

Doctor-patient Relationship: from Medical Paternalism to Enhanced Autonomy

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ABSTRACT

For centuries, physicians have been allowed to interfere and overrule patient's preferences with the aim of securing patient benefit or preventing harm. With the radical rise in emphasis on individual control and freedom, medical paternalism no longer receives unquestioned acceptance by society as the dominant mode for decision-making in health care. But neither is a decision-making approach based on absolute patient autonomy a satisfactory one. A more ethical and effective approach is to enhance a patient's autonomy by advocating a medical beneficence that incorporates patients' values and perspectives. This can be achieved through a model for shared decision making, acknowledging that though the final choices reside ultimately in patients, only through physician beneficence can the patient be empowered to make meaningful decisions that serve them best. For such a model to function effectively, the restoration of trust in doctor-patient relationship and the adoption of patient-centred communication are both crucial.

Keywords: paternalism, beneficence, autonomy

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One of the oldest and most fundamental tenets of the medical profession has been the obligation to achieve patient benefit. From the days when the Hippocratic traditions were developed, generations of physicians have pledged to do their best to protect patients from harm, and to restore them to health. The physician is readily recognised and accepted as the guardian who uses his specialised knowledge and training to benefit patients, including deciding unilaterally what constitutes a benefit. The relationship therefore resembles that between a wise and caring father and his child, hence the use of the term “paternalism”. For centuries, medical beneficence stood firm and unchallenged as the *modus operandi* for doctor-patient relationships. Such a father-child relationship worked well, securing the medical profession's special and

indispensable role in society, and facilitating the many contributions of medicine to mankind⁽¹⁾.

In the past few centuries, various social and philosophical developments, dated by some to as early as the Lutheran Reformation in Christianity⁽²⁾, have gradually but surely relocated the authority of decision making to the individual, away from political and religious authority. Medicine, in essence a social institution, faces similar, albeit somewhat later and slower transformation by the rise of Western liberalism. This change is also well illustrated by a comparison of the ethical codes of the American Medical Association (AMA) in the last two centuries⁽³⁾. In article II of the 1847 AMA ethical code entitled “Obligations of patients to their physicians”, the following statement was found in section 6:

“The obedience of a patient to the prescriptions of his physician should be prompt and implicit. He should never permit his own crude opinions as to their fitness, to influence his attention to them. A failure in one particular may render an otherwise judicious treatment dangerous, and even fatal⁽⁴⁾.”

In contrast, AMA's opinion in 1990 on “Fundamental Elements of the Patient-Physician Relationship” now states a radically different position:

“The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment⁽⁵⁾.”

Today, the principle of patient autonomy and self-determination has emerged as the dominant ethos in health care, threatening in many instances to totally eclipse the principle of medical beneficence. The pendulum has taken such a drastic swing that, with the exception perhaps of soft weak paternalism in the case of non-autonomous patients, paternalism is almost always perceived in negative light, regardless of intention and outcome. But medicine is, after all, a human activity aimed at healing and restoration of health. The inherently fiduciary nature of the relationship obligates the more knowledgeable physician to benefit the less informed and vulnerable patient. Can medicine therefore continue to serve the patient if cleansed totally of a paternal motivation?

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This issue of the Journal showcases the two winning essays of year 2001's Singapore Medical Association Undergraduates Ethics Essay Competition, in their unedited and original form^(6,7). The two young authors responded enthusiastically to the provocative topic of "*Medical Paternalism serves the patient best*", albeit with slightly different perspectives.

The essay by Tan NHSS⁽⁶⁾ rejects the validity of medical paternalism, arguing vehemently for its deconstruction. Advocating passionately for absolute patient autonomy against "excessive expression of beneficence", many of Tan's ideas are, however, less than persuasive due to deficiencies in development and validation. To illustrate this point, his "real-life" example of paternalism was a case of a physician declaring a patient unsound solely on the grounds of non-compliance. However, such provocative and radical examples are no longer common. The incompetent status of a patient, and hence his or her disqualification from making decisions as an autonomous individual, is rarely so recklessly determined. In this present day especially, due process supported by legal provisions is needed before a patient can be declared legally incompetent, and this includes a pre-existing psychopathology and a systematic assessment of decisional capacity and cognitive function. One further example would be Tan's allegation that the move by Singapore's Ministry of Health to regulate the practice of traditional Chinese Medicine (TCM) was "laughable"⁽⁶⁾. He seems to have missed the point that regardless of the review methodology used, any system of medicine that is seeking acceptance and official recognition in society has to provide an appropriate level of assurance to the public in terms of safety of its practices and minimal standards of its practitioners. Such concepts are not what Tan labels as "Western medical criteria", but are instead very basic qualifying standards demanded by regulatory authorities to ensure public safety. Society's choice over which system of medicine it adopts as mainstream, be it allopathic or homeopathic, experimental or empirical, is hardly a result of paternalism in Western medicine. Tan is nevertheless right in suggesting that the 'western-trained' doctor needs to adopt an open mind to alternative schools of medicine. But this can only go as far as an honest admission of ignorance and a willingness to critically examine any available evidence. Humility cannot, and should not, equate unfounded endorsement and recommendation of therapies for which a doctor lacks understanding or conviction.

For those who strongly oppose beneficence as the justification to overrule patients' choices, a model advocating supremacy of individual freedom and autonomy is advocated. In this approach, labelled by

some as the "informative model"⁽⁸⁾, the role of the physician is relegated to that of a technical specialist who only provides the patient with the relevant information, leaving the patient to decide on his own. Such a model is problematic in clinical care as it makes several questionable assumptions.

Firstly, it assumes that the physician's role in a medical encounter is no more than a passive information provider. Such a posture is a sadly simplistic view of the profession's responsibilities and duties, though admittedly some physicians are guilty of promoting such a perception by neglecting the humanistic component of their practice. Furthermore, physicians who are fearful of the consequences of not respecting and recognising patient autonomy have been known to adopt such a model. This can lead to a neglect of their professional obligations, with a possible danger of administering therapies that are not medically indicated or appropriate⁽⁹⁾. If in the name of honouring autonomy and freedom, physicians merely offer possible options without any professional input, then this informative model is unlikely to serve patient's interest. Under such a system, even non-coercive and non-manipulative attempts to discuss with patients the pros and cons of their decisions can be considered a violation of their freedom or rights when in fact, such efforts merely reflect appropriate care and concern for the patient's well-being. This model of clinical encounter is thus unsatisfactory as it can lead to a form of moral and professional abandonment by the physician⁽¹⁰⁾.

Secondly, it assumes that all competent individuals are capable of managing their own affairs and pursue their own life goals according to their own values, beliefs and experiences. This capacity is naturally extended to include decision making in health care. It also presupposes that patients will logically be able to make decisions that best serve themselves. And Tan appears to agree with this when he cited a 1978 opinion that illness has no impact at all on a patient's emotional and cognitive capacity to making treatment decision⁽⁶⁾. This used to be a debatable issue, though it is now generally recognised that although patients' moral status and rights are deemed unchanged by most diseases, increased vulnerabilities due to the biophysical and psychosocial impact of illness can reduce patients' capacity to make and to execute informed choices⁽¹¹⁻¹³⁾. Furthermore, in a free society like ours today, the standard set for one to qualify as a competent person is low. To question this competence in anyone, the burden of proof lies with the questioner, who must prove the presence of mental incapacity or psychopathology. When such a low threshold is similarly applied in health care decision-making, using freedom as an ultimate "trump card" against medical beneficence is wrought with problems⁽¹⁴⁾. Competent

patients have been known to make irrational choices, especially when complex and emotional issues are at stake⁽¹⁵⁾. Here the patient's plight is further aggravated as the informative model leaves the patient in the untenable position of having to make treatment decisions alone, a role that they are neither fit nor prepared for. Such a complete rejection is unlikely to "serve the patient best" in a real world where numerous medical options deemed beneficial by well-meaning physicians usually do not clash irreconcilably with the patients' choices. And even when they differ, a compromise and consensus can usually be arrived at without having to forego beneficence completely for autonomy, and vice versa. In Stephen Wear's insightful work on informed consent in health care, he observed that it may be more harmful for patients to exercise their rights of autonomy to overrule doctor's choice, simply for the sake of freedom and control, without exercising the necessary deliberation of their own choice⁽¹⁴⁾. Absolute freedom without the support of moral responsibility can be destructive and counter-productive to achieving the goals of medicine⁽¹⁶⁾.

Patients may thus be better served if efforts are directed instead to finding ways of minimising hard paternalism without too great a compromise on patient's freedom. Interestingly, despite his advocacy to deconstruct paternalism, the weakness of such a model was fleetingly acknowledged by Tan when he briefly commented that an exercise of autonomy "may fulfil the patient's expressed desire" but "not necessarily translate to serving the patient best, if at all". Unfortunately, he did not further develop this potentially enlightening idea⁽⁶⁾. The essay by Lim SL, on the other hand, appears more balanced and pragmatic, where the author takes a more realistic and constructive approach towards the issue of paternalism⁽⁷⁾. Lim's essay displays a good command of language and an excellent grasp of the issues on both sides. He rightly points out that polarised and hard paternalism is uncommon in today's medical practice, and that the majority are the so-called "grey cases". Many patients may not be prepared or ready for absolute autonomy, and may be best served by a model that he calls "guided paternalism" whose objective is to strive to enhance and optimise the patient's autonomy⁽¹⁷⁾. This approach, while acknowledging that the final say should ultimately reside with the patient who has to live with the consequences of the medical decision, stresses on responsibility of the patient⁽¹⁶⁾, and the effectiveness of the clinical management. As a "deliberative model"⁽⁸⁾, it sees the physician as a teacher and a friend who helps the patient in value clarification and in processing the various potential interventions. The aim is not only to discuss what

the patient could do, but also what the patient should do in a particular situation. This will help the patient to formulate plans and make decisions that are most authentic and relevant to him. Such a model that provides for professional guidance is especially relevant in this Internet age, where patients are flooded with information, some of which are unprocessed and lack validation. Conceptually, this is consistent with what Pellegrino and Thomasma advocate as "true beneficence"⁽¹⁰⁾; the physician's efforts to help make decisions in the patient's best interests should include facilitating and enhancing the latter's capacity for self-determination, in accordance to the patient's own perspectives. Beneficence and autonomy are therefore not conflicting, but congruent principles.

Putting this model into practice calls for a genuine and sincere process of shared decision making between patients and doctors⁽¹⁷⁻¹⁹⁾. The physician needs to cultivate a partnership with the patient, and together negotiate a management plan which allows for physician's professional recommendations and for patient's ideas, concerns and expectations. This "shared"⁽¹⁸⁾ or "deliberative"⁽⁸⁾ model requires a reasonable amount of mutual trust and understanding between the physician and patient. One of the main reasons why hard paternalism is no longer valid is erosion of the faith and high regard that the public once held for the medical profession. This, together with our increasingly pluralistic society, means that doctors and patients meet often as "moral strangers" with little shared values and beliefs⁽²⁰⁾, and poor understanding of each other's roles, goals, agenda and practices. In such a practice environment, paternalistic attitudes will likely end up appearing insensitive, unethical and even tyrannical.

That Tan writes from the perspectives of a "non medical" person is, in some ways, disconcerting. One cannot help but wonder if Tan's sweeping portrayal of the medical profession as one badly in need of humility and humanity echoes the sentiments of the "non-medical" segment of our society. Although it seems an unjust verdict based on a minority of offenders, it does suggest that it is perhaps timely for the profession to do some soul searching to explore why the public has such a negative impression of a profession that has served them well for generations, and whose public health achievements have helped improve quality of life beyond the imagination of our forefathers⁽¹⁾. One suspects the pathology of the problem is multifaceted, and needs to be tackled simultaneously at different levels, including the need to educate doctors and patients in Singapore on the ethical and practical merits of the shared model of doctor-patient relationship.

In response, physicians need firstly to be sensitised to the problems, and then to explore systemic reforms that

seek to establish a trusting and constructive partnership in decision making with patients. For example, there needs to be concerted efforts to ensure that patients are managed by regular doctors, and to educate patients on the benefits of building a good doctor-patient relationship. Time and funding constraints in current health care systems, which are frequently disincentives to a shared decision making model, need to be seriously addressed. In many instances, whether a physician's attitude is paternalistic rests on how the information and advice are communicated across to the patient. It is therefore important for physicians to acquire effective patient-centred communication skills that are essential tools to promote patient understanding and participation⁽²¹⁾.

For patients, there should be a greater willingness to exercise accountability and responsibility for their own health care. This will include active communication with physicians, diligent compliance with therapeutic agreements, and a readiness to nurture trust in the face of medical uncertainty. If ethical and effective communication is essential to the enhancement of patient autonomy and therapeutic efficacy, then endorsement by society and patients should include proportionate investment of financial and manpower resources into the health care system.

One final point of clarification in this commentary relates to the statements by both Tan⁽⁶⁾ and Lim⁽⁷⁾ on medical futility. This is an area where paternalism is frequently on trial for interfering with the "autonomy" of patient's family or guardian. The controversy is, however, very different from the scenario painted by both authors. Cases where permanently unconscious patients are being kept alive by their paternalistic doctors using "major advances in medical science and technology" have been uncommon since the early 1990s; policies promoting such a scenario are almost unheard of. On the contrary, the majority of the debate on medical futility in the context of medical paternalism centres on whether the doctor has the professional right to unilaterally withdraw or withhold life-sustaining treatment against the wishes of the patient's family or surrogates. It is therefore the family that is interfering with patient's individual autonomy and the doctor's professional autonomy. Here, it is fair to say that the Advanced Medical Directive (AMD) Act in Singapore is today a provision to uphold patient's autonomy against the potential paternalism of family and relatives, rather than that of doctors.

In some ways, today's patients are no longer "children" but "adults", and are therefore entitled to their rightful place in the process of decision making. The sophistication and complexity of society also means that patients are at liberty to prioritise other life goals above medical goals. The caring attitude and the guidance from the physician ('father') should, however,

continue, as long as he grants the patient ('child') the final say. As Devettere points out, there is no real need to make an absolute distinction between paternalism and autonomy, and to prefer one over the other⁽²⁾. The motivation behind paternalism is beneficence, doing good for the patient. The driving force behind autonomy is the recognition that patients are ultimately responsible and free to make important personal choices in life. An approach that serves the patient best is probably one that promotes a harmonious marriage of beneficence and autonomy. By sharing the decision making, the meaning, richness and accuracy of patient's choices can be enhanced by the physician's recommendations and advice. It is readily acknowledged that a physician is not the God of his patient, but neither is he "just a technician with an education"⁽²²⁾. He is, to his patient, a wise friend, and a caring partner in the journey towards healing and comfort.

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