiatric illness could significantly alter the suicide risk" (1999).

Still, physicians might know for themselves what is best for the situation as they perceive it, but that knowledge does not necessarily translate to what may be best for the patient. Ruddick adds, "(Current) hospital specialists, it is said, rarely know their patient (or themselves) well enough to make this assumption without serious risk of ignorant arrogance" (1998; par. 5). Therefore while much debate has gone on about medical paternalism and patient autonomy, the definition on what serves the patient best remains unanswered, but the notion of medical paternalism continue to be redefined.

On the other side of the argument, proponents of patient autonomy hold that the final say lies with the patient. "It is the patient's life or health which is at stake, not the physician's...so it must be the patient, not the physician, who must be allowed to decide whether the game is worth the candle" (Matthews, 1986; p.134).

The notion of patient autonomy largely derives from philosophies of Immanuel Kant and John Stuart Mill, who, through different postulations, arrived at the same conclusion – that freedom of choice is paramount. Autonomy "asserts a right to non-interference and a correlative obligation not to restrain choice" (Pollard, 1993, p. 797). Retroactively, the emergence of the idea of patient autonomy has slowly eroded the normative model of medical paternalism. Dr K O Lee and Dr T C Quah (1997) observe "(the) commercialisation and cost of medicine, the loss of absolutes in morality, indeed the dominance of pluralism such that ethical issues are discussed without firm foundations, these have all led to fewer patients (or their relatives) saying 'Doctor, you do what you think is best - Sir'." (par. 3).

Unlike the paternalist view that deems illness as an impediment to autonomy, the patient autonomy model, as Cassel asserts, sees the patient "simply as a well person with a disease, rather than as qualitatively different, not only physically but also socially, emotionally and even cognitively" (1978, p.1675). Thus, proponents of patient autonomy rationalise, "Who better to determine what's best for the patient than the patient themselves?"

This shift in thinking has increasingly made patient autonomy the desirable standard for medical relationships. The advance medical directive (AMD), legislated in 1991 in America and 1996 in Singapore, reflects such a shift, albeit legal, towards providing power to patient choice. The AMD is a document

that "is basically designed to provide autonomy to patients to determine in advance their wish to die naturally and with dignity when death is imminent and when they lose their capacity to decide or communicate" (Agasthian, 1997; par. 1).

There is, however, little consensus as to what autonomy entails. According to Thomas Shannon, autonomy has two elements: "First, there is the capacity to deliberate about a plan of action. One must be capable of examining alternatives and distinguishing between them. Second, one must have the capacity to put one's plan into action. Autonomy includes the ability to actualise or carry out what one has decided" (1997; p.24). Nessa and Maltrud (1998) say "[within] the biomedical tradition, patient autonomy implies a right to set limits for medical intervention" (p.397). Pollard (1993) understands autonomy as "a person's cognitive, psychological and emotional abilities to make rational decisions" (p.797). With each definition, the interwoven faculties of personal liberty, voluntariness, being informed, and competence to engage in a plan of action appear. Philosophically, these faculties are subject, and subject autonomy, to varying degrees.

This subjectivity begs the question, "What construes as a mentally competent patient?" How much would an illness impede a patient's autonomy? How much autonomy does a person have with respect to his or her obligations to the community? Can a person ever have true and full access to information in order to make an informed decision?

Criticism towards advocates of patient autonomy also point out that patients sometimes "choose immediate gratification over long-term benefits" (Weiss, 1985; p.186). An exercise of autonomy may fulfil the patient's expressed desire but not necessarily translate to serving the patient best, if at all. Even with the patient autonomy model, then, the question as to what serves the patient best goes unanswered and gives way to what the patient wants.

To the extent that medical paternalism is discussed in relation with patient autonomy, current debates talk only about 'who' should determine the best interests of the patient but not 'what' the best interests of the patient should be. Thus, the principle of beneficence cannot be attained in both the minds of the physician or the patient.

Where current debate about paternalism sidesteps beneficence as the motivation for paternalism, medical paternalism itself sidesteps questions of its own validity through the established dominant Western thinking. Eric Matthews argues that "paternalism rests on the claim that the goods which medicine pursues are determined by the medical profession rather than the patients who make uses of their service" (p.135). In this argument, medical paternalism also determines the very medicine the medical profession uses and leaves the patient with little or no choice for 'alternatives'.

"Whether they agreed or not, physicians needed to become more knowledgeable about alternative regimes", reports Eugene Taylor on the use of alternative therapies (2000; p. 33). Only in recent times, with the proliferation of information spurred by the advent of the Internet age has given an indication about how little the dominant Western medical school of thought knows about other existing and so-called 'alternative' healing therapies and are beginning to react. In America, the National Center for Complementary and Alternative Medicines' (NCCAM) budget "exploded from $2 million in 1993 to $50 million in 1999" (Waltman, 2000; p.39). Singapore is now looking into developing traditional Chinese medicine (TCM) "research and education to the tune of US$100 million" (Kao, 2001; p.3). Going with this positive trend, Dr. P H Feng (2000) surmised that someday patients will have "unlimited access to medical information" (p. 524).

Despite the growing acceptance of alternative medical therapies, the Western medical profession also exacts paternalistic standards on alternative medicines. Take the example of TCM, of which studies in China have revived over the past few decades. A Singaporean report on TCM in 1995 reviewed "the standards of training and practice of TCM in Singapore...to ensure a higher quality of TCM practice...(and) to safeguard patient interest and safety" (Traditional Chinese Medicine, 1995; par. 2, 3). Yet to demand that 'alternative' therapies undergo review under Western medical criteria is as laughable as it is paternalistic. Says Eugene Taylor, "Can we actually understand acupuncture without reading the Five Confucian Classics or The Yellow Emperor's Classic on Traditional Chinese Medicine? Western practitioners would say we don't need them if we have the scientific evidence; Chinese practitioners would consider this the answer of an uncultivated dog-faced barbarian" (p. 33).

Ironically, while Western scientific method emerged from Cartesian thought in the 17th century, Jeffrey Singer notes that the Chinese had "documented theories about circulation, pulse, and the heart over 4,000 years before European medicine had any concept about them" (2000; par. 3). Other regimes like homeopathy and aromatherapy have been in existence for centuries but are now deemed "alternative", pseudonyms for "non-Western". This is paternalism at its worst because

so-called "alternative" therapies do not hold water, or are even oppressed by, a dominant Western medical standard.

Wrote Angela Coulter, "Assumptions that doctor (or nurse) knows best, making decisions on behalf of patients without involving them and feeling threatened when patients have access to alternative sources of medical information - these signs of paternalism should have no place in modern health care" (1999; p.719). The principle of beneficence is furthermore stymied through this kind of medical paternalism – how can the medical profession presume to serve the patient best when it fails to acknowledge other therapies that work? The medical profession must begin to re-look itself.

Thus far, solutions towards resolving the paternalism problem deal exclusively with advocating either paternalism, autonomy, or middle-road, shared decision patient-physician relationship models such as the one proposed by Elywn, Edwards, Gwyn and Grol. They propose "sharing the uncertainties about the outcomes of medical processes and...exposing the fact that data are often unavailable or not known" (1999; p.753). Again, proposed shared-decision solutions deal with co-responsibility of medical decisions, but the solutions do not determine the decision itself, and whether the decision serves the patient best.

Indeed, a quantitative solution may be near impossible, such is the dynamics of any ethical issue. Medical paternalism, however, must be deconstructed as an issue by both the medical profession and the patient. To approach a resolution through the eyes of the medical profession only serves to perpetuate medical paternalism, albeit in another form, which would not serve the patient. Surmises R S Downie, "The antidote to paternalism, or an inappropriate excessive expression of beneficence is a sense of justice and honesty" (1996; p.5). Medical practitioners then must also start recognising their own limitations as a healthcare provider and the limitations of knowledge in their own profession. It is a certain humility reflected in a physician's comment during a study by Sullivan, Menapace and White (2001), "I'm not the God of this patient, just a technician with an education".

REFERENCES

1. Agasthian T. Advance directive – A surgical viewpoint. Singapore Medical Journal (Online serial), 1997; 38(4). Retrieved June 23, 2001 from the World Wide Web: http://www.sma.org.sg/smj/3804/articles/3804e2.htm
2. Breeding J. Electroshock and informed consent. The Journal of Humanistic Psychology, 2000; 40:65-79.
3. Cassel E. Therapeutic relationship: contemporary medical perspective. In W. Reich (Ed), Encyclopaedia of Ethics (p.1675). New York: Macmillan. 1978.
4. Coulter A. Paternalism or partnership? British Medical Journal, 1999; 319:719-20.
5. Downie RS. Professional ethics and business ethics. In S.A.M. McLean (Ed.), Contemporary Issues in Law, Medicine and Ethics. Vermont: Dartmouth. 1996.
6. Elwyn G, Edwards A, Gwyn R and Grol R. Towards a feasible model for shared decision making: focus group study with general practice registrars. British Medical Journal 1999; 319:753-6.
7. Feng PH. Medicine in the digital era – Opportunities and challenges. Singapore Medical Journal, 2000; 41:522-4.
8. Kao C. $175m plan for Chinese medicine. The Straits Times, 9 September 2001; p.3.
9. Lai YM and Ko SM. What you need to know – Assessment of suicide risk. Singapore Medical Journal (Online serial), 1999; 40(5). Retrieved June 23, 2001 from the World Wide Web: http://www.sma.org.sg/smj/4005/articles/4005me2.html
10. Lee KO and Quah TC. Living, dying, death and advance directives. Singapore Medical Journal (Online serial), 1997; 38(4). Retrieved June 23, 2001 from the World Wide Web: http://www.sma.org.sg/smj/3804/articles/3804e1.htm
11. Mappes TA and DeGrazia D. Biomedical ethics (4th ed.). New York: McGraw-Hill. 1996.
12. Matthews E. Can paternalism be modernised? Journal of Medical Ethics 1986; 12:133-5.
13. Nessa J and Malterud K. Tell me what's wrong with me: a discourse analysis approach to the concept of patient autonomy. Journal of Medical Ethics, 1998; 24:394-400.
14. Pollard BJ. Autonomy and paternalism in medicine. The Medical Journal of Australia, 1993; 159:797-802.
15. Ruddick W. Medical Ethics (Online), 1998. Retrieved June 23, 2001 from the World Wide Web: http://www.nyu.edu/gsas/dept/philo/faculty/ruddick/papers/medethics.html
16. Singer JA. Acupuncture, a brief introduction (Online), 2000. Retrieved September 8, 2001 from the World Wide Web: http://www.acupuncture.com/Acup/Acupuncture.htm
17. Singapore Medical Council Physician's Pledge. (n.d.). SMA Centre for Medical Ethics and Professionalism (Online). Retrieved June 23, 2001 from the World Wide Web: http://www.sma.org.sg/cmep/medical_ethics/MEA2/MEA2A.html
18. Sullivan RJ, Menapace LW and White RM. Truth-telling and patient diagnoses. Journal of Medical Ethics, 2001; 27:192-7.
19. Taylor E. Mind-body medicine and alternative therapies at harvard: Is this the reintroduction of psychology into general medical practice? Alternative Therapies in Health and Medicine, 2000; 6(6):32-4.
20. Traditional Chinese Medicine. Ministry of Health (Online), 1995. Retrieved 8 September, 2001 from the World Wide Web: http://www.gov.sg/moh/mohiss/tcm/tcmrpt.html
21. Waltman AB. Alternative medicine goes mainstream. Psychology Today, May/April 2000; 38-9.
22. Weiss GB. Paternalism modernised. Journal of Medical Ethics, 1985; 11:184-7.