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I am submitting herewith a thesis written by Kathleen Marie Merek entitled "Paternalism as an Organizational Institution in Medicine." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the Degree of Master of Arts, with a major in Philosophy.

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PATERNALISM AS AN ORGANIZATIONAL INSTITUTION IN MEDICINE

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ABSTRACT

This thesis deals with paternalism as an organizational institution in medicine. Institution is to be understood as a characteristic or persistent element of a culture that is widely sanctioned and which structures the interrelationships of different groups. To say that paternalism is an organizational institution is to limit the culture involved. The organization that shall be dealt with in this thesis is the organization of medicine.

It will be asserted that paternalism as an organizational institution structures the interrelationships of physicians and patients. It forces upon their interaction a specific nature, a particular power structure. It ensures that therapeutic decisions will be made in the context of a circumscribed value system. As paternalism is an institution of medicine, the nature and structure of the medical organization will shape the development of paternalism. Medicine is not only an organization, but is a profession. Consequently, the nature of paternalism will be strongly affected by the history and development of medical professionalization.

The definition of paternalism operant throughout this thesis is one developed by Allen Buchanan. It is,

> . . . paternalism is interference with a person's freedom of action or freedom of information, or the deliberate dissemination of misinformation, where the alleged justification of interfering or misinforming is that it is for the good of the person interfered with or misinformed. (Buchanan, 1978: 372)

This definition will be used only in its application to paternalism as

an organizational institution. It will only refer to interference with freedom of action or freedom of information as a characteristic style used by physicians in dealing with their patients, not as an occasional occurrence.

This thesis has two major tasks: to prove that paternalism is an organizational institution in medicine and to show why this is problematic ethically. The first task will be accomplished by means of an analysis of the history of paternalism in medicine and an examination of the way in which the structure of the organization of medicine shapes paternalism as an institution. The second task will be dealt with by revealing paternalism as an organizational institution as a denial of the moral responsibility and autonomy of patients. Arguments for paternalism will be exposed as internally incoherent. Paternalism as an institution will be shown to be inconsistent with the goals which paternalism professes, the production and preservation of the benefit of patients.

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INTRODUCTION

There are many different ways of examining paternalism.[1] It can be seen as an individual incident or event or as a custom or trend. It can be something accomplished between two persons or a system for the organization of the dealings of two million persons. It's scope can be limited to familial relations or can be as pervasive as a cultural hegemony. Paternalism can be understood as beneficent or as a vehicle for the maintenance of authority and power. There are definitions and stances to match each possibility.

This paper will deal with paternalism as an organizational institution. Institution here is to be understood as a characteristic or persistent element of a culture that is widely sanctioned and which structures the interrelationships of different groups. More simply put, it is one group's characteristic way of dealing with other groups. To say that paternalism is an organizational institution is to limit the culture involved. The organization that shall be dealt with in this thesis shall be the organization of medicine.

To say then that paternalism is an organizational institution is to say that paternalism is a characteristic or persistent element of the organization of medicine that is widely sanctioned and which structures the interrelationships of different groups. In this case"groups" refers to the group of physicians and the group of patients. To say that

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[1]The author opposes the use of the term parentalism because it is not sensitive to a major component of paternalistic behavior which is sexism. Paternalism is still primarily a male activity. Most frequently the male physician dominates the female patient. Parentalism masks the sexist value structures and policies involved in this type of behavior.

paternalism is a characteristic element is to say that paternalism is not accidental to medicine. Rather, it will be shown that medicine is inherently paternalistic.

Medicine has been and remains persistently paternalistic. The practice of paternalism as a characteristic way of dealing with patients has a history almost as long as the history of medicine itself, extending at least as far back as the fourth century B. C. Medicine is also persistently paternalistic in that in spite of numerous greater cultural changes of the most dramatic nature, medicine is still organizing its relationships with a specific population, patients, in the same manner, paternalistically.

Paternalism as an organizational institution is widely sanctioned. It should be no surprise that its greatest proponents are physicians, but its influence is as far reaching as is the acceptance of the medical model. Paternalism as an institution structures the interrelationships between physicians and patients. It forces upon their interaction a specific nature, a particular power structure. It ensures that therapeutic decisions will be made in the context of a circumscribed value system.

As paternalism is an institution of medicine the nature of the medical organization will shape the development and expression of paternalism. Medicine is not only an organization but is a profession. Consequently, the nature of paternalism will be strongly affected by the history and development of medical professionalization. In fact, the professionalization of medicine will be one of the greatest influences on institutional paternalism. Yet paternalism must not be seen as simply a professional concept. Its scope is much broader.

Professionalization intensifies and gives a more formal structure to paternalism but in the case of medicine it did not create it.

So far paternalism has been described as an organizational institution, its scope and nature have been given, but no definition for paternalism has yet been proposed. That shall be remedied here. The definition of paternalism that shall be operant throughout this thesis is one developed by Allen Buchanan. It is,

> . . . paternalism is interference with a person's freedom of action or freedom of information, or the deliberate dissemination of misinformation, where the alleged justification of interfereing or misinforming is that it is for the good of the person who is interfered with or misinformed. (Buchanan, 1978: 372)

It should be stressed that this definition is to be used only in its application to paternalism as an organizational institution. That is, this thesis will deal only with the interference with freedom of action or information as a characteristic style used by physicians in dealing with their patients, not as an occasional occurrence. It is not doubted that paternalism has its purposes and is valid in extreme or rare circumstances. However, it will be the position of this paper that the existence of paternalism as an organizational institution is unethical, and inconsistent with the goals paternalism professes.

The limits of the definition of paternalism should also be made clear here. This definition will only be applied to rational, competent adults. The reference group of the definition consists only of persons who have attained adult years, (18 years old) ; have sufficient maturity, aren't mentally or emotionally impaired and are in control

of themselves and acting in a self-determined manner. Because of this specification of the reference group, the voluntariness standard proposed by Feinberg will be accepted as justified and ethical. The organization of medicine and the state shall be allowed to reserve the right to misinform or to prevent self-regarding conduct when the individual's intended action is substantially non-volantary or when time is needed to determine whether it is voluntary or not. (Harris, 1977: 86) Limitations under these circumstances shall not be considered paternalism. However, the voluntariness principle shall not be allowed to develop into a vehicle substituting medical or societal values for confirmed patient values through a narrow, value-laden criterion of voluntariness. Its only purpose is to establish that the patient is competent and in control of her/his actions. [2]

The definition of paternalism operant in this work and its application only as an organizational institution, combined with the restricted nature of the reference group and the use of the voluntariness standard might seem to preclude any demonstration of the existence of such a paternalism, let alone its ethical reprehensibility. Yet, both will be established. In fact, many persons may be surprised at the pervasiveness of such a paternalism in medical practice.

This thesis has two tasks to be undertaken in its four chapters. The first task is to establish that paternalism is an organizational

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[2] Patients will be referred to throughout this thesis with the use of both the masculine and feminine forms of the personal pronoun and possessive adjective. As physicians have always been and remain a predominantly male group they will only be referred to by the use of the masculine forms.

institution in medical practice. This job will be accomplished in the first three chapters of the thesis. The first chapter will deal with the history of paternalism in medicine. The second shall show how paternalism as an institution is shaped by the structure of the organization of medicine as well as establish how paternalism as an institution is accomplished on a daily basis. The third chapter will provide illustrations of paternalism as an organizational institution.

The second task of this thesis is to establish why paternalism as an organizational institution is ethically problematic. This task shall be dealt with in the fourth and final chapter of this work. This last chapter is divided into three parts. The first part will deal with the relationship of paternalism and the moral reponsibility of patients. The second shall discuss paternalism as the denial of patient autonomy. The third part will examine paternalistic reasoning and establish its logical inadequacy. The inconsistency between the reality of paternalism as an organizational institution and the goals which paternalism professes will also be disclosed. Following the third part of this chapter there will be some brief conclusory remarks.

CHAPTER 1

THE HISTORY OF PATERNALISM IN MEDICINE

The history of paternalism as an institution in medicine is almost as long as is the history of medicine itself. One of the earliest concrete expressions of paternalism as an accepted mode of practice in medicine is the Hippocratic Oath. Institutional paternalism should not be considered to be limited to the Oath however. It permeates the entire Hippocratic corpus.

The Hippocratic Oath was probably first outlined in the second half of the fourth century B. C. and completed toward the end of that century by followers of the physician Cos. The Oath was a vow of loyalty and secrecy to the religio-scientific cult of Pythagoreanism. (Veatch, 1978b: 241) Consequently, its text reflects the Pythagorean value system and beliefs.

What in the Oath and in the greater Hippocratic corpus indicates the development of institutional paternalism? Initially there is the benefit language of the Oath.

> I will apply dietetic measures for the benefit of the sick. . . . (Temkin, 1967: 6)

The use of this type of language is dangerous because it does not limit the sphere of influence of the physician to restoring health or usual bodily function. It leaves the physician's domain as unstated with the implications of boundlessness.

This benefit language becomes paternalistic when it is established that the physician rather than the sick person or patient is to be the

judge of what constitutes the latter's benefit. By denying the patient's ability to judge what is best for herself/himself and substituting the values of the physician for those of the patient, the physician becomes moralist and paternalist. When this ordering of the relationship between physician and patient is enshrined in the vow of induction to the fraternity of Hippocratic medicine, paternalism becomes established as an organizational institution. It becomes a characteristic way of dealing with patients, or at least a norm for such dealings, rather than an infrequent occurrence.

But not only does the language of the Oath create a shift in world views dominant in the therapeutic milieu, it also enjoins the physician to become an ordering force in the patient's greater moral life. The physician swears,

> I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice. (Temkin, 1967: 6)

When this statement is understood in the context of the Pythagorean system its meaning becomes clear. The Pythagoreans believed that anything taken into the body affects the soul. Different types of foods cause different actions of the soul. Consequently, when the Hippocratic physician promises to benefit the sick according to his standards and keep them from harm and injustice he promises to protect his patients from the injuries and immoralities which may come upon them through their choice of an improper diet. (Temkin, 1967: 25) In so doing, one noted historian of medicine, Ludwig Edelstein, says that the physician swears to be,

> . . . a physician of the soul no less than the body. . . not to overlook the moral implications of his actions, nor even the negative indices to be watched; for the regimen followed by a person concerns both his bodily and psychic constitution. (Temkin, 1967: 25)

If it is recalled that Aristoxenus interpreted the Pythagoreans as explaining most diseases as the result of unreasonable living, (Temkin, 1967: 30-31), Hippocratic medicine becomes the attempt to regain and maintain health through the proper legislation of the patient's life. This paternalism became more readily accomplished by the Hippocratic physician through another assertion of the Hippocratic corpus. That is the assertion that patients are ignorant of the true causes and cures of their maladies as well as being generally untrustworthy. Temkin asserts that the corpus viewed the average patient as,

> . . . credulous, devoid of real judgment, and a liar, opinions which are indicative of the opposition on which the physician must count. (Temkin, 1967: 99)

This opinion left the corpus free to assert the desirability of good patient relations without fundamentally alterating the therapeutic power and value structure. The paternalism is clear,

> If the physician is to help, his relationship to his patient must be that of the person in command to the one who obeys. The patient must be in the physician's hands. . ., though such a relationship is difficult to obtain. (Temkin, 1967: 98)

It should be clear at this point that the Hippocratic corpus was thoroughly paternalistic. Yet it has not been established what degree

of general acceptance, if any, this doctrine had in its time. The view of medicine espoused by the Hippocratic corpus was far from pervasive and actually had very little effect on the practice of Greek medicine of the period. The prohibition against assisting suicide, performing abortions and surgery set the Hippocratic physician in a distinctive minority. The power structure of the therapeutic situation that the corpus advocated was also unpopular. Contrary to the situation today, the Greek physician was not a highly honored professional to be instinctively obeyed. The concept of medicine as a profession had not yet developed. Rather, the physician was seen as a businessman or craftsman and had a relatively low postition in society. As a businessman he was not recognized as an authority in the field but as someone who must prove that he performed quality work as well as made money. In the greater scope of Greek medicine, power to determine what should be done as well as what values were to be used remained with the patients.

The concept of medicine as a profession did not develop until early in the first century A. D. in the writings of Scribonius Largus. A profession at that time was understood to be an occupation with specific moral connotations. As a profession, Scribonius described medicine as having three special attributes: a specific knowledge base; a service orientation , that is, responsibilities and duties arising from the physician's understanding of the nature of his profession; and the ability and right of medicine to be the only standard of right conduct for medicine. (Temkin, 1967: 338-339)

The writings of Scribonius were substantially different from the Hippocratic corpus in the great emphasis that they placed on the service orientation and its consequent medical humanism. The Hippocratic corpus

enjoined its physicians to its views so as to follow the tenets of Pythagoreanism and also succeed monetarily with patients. Scribonius enjoined his readers to his tenets because of the nature of medicine itself as well as for a love for mankind. The writings of Scribonius were also not as paternalistic as was the Hippocratic corpus. Patients were to maintain their self-determining status. However, the writings of Scribonius had relatively little influence. With the rise of Neo-Platonism, Galen became established im medicine; and professional ethos as well as the Hippocratic corpus ceased to have a significant influence.

It was not until the end of antiquity that the Hippocratic Oath became widely used and its teachings were followed. This was largely due to the great concordance between the principles of Christianity and Pythagoreanism. (Temkin, 1967: 62) With the institutional support of the Church the dominion of the Oath grew until it became the standard of medicine.

The connections between Christianity and the Hippocratic Oath are fascinating to explore. Why was the Oath so popular with this major religious force? Edelstein suggests it was because the Pythagorean relationship between illness and unreasonable living meshed so well with the Christian concepts of illness originating with sin and illness as a trial by God. (Temkin, 1977: 54) The benefit language of the Oath was also acceptable to the Christians.

With the support of the Christian Church paternalism as an organizational institution flourished. Christianity's connection between physical and moral illness coupled with the Church's all-pervasive sphere of authority made paternalism an established and expected practice in medicine. The relationship between illness and sin made the

patient-penitent vulnerable to correction-care. Further, because the patient was also a sinner her/his value judgments became questionable and perhaps invalid. This enabled the physicians to function with the sanction of the Church and substitute their values for patient values and establish a cure. The patient-penitent's determinations and freedom fell by the wayside. In cases of extremely recalcitrant patients who showed no signs of wanting to give up the lives of sin that lead to disease physicians were compelled to insist that the patients confess before they were treated. In fact, this was no small decree. It was made by Pope Innocence III at the Fourth Lateran Council of 1215 and any physician who failed to comply would be excommunicated. (Temkin, 1977: 54)

The Church's view of the care of the sick as an act of charity also enhanced the passive patient role and increased paternalism. As care was charity, most patients had little or no recourse but to accept "care" from physicians and others on the caregiver's terms. Patient self-determination was therefore greatly diminished. Also care as charity switched the emphasis of therapy from service to man to service to God. The patients subsequently lost status in the situation and therefore their desires were not heard or acted upon.

The death blow to patient self-determination came from the belief that the patient was morally bound to lead a healthy life and to call upon the physician in time of need. (Temkin, 1977: 55) The body was interpreted as the dwelling place of the soul of man. Consequently, man had a duty to God to care for it. This belief amounted to a Church sanction of medical practice. With it not only could physicians alter

the self-determining will of persons if they were ill, but now the patient had to sumbit to such "care" or risk the wrath of God. This made the paternalism almost unavoidable from the patient's perspective. The institution's arm covered all.

With the Renaissance, medical practitioners began to be organized as a secular class. The religious orientation and its views on illness were predominantly dropped in favor of a greater humanistic orientation similar to that of Scribonius. Yet the patient did not recover her/his self-determining power. For now there was another justification for a stratified power structure: a pronounced knowledge gap. The physician began to assert his existence as a professional along Scribonius' terms and claimed a specified knowledge base and a service orientation. However, the physician after the Renaissance proclaimed in the tradition of the Hippocratic corpus the ignorance of patients and their general inability to comprehend the true nature of their illnesses. Because of this unfortunate, though understandable lack, they had to be protected from themselves. Paternalism as an organizational institution took a turn but still survived.

In the seventeenth and eighteenth centuries physicians began to come into social positions from which they were able to control still more of the nature and tone of the therapeutic interaction. (Temkin, 1977: 60) The connection between illness and immorality that had been subdued but not lost with the Renaissance came back with increased vigor, (if not with its original strength). Physicians increasingly sought to expand the influence of their world view. This not only included specific theories of diseases but assessments of the relative values

of health and other goods as well.

It was in this period that Thomas Percival came onto the medical scene. Percival was born on September 29, 1740 in Lancanshire England. He entered Edinburg in 1761, took his M. D. at Leyden in 1765 and was made in the same year a fellow of the Royal Society. He entered private practice in Manchester. Percival was the author of Medical Ethics, one of the most famous modern codes of conduct for medical practitioners. This text was widely read at the time and was of significant influence in the establishment of later codes, including the first codes of the American Medical Association. It was largely a text of professional and inter-professional etiquette.

In the eighteenth century there were three groups of medical practitioners in England: (1) physicians, who had the best social standing and who were supposed to have the best training and cultural background; (2) surgeons, who were practical people involved in advancing surgery to a more respectable position; (3) apothecaries who were the medical practitioners to the poor and those in rural districts. (Leake, 1927: 29) Relations between the three groups were not very smooth. Percival became involved when he was petitioned by the physicians and surgeons of the Manchester Infirmary to develop a code of ethics, defining relationships between the groups and describing moral conduct for medical practitioners in general. In 1797 he began the code. It had four parts, the first part dealt with the practitioners' relationships with hospitals and other medical charities. The second part dealt with professional conduct in private practice. The third dealt with the interrelationships of physicians and apothecaries. The fourth involved the professional duties of the practitioner

requiring a knowledge of law. (Leake, 1927: 35)

Percival's code did make the relationships between the various echelons of medical practitioners more harmonious. Unfortunately it also further entrenched paternalism as an organizational institution. Percival continued the tradition of the medical practitioner as the only significant power in the therapeutic interaction. The myth of patient ignorance was also continued. The role of the patient was still that of obedient child-dependent. Patients were the objects of practitioners' kind skills, recipients of grace and charity. They were expected to act accordingly. The values of the patient were not allowed to alter the doctor's decisions with respect to diagnosis or treatment modality. In circumstances where the values of the patients were "unhealthy" or immoral in the eyes of the practitioner, Percival enjoined him to correct the patient. He justified this by appealing to benefit language. He said, for example,

> The opportunities, which a physician not unfrequently enjoys, of promoting and strengthening the good resolutions of his patients, suffering under the consequences of vicious conduct, ought never to be neglected. And his councils, or even remonstrances, will give satisfaction, not disgust, if they be conducted with politeness, and evince a genuine love of virtue, accompanied by a sincere interest in the welfare of the person to whom they are addressed. (Leake, 1927: 107)

One of the truly unfortunate aspects of Percival's code was that it institutionalized the practice of not informing patients of their treatments or the potential developments of their diseases. Patients were not even warned of approaching death. This practice almost completely removed patients from having any relation with their care at

all. Not only were patients denied a voice in the actions that would be taken for them, they were also kept unaware of what these actions were! This complete alienation of patients from a determining role in medical care contributed to the mysterious aura of the physician and heightened his powers. It also assisted the doctor in avoiding the complaints of his patients. It made medical care more convenient from the provider's perspective. However, it meant that the patient had to abdicate completely her/his position of knowledgeable self-determined action in order to be cured.

Percival opposed informing patients of their treatments or prognoses on the basis of an argument from non-maleficence. He believed that all people, especially physicians, have a positive duty to protect others from harm. He argued that the rights of patients to information are suspended when the discovery of the truth would be injurious to them. He also argued on a contractual basis that the trust between patient and physician demands that the patient's welfare be an absolute good and take precedence over the duty of truth telling.

> To a patient, therefore, perhaps the father of a numerous family, or one whose life is of the highest importance to the community, who makes inquiries which, if faithfully answered, might prove fatal to him, it would be a gross and unfeeling wrong to reveal the truth. His right to it is suspended, and even annihilated, because its beneficial nature being reversed, it would be deeply injurious to himself, to his family and to the public. And he has the strongest claim, from the trust reposed in his physician as well as from the common principles of humanity, to be guarded against whatever would be detrimental to him. In such a situation, therefore, the only point at issue is, whether the practitioner shall sacrifice that delicate sense of

> veracity, which is so ornamental to, and indeed forms a characteristic excellence of the virtuous man, to this claim of justice and social duty. (Leake, 1927: 194)

Through the establishment of this argument as a rule of his code, Percival insititutionalized the practice of paternalism by the withholding of information and further alienated patients from control or knowledge of the course or details of their care.

In America the rise and development of medical paternalism had a very interesting relation to the development and nature of the nation's government. In the incipient colonial period there were neither colonial medical educational institutions nor colonial licensing procedures. Medical practitioners were ship's doctors, barbers of the vessels on which the settlers arranged passage. Later, graduates of English and French medical programs came to the colonies and were themselves settlers. These practitioners maintained their ties to their parent nations and home medical institutions and fraternities.

With the American Revolution, a truly unique and American system of medicine came into being. Americans dropped the English custom of referring to physicians solely with the title "doctor," and calling surgeons and apothecaries simply "mister." In fact, in America, the very differences between the three types of practitioners were eradicated. The educational patterns of the practitioners were not distinct in America, and because of the dirth of practitioners right after the war, their duties were indiscernible. Americans largely broke with the European method of medical education in either universities or separate teaching hospitals. The American educational system was established

predominantly as an apprentice system. Young men learned medicine from older practitioners and in return cared after the practitioners' medicines and tools.

The only license to practice in the new American system was a certificate of competence signed by the preceptor with whom the practitioner had served as an apprentice. (Bordley, 1976: 334) Licenses were not issued primarily because the American people did not want them. Citizens did not want licensure because licensure would give professionals the control over the admissions process to the healing arts. The American people were fearful and skeptical of the professionals. (Rothstein, 1972: 26) They saw the whole concept of a profession as elitist and they interpreted licensure as government-legitimated monopoly, or tyranny.

By banning the licensure of medical practitioners, patients retained power in the medical setting. Their power was furthered by the states' support of patients as the final arbiters of therapeutic modalities and values. State governments assumed that the knowledge of medicine was available to and in fact posessed by the bulk of the population. Medicine was definitely not interpreted by the states as an esoteric art. Because the knowledge of medicine was held in common by the people, the people were given final judgmant as to the application and limitation of medicine. The states assumed that if ever a practitioner transgressed the established policies of medicine, he would be corrected by the patient, or by older, more experienced members of the community. (Rothstein, 1972: 37)

The radical equality of the relationship between the medical

practitioner and the patient bespoke the committment of the state and federal governments to thoroughgoing equality and freedom. Free men were not amenable to special limitations or privileges. America was in the age of small government, of the independent, free-thinking frontiersman or pioneer. People protected, and did most of the work of living, themselves. To many, the whole idea of the Revolution had been freedom from the oppression of rule by others. Consequently, stratified power or value relationships were considered to be opposed to the spirit of the new government and its earliest documents. Paternalism was almost unknown.

Assisted by the lack of licensing procedures and the apprentice educational system, the numbers of physicians in America soon began to swell. Physicians, who initiated the attempts at licensing began to agitate for it more passionately. With the increase in practitioners fees dropped and competition became fierce. Physicians sought licensing legislation both as a means to regulate their own numbers and as a way of limiting the competition from other practitioners. (Rothstein, 1972: 20) Physicians became aware of their common professional interests and goals and began to establish local medical societies in the more populated regions. (Rothstein, 1972: 74) Physicians used these new societies as an effective tool to lobby and bargain for licensing laws with the new state legislatures. The societies in turn, saw potential licensing both as a means of obtaining state sanction for their exclusivist policies and as a vehicle which would enable them to gain more control over their individual society members. (Rothstein, 1872: 74) Licensing would also provide income to the societies in the form of

testing or licensing fees. With the added sophistication of the societies and the increased support of larger numbers of sympathetic physicians the medical lobby for licensing legislation became more intense.

The lobby was not initially successful however. The first licensing laws after the Revolution placed the predominant amount of power over the medical profession in the hands of laymen. In New Jersey the legislature gave the power for licensing activities to political and judicial office holders. No physician or medical practitioner sat on the licensing board. However, physicians did get some input to the board as board members were allowed to solicit physicians' advice.

With the 1780's government became increasingly involved with the practice of medicine. "Government" was predominantly state government because in light of the Tenth Ammendment to the Constitution , as no powers in health concerns were specifically granted to the federal government, the health of the people was considered to be the responsibility of the states. (Bordley, 1976: 47) Government officials became concerned in the 1780's with the large number of unskilled individuals practicing medicine. They believed the potential dangers to the populace to be too great. Therefore the legislatures acquiesced to the medical societies' pleas for licensing with medical control. In the smaller states, where the population was concentrated in city areas and where state medical societies could be more effective lobbying agents, licensing legislation was enacted as part of the legislation establishing state medical societies. This occurred in Massachusetts in 1781, in New Hampshire in 1791, in Connecticut in 1792, in Maryland in 1799 and in Rhode Island in 1812. (Rothstein, 1972: 74) In the larger states

where lower population density and sheer size precluded effective medical societies, licensing laws were either unestablished until the middle of the ninteenth century or passed marginally and put in the hands of smaller, less powerful and loosely organized state medical groups. (Rothstein, 1972: 74)

By the act of the States then, more power came to the medical societies. They collected licensing fees that constituted the bulk of their annual incomes. (Duffy, 1979: 177) These fees enabled the societies to become more powerful and better organized. Yet, the states were careful to keep the power of the medical societies tightly reined. The nation's radical equality orientation was still strong and the government was very sensitive to the problems possible if they raised a new elite calss. Therefore, they did not impede the traffic of other medical practitioners. Homeopaths, Eclectics, and Thomasonians were not included in licensing legislation, thereby remaining free to practice as they would. Licensing laws were weak, deliberately so. They often did no more than to allow only the licensed practitioner to sue for the collection of fees. Fines were small or non-existent and the revoking of licenses was almost unknown. Many unlicensed practitioners could still ply their art. Enforcement was weak and sporadic.

The states believed that such licensing laws left choice and power in the hands of the citizen-patient while at the same time protecting her/him from the greatest amount and degree of abuse. Individuals could choose from a variety of practitioners and thereby obtain the care best suited to them. And as patients retained significant power in the choice of alternate systems, physicians and other practitioners

were forced to either validate their positions or not be chosen. Due to patient power in the choice of therapy modalities and values, medical paternalism remained very limited, virtually unknown.

This situation prevailed until the 1870's. At that time state governments encountered a major threatening force: great epidemics of yellow fever and cholera. These epidemics were fearsome not only from a health standpoint; state officials viewed them as threatening their way of life. For cholera was commonly thought to be caused by moral dereliction rather than by poor sanitation. (Bordley, 1976: 49) The states conceptualized the epidemic diseases as forms of deviance, delinquency. (Bordley, 1976: 49) Illness constituted a real threat then to the continuation of the state. Yellow fever ran rampant through the whole of the Mississippi valley in 1878, crippling and killing whereever it went. (Duffy, 1979: 315) The states realized that if they were to survive they would have to devise an effective means of coping with the deviancy, the threat of illness.

By 1876, of the thirty-eight states in the Union, twelve had established state boards of health to deal with the epidemics. (Bordley, 1976: 47) These boards were primarily composed of lay persons: government officials, engineers and clergymembers. They employed physicians to enforce quarantine laws and screen individuals arriving from foreign countries in order to prevent the incursion of new bouts of disease. Physicians as a profession had relatively little to do with the first efforts in public health. They were disinterested. But the states were vitally motivated, and for the first time in the history of the nation, citizens were forced to accept medical treatment. The

cost of this treatment was underwritten by the legislatures. The "care" was centered around the goal of the preservation of the states and municipalities and often amounted to little more than a quarantine. Through the denial of patient autonomy and the diminishment of patient power that such mandatory "treatment" constituted, paternalism gained a foothold and a precedent was established.

The ease with which the great epidemics passed the state boundaries led to regional and finally federal systems of public health. A National Board of Health was established in 1879 and functioned until 1883. (Duffy, 1979: 315) In 1878 Congress gave broad authority to the government owned and operated Marine Hospital Service to cooperate with state and local health authorities in the research and control of epidemic diseases. This Marine Hospital Service developed into the U. S. Public Health Service. (Bordley, 1976: 51) At the same time the field of public health expanded to include vaccinations; quarantines; measures to obtain greater purity in food, milk and water; better sanitation facilities, and less crowded living environments. Physicians as a profession became involved. State and federally mandated public health reports, physical examinations and inoculations became an accepted and encouraged part of medicine. American medical colleges took up the battle standard, and classes in bacteriology and sanitation began to be offered. As the etiology and courses of the diseases became known more effective methods of prevention became possible.

The bond between the medical profession and the government was augmented in the 1900's. Physicians and governmental officials began to see each other as allies. There existed areas of interest common to

both and the goals of each were bartered for the desires of the other. The Association of State Examining and Licensing Boards had already succeeded in obtaining something which many physicians desired greatly: higher educational entrance requirements for medical schools and increased duration of university medical education from two to three years. (Stevens, 1971: 59) This toughening of requirements lessened the numbers of graduating physicians. A glut of physicians had arisen and consequently, attainable fees were low. Physicians wanted a decrease in doctors. The state wanted less incompetent practitioners and safer, better trained physicians. Through collaboration the goals of both groups were met.

Physicians also assisted the government in the compilation of accurate census and public health reports. The states required accurate death statistics in order to plan their public health assaults on disease. Physicians were the ones to first compile and supply these figures to the states.

With the first World War, physicians became further involved with government, asserting the military goals of the state. The government sought to avoid the medical disasters of the Spanish-American Wars in which only 289 men had been killed in battle or were mortally wounded whereas 3,700 men died of disease. (Bordley, 1976: 334-335) In World War I the medical profession was given substantial responsibilities under the Medical Division of the Council of National Defence created by President Wilson in 1916. (Bordley, 1976: 353) This division was accountable for sanitation in military camps, the prevention of typhoid, and the medical preservation of military manpower. It encouraged the

development of new surgical techniques, and through anti-sepsis and later asepsis, many lives were saved and much debilitating infection prevented. However, one of the biggest wartime problems with which the medical profession, through the Division, was asked to deal with were the venereal diseases. And it was through the recommendation of the Medical Division that the first major federal appropriation specifically designated for medical research was made in 1918 under the Chamberlain-Kahn Act. (Bordley, 1976: 353) With each new collaboration, the profession of medicine and the government became more and more tightly bound.

While medicine developed from a croft craft to a science with its own national organization, the nature of the federal government had been subtly changing. Rugged individualism was no longer quite as prominent as it was in the Revolutionary days. The age of the New Deal replaced the age of the independent frontiersman. Government became involved in legislating and protecting the lives of the people. The state developed Workman's Compensation, and Aid to Families with Dependent Children. The people received mandatory education and vaccines. Governmental requirements or provisions gradually permeated more and more of the daily lives of the citizenry. Government involvement, or interference became a reality for the people and gained a greater acceptance with them. People became accustomed to a more restricted area of self-directed activity, and thus became more susceptible to paternalistic intervention.

As the knowledge base of medicine became more secure and antisepsis and asepsis made recovery reality for greater numbers of the sick and injured, medicine and the authority of the medical profession became better established and increasingly accepted by the government and

subsequently with the general populace. With the establishment of the medical profession as a national power, the power of the individual patient waned. With the collaboration of medicine and the state, the values and priorities of the single patient became lost. With each new advance in medicine patient authority dwindled. Paternalism grew.

This phenomenon, the passage from patient as power to profession as power is one of the most curious of our American cultural events. Up until 1900 it seems that patient autonomy, patient power behavior was unbridled. Then after 1900 it disappeared suddenly and seemingly without a trace. It is a rather curious situation indeed! And as the twentieth century progressed, patient autonomy, patient power waned until it was almost non-existent in the 1930's to 1950's. It is only now experiencing a Renaissance.

It is the opinion of the author that the most plausible historical explanation of this phenomenon is found in the collaborative development and expanded authority and dominion of the government and medical profession of the late nineteenth and early twentieth centuries. Yet it should also be stated that patients must have had a part in their own fall from power. Perhaps they were lulled by the technological advances of medicine and gave up the fight for self-determination and allowed themselves to be ruled by others. Perhaps they mistook technological expertise for expertise in the formulation of value judgments. No one will ever know with certainty why it happened. Yet patients had a hand in their own demise in that they allowed it to occur, apparently without much in the way of a fight.

With the waning of patients as powers came the waxing of medical

paternalism. And as time went on the medical profession appeared to be pulling all the strings of a puppet people. The contemporary manifestation of the profession of medicine came into flower. The profession of medicine legitimated its paternalism by making a claim to: esoteric competence, special consideration for the quality of its work, and the extraordinary benefits of its labor to society. The profession in turn obtained from the state sole proprietorship over the medical arts as well as control of the medical training process and the authority and right to determine the manner in which medical tasks were accomplished. (Freidson, 1973: 22)

The entrenchment of paternalism as a medical institution was complete. The incumbency of the physician in an expert status was used to assert the impossibility of patient self-determination. The patients did not have the incredibly complex information from which to assess the possibilities open to them. Consequently, their decisions would be impaired and they would come to harm. The service-orientation or the benefit-tradition of the profession could not allow this to happen. Consequently, patients couldn't be allowed to be self-determining. The alienation of patients from their status as autonomous adults was made complete by the state system which justified therapeutic privilege and used existing standards of medical practice with regard to disclosure to judge how much information the physician had to communicate to the patient.

A virtual curtain of secrecy existed around the medical sciences. Results of physicals or tests were not provided to patients. Access to their medical charts was forbidden them. Explanations of the history, nature or prospective courses of patients' diseases were largely

withheld. Treatment modalities were not described nor were alternative possibilities detailed for the choice of the patient. The physician determined the treatment modality in the majority of cases. Drug reactions were not specified, nor were even the names of the drugs given to patients. The secrecy was so great that it was an established practice of ninety percent of the physicians in a particular study as late as 1967 not to inform the majority of their patients of their impending deaths. (Buchanan, 1978: 373)

The alienation of the patient from a determining role in the delivery of her/his health care was replete and was justified by saying that disclosure would cause harm to the patients. This argument functioned to "protect" rational, adult individuals from their own decisions and values when they differed from those of the medical profession. It maintained a stratified position of power wherein the physician determined what information was to be provided and what course of action would be taken, and the patient simply listened. It constituted a switch in the locus of control in the therapeutic milieu from the patient to the physician and substituted medical values for the values of the individual patient involved.

This trend toward more extensive, organizational institutionalized paternalism has not been unlimited, though. Patients with the help of the state have been actively pursuing the reattainment of their rights to self-determination in the medical setting. Therapeutic privilege is becoming a less secure legal posture. Since Canterbury v. Spence physicians must meet informed consent requirements which, although imperfect, do return some of the decision making capacities to the

patient. Yet there is still farther to go. Little of what patients have garnered in self-determination has been won with the annotation of it as a patient right. Most has just been "graciously" provided by physicians thus maintaining the stratified doctor-patient power structure.

Physicians have retained the upper hand with regard to informing patients and determining the therapeutic course however. For the patient still does not determine how much information s/he gets. The physician most usually assesses the patient's intelligence, maturity, and need, and thus determines the quality and quantity of information to be given. (Novack, 1979: 898) If a physician wishes to ensure a particular therapeutic choice, he makes use of presentational or persuasional tactics, subtly structuring the patient's information and thus insuring the choice. (Fisher, 1981) Paternalism remains entrenched as an organizational institution. Control lingers in the hands of the physician. Physician privilege still overrides patient's rights. A stratified power structure endures and is legitimated and, until it is condemned and destroyed, paternalism will be rampant as an institutional practice.

CHAPTER 2

THE ORGANIZATION OF MEDICINE AND INSTITUTIONAL PATERNALISM

This section will establish how paternalism as an institution is shaped by the structure of the organization of medicine. It will also illustrate how paternalism is accomplished on a daily basis.

Four factors construct the contemporary medical emphasis on patient cooperation and passivity. First is the historical precedent of the alienation of patients from a knowledge of and control over their medical conditions and medical therapies. Second is the tendency of medicine to use benefit-language to substitute medical values for patient values. The structural perception of illness as a deviancy for which the patient does not bear responsibility and which is conditionally legitimated upon the acceptance of medical help is the third factor. Last is the status of medical practitioners as sole proprietors of the medical sciences and as gate-keepers for the state. These factors have all been detailed in the previous chapter. Yet their significance will be further demonstrated here. The result of these peculiar historical legacies, the special ideology of illness and the interrelationships of medicine and the state, is that the structure of the organization of medicine is inherently paternalistic. This means that medical paternalism and medical therapy will be almost inseparable in the contemporary system.

Yet the structure of medicine is not all of one piece. There are many aspects of the organization of medicine and each shapes the specific brand of paternalism to be encountered by the players in the

setting, the physicians and patients. The manifestation of paternalism varies with the details of the organization and by following this pas de deux, the manner in which institutionalized paternalism is accomplished on a daily basis shall become more clear.

There are three major components in the structure of the organization of medicine to which I wish to call specific attention in this chapter: the type of practice; ideologies of practice, and the type of medical specialty and the manner of payment in which the therapeutic setting is conducted. Each shall be dealt with separately in this chapter, but all shape the nature of the paternalism experienced in the setting.

There are also other factors which affect the manner in which paternalism is accomplished in the medical setting. These include the severity and social legitimation of the patient's illness and patient/physician use of language in the therapeutic milieu. These are factors which rather than construct institutional paternalism, constrain it. They channel or focus the structures of the organization of medicine, and in so doing produce different, varied, levels of paternalistic intervention. They operate on the organization to engender the brands of paternalism which we encounter daily. They will be discussed separately at the end of this chapter.

Type of Practice

There are two major types of practice, the client-dependent practice and the colleague-dependent practice. On the one hand, exists a therapeutic setting that is wholly dependent for its economic sustenance

on lay or client evaluation, and is thus said to be client-dependent. (Freidson, 1970: 107) [3] On the other hand is a setting which does not attain its clients directly, but by referral from other colleagues and professional organizations which do so. Thus, it derives its economic sustenance from the satisfaction of colleagues, and is considered a colleague-dependent practice. (Freidson, 1970: 107)

As client-dependent practices are contingent upon patient satisfaction they are more likely to operate under patient definitions of illness and health than are the colleague-dependent practices. They are consequently more open to direction of the therapeutic interaction by patients. As the patient is able to exercise greater self-determination with regard to both treatment modalities and the system of values operant in the setting, client-dependent practices exercise a lesser degree of paternalism than do the colleague-dependent practices. Elliot Freidson discusses the client-dependent practice.

> When he first feels ill, the patient feels he is competent to judge whether he is actually ill and what general class of illness it is. On this basis he treats himself. Failure of this and other informal modes of treatment leads him to a physician. The physician, it should be clear, is chosen on the basis of lay conceptions of what is needed, not by professional criteria. In order to stay in practice he must offer services of a sort that laymen themselves feel that they need. . . . And to be chosen again and survive, he must be

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[3] The author would like to acknowledge the significant influence that the thought of Elliot Freidson had on this work. His ideas were fundamental to the formulation of the arguments in this chapter especially.

> prepared to provide services that honor the client's prejudices sufficiently to make him feel that what he thinks bothers him is being treated properly. (Freidson, 1970: 107)

Colleague-dependent practices usually operate under professional definitions of health, illness and patient problems. This in itself tends to minimize or ignore the patient role in the therapeutic relationship thus enhancing paternalism. Further, colleague-dependent practices are almost always referral practices. The physician in this type of setting sees a patient with a problem that her/his regular physician did not feel qualified to treat. The colleague-dependent practitioner is therefore not usually responsible for standard or primary care. Because of this, this type of physician has a limited interaction with the patient and a sustained interaction with the referring physician. Consequently, the referring physician is often seen as the client. It is he who receives any information that is to be had. The patient may become relegated to the status of an object to be examined or analyzed. As the referring physician receives the information the patient would normally receive, the alienation of the patient from knowledge or control over her/his care becomes almost complete. When it is further considered that the patient has little choice but to accept the referred care as her/his primary physician has declared incompetence, paternalism becomes absolute. Freidson speaks of the colleague-dependent practice,

> Unlike the first level practitioner, the consultant who receives referrals from other professionals is not dependent on client choice for his professional survival. He is dependent instead upon the referrals of colleagues, thus having a <u>colleague-dependent practice</u>. As such he must be sensitive to the needs and prejudices of the professionals than

> of the laymen. . . . However, while the patient may choose his own first level services, once the physician he chooses confesses his failure or incapacity to cure, and refers him deeper into the professional system, the patient is often able to do no more than to choose to accept what is offered to him or drop out of the system entirely against the weight of medical evidence. When he enters a colleague-dependent practice he has little of the influence available to him in a client-dependent practice and must accept the services chosen for him. (Freidson, 1970: 307)

Ideologies of Practice

Three dominant practice ideologies can be distinguished in medicine: the medical intervention or active-passive model; guidance-cooperation, and the therapeutic interaction or mutual participation model. These ideologies can be understood as conceptual frameworks of the power structure of the therapeutic interaction. Consequently the type ideology operant in any particular setting affects the measure of paternalism established.

The medical intervention or active-passive model is completely controlled by the physician. The physician sees the patient's problem as a temporary technical malfunction that can be corrected by surgical or chemical means. However, the physician is the only individual qualified to correct this malfunction and, in order for the repair to occur, the patient, who is incompetent to judge what must be done, must put herself/himself into the charge of the physician. The primary quality of the patient is obedience. S/he is to allow the physician to do whatever the physician feels is necessary. The health care team in this model is a highly stratified professional chain of authority with

the physician occupying the command post. Interaction with the patient is impersonal. (Freidson, 1970: 132-133)

This ideology of practice maximizes paternalistic intervention by minimizing patient self-determination and power. The patient has very little to contribute to the therapeutic setting except the presence of an unhealthy body. To the extent that this model is used the patient will be maintained in a child/dependent role. The physician as parent will direct.

The guidance-cooperation model is considered by many to be the dominant ideology of practice. In this model the patient seeks the aid of the physician and is willing to cooperate with medical requirements. In return the physician gives the patient a more active role then was available under the medical intervention model. The patient's consent to accept and follow advice is necessary, but the patient is expected for the most part to do as s/he is told. (Freidson, 1970: 316-317)

If the active-passive model is a child-parent one, the guidance-cooperation model is an adolescent-parent ideology. (Schain, 1980: 1036-1037) For in this model, the patient must begin by acknowledging the authority and power of the physician. Then s/he receives an allotment of self-determination as a dole. The rations are short however, for the role of the patient is essentially to go along with the approaches the physician suggests. Should the patient prove unwilling or obstinate the physician will revoke the "trust" and pull back the dollop of self-determination which was initially bestowed. The active-passive model is simply right around the corner.

The guidance-cooperation model is the model in which the traditional

picture of the family's general practitioner is to be found. Here the physician is a kindly old fellow who always gives good advice and manages everyone without becoming abusive about it. No one likes to think of this as paternalism or as unjustified or dangerous because it carries such a gentle exterior. However, it is the opinion of the author (which will be defended in Chapter 4) that not only is it paternalism but that this particular variety is the most treacherous of all types because of its facade. Here patients remain in subservient, subordinate, powerless roles. But they are presented the illusion of power as a gift. They are given a small amount of self-determination not as a right or that which is their due, but either as a supererogatory act on the part of physicians or as a strategy to gain compliance. This is little more than a re-creation of the beneficent master-slave relationship. It is an <u>insult</u> to anyone aware of their rights to be presented that which is by right already theirs, and which has been unjustly denied them as a gift. This manner of paternalism is also very dangerous because those unaware of their free state are easily taken in and unwittingly play out the master-slave dialectic in other facets of their lives. The guidance-cooperation model is thus paternalistic, insidiously so, as it expects to win the patients over to an acceptance of the physician as parent-significant power by seeming to return that which is rightfully their own.

The therapeutic interaction or mutual-participation model offers the patient the greatest freedom and the nearest approximation to equality obtainable in any of the three models. In this model,

> . . . patients are . . . <u>required</u> to take care

> of themselves - as in the case of the management of some chronic illnesses. . . . emphasis mine (Freidson, 1970: 317)

Patients must then take equal responsibility with the physician for their own recovery and well-being. They are expected to care for themselves. In this model,

> . . . the physician does not profess to know exactly what is best for the patient. The search for this becomes the essence of the therapeutic interaction. (Freidson, 1970: 317)

The therapeutic interaction model is as close to liberation from paternalism as is to be found in the contemporary medical system. It comes very close to constituting complete freedom but falls just short. In this ideology, the patient has an equal opportunity with the physician to define the values to be sought in the therapeutic setting. The patient must also work as hard as must the physician if the goals are to be attained. Yet the key to this author's reservations about this model is to be found in the language with which it was described. As Freidson says, patients are required to take equal responsibility. The term required betrays the old stratified power structure. Power and authority still lie by heritage and right with the physician. The physician delegates them to the patient rather than accepting equal status as a right of the patient by virtue of her/his standing as a competent adult.

Type of Medical Specialty and Manner of Payment

The type of medical specialty and the manner of payment in which the therapeutic interaction is conducted also affect the manifestation of paternalistic intervention encountered. As Freidson indicates, pediatrics and surgical specialties tend to operate under the medical intervention

model and require the almost complete passivity of the patient, (or parent-client in the case of pediatrics), thus equating therapy with paternalistic intervention. (Freidson, 1970: 321) Internal medicine and general practice are usually patterned after the guidance-cooperation model, allowing a somewhat greater circle of influence for the patient. Rehabilitative medicine, chronic care and psychotherapy usually operate on the therapeutic interaction model. In these practices, patients enjoy the greatest amount of freedom possible under the present system.

But in many ways, the most interesting specialty with regard to its expression of paternalistic interaction is the new specialty of family medicine. For family medicine falls to both extremes with regard to paternalistic practice. It is the opinion of the author that this confusion results from its nature as both a high-prestige continuation of general practice and as a psycho-social specialty within medicine.

Family medicine rose out of the ashes of general practice. Throughout the middle part of this century, the number of physicians engaged in general practice dropped drastically. This was due to the increased wealth, prestige and intellectual satisfaction to be found in the burgeoning specialty areas of medicine. In the late 1960's there was a crisis of primary care in this country. For a long time the American Medical Association had been interested in developing family medicine, but in 1964 they acquired added incentives in the way of government grants. By 1969, fifteen pilot family medicine programs were approved by the Committee on Requirements for the Certification of the American Academy of General Practice, and the first family practitioners soon afterwards emerged as specialists. (Lewy, 1977: 877)

Family medicine had difficulties asserting itself as a specialty

though, even after its official establishment as the twenty-first medical specialty on February 8, 1969 by the American Board of Family Practice. This is largely due to its difficulties in establishing either a clearly defined intellectual content or adequate documentation to compete as a specialty with other specialties. (Bryan, 1968: 8) Because of this inability to stand on equal ground with other specialties, family medicine straddles the crossway between general practice and psycho-social specialty, unable to get to the one side, completely unwilling to go back to the other.

The general practice aspect of family medicine operates under the client-dependent model of practice and the mutual participation or therapeutic interaction ideology. Consequently it allows for the greatest degree of patient self-determination in treatment. This combination is therefore the lowest level of paternalism possible in contemporary medicine and is thus greatly to be desired. Characteristic of this form of family medicine is the statement by the Annual Conference on Research in Medical Education,

> Family Practice, the only specialty to define its mission as exclusively primary care places its practitioners in a client dependent role. . . . Their patients are not as likely to come from referral by another physician, but by referral from friends, family or colleagues of patients. Thus, it is more likely that the family physicians will be attuned to the prejudices of his/her patient rather than other physicians. The need for deriving satisfaction from patient evaluation is greater. (Wade, 1979: 293)

However, the psycho-social aspect of family medicine tends to view itself as the <u>uber</u> specialty. They feel that their psychological and behavioral training, coupled with their increased contact with the patient puts them in the position to organize all aspects of the patient's life, as well as dictate the application of other medical specialties. Thus

their control over the patient is so great that it transcends paternalistic interference to the realm of positive autocracy. Characteristic of this perspective is the statement by the Family Health Foundation of America,

> Surely the motivation to study the human being in his environment, to counsel and guide him, to prescribe and interpret whatever special resources may be required by him at a given time and place - this challenge to play a central role in caring for people is nothing new. . . . It is the counterpart of the conductor in the symphony orchestra, the general manager of a corporate enterprise, the admiral on his flagship. There must be as many doctors today who would like to play the leading part in the medical drama, who know that the whole human being is a more interesting subject than any of the illnesses that affect him. (Bryan, 1968: 5-6)

Thus family medicine is an interesting study in contradictions. The aspect that traditionally would be most paternalistic, the general practice perspective, is the greatest patient emancipator. The modality that might be expected to be enlightened and non-stratified, appears to be more autocratic.

The manner of payment for services also affects the manifestation of paternalism in the therapeutic setting. Charity, Medicare and Medicaid patients are more likely to be treated under the medical intervention or active-passive model than fee-for-service patients regardless of the type of medical specialty involved. This is largely due to the fact that these patients are constrained by economic and geographic barriers from seeing more than a small population of physicians. The physicians, aware of this situation, know that these patients must accept care from them or opt out of the medical system completely. Fee-for-service patients, are more likely to be treated under the other two models. Physicians are aware that they exercise some control over their care simply by retaining the ability to go elsewhere for it.

Severity and the Social Legitimation of the Patient's Illness and Patient Physician Use of Language

There are two other factors which affect the manner in which paternalism is accomplished in the medical setting. These are the severity and social legitimation of the patient's illness and patient/physician use of language in the therapeutic milieu. These are factors which rather than construct institutional paternalism, constrain it. They impose upon the structures of the organization of medicine a certain focus. In so doing they produce the varied brands of paternalism which we encounter daily.

Severity is involved in that when the patient's illness is not very serious or when the patient is not in a considerable amount of pain s/he is less likely to be subject to paternalistic intervention than s/he would be if seriously or critically ill. For when the patient is not subdued by either pain or fear of illness, s/he always has the opportunity of leaving her/his physician and going elsewhere for consultation more familiar or agreeable to her/him. (Freidson, 1970: 317)

If the patient's illness is a socially recognized and legitimated one such as cancer, pneumonia, measles or the common cold, s/he is more likely to encounter therapy based on the guidance-cooperation practice ideology. If the illness is stigmatized, not socially accepted, the patient is likely to suffer under the medical intervention or active-passive model and thus be the victim of the greatest possible degree of paternalistic intervention. Examples of stigmatized illnesses are: Epilepsy, venereal disease, alcoholism and mental illness. If the patient's illness is neither fully legitimated by society nor stigmatized, such as limited problems of overwieght, and borderline hypertension, the mutual

participation model of practice is the most likely to be encountered. For when the illness bears neither stigmatization nor legitimation, the authority of the physician is predominantly withheld, encouraging the pattern where patient and physician assume the most equal responsibility in the therapeutic setting and where paternalistic intervention is at its ebb. (Freidson, 1970: 321-322)

Patient/physician use of language also influences the manifestation of paternalism in the medical setting. Poor or working class patients often tend to present desires by means of non-verbal signals, shying away from the use of questioning to change the course of therapy. (Krause, 1978: 98) Patients' use of restricted or unelaborated verbal codes is assumed by physicians to signify the inability to understand highly developed codes. The physicians consequently supply less information than the patients actually request. Because of assumed patient ignorance or lack of interest, physicians engage in more stratified power relationships with the patient. The patient becomes more susceptible to intervention under the active-passive model and hence becomes the victim of a greater level of paternalistic intervention.

Actually, the poor and working class patients' usage patterns have little to do with their ability to understand spoken elaborate codes. Krause points out that these patients are fully able to understand this terminology, but that their exposure to it is not sufficient to make them comfortable with its <u>expression</u>. Consequently, they confine themselves to the use of the more familiar, restricted patterns. Physicians incorrectly interpret the usage of the limited codes as a sign of low intelligence or education and consequently restrict not only the quantity of information, but diminish its quality also. They fail to give these

patients adequate explanations of diseases or drugs, often not even referring to their medical problem or drug by name.

Patient/physician use of language also influences the manifestation of paternalism in the medical setting. Physicians use language strategy in their presentation of treatment options to sell the patient specific forms of therapy. (Fisher, 1981) Through the use of presentational or persuasional strategies doctors provide patients with information while simultaneously giving them favored means of interpreting this information. (Fisher, 1981: 34) In so doing, they subtly lead patients to the acceptance of specific options or techniques. By limiting patients' knowledge or perception of the various modes of treatment available to them, doctors surreptitiously ensure or coerce patient choice. The use of such strategies constitutes a perversion of consent requirements, contributes to the imbalance of power in the therapeutic situation and embodies paternalism as a restriction of freedom of action and information. Roth describes the strategy saying,

> The doling out of information to hospital patients by staff members, then, is simply not a matter of a group of specialists striving to fill the needs of consumers of information. In giving information (and in withholding it) the staff members are trying to create an effect. The effect, if successful, should be one that causes the patients to make the right decisions and to conduct themselves in a proper manner. What is right and proper in this case is defined by the staff. The patient, if he were fully informed, would not always agree. (Roth, 1963: 308)

CHAPTER 3

ILLUSTRATIONS

This chapter will provide four illustrations of paternalism as an organizational institution. It should be stressed that they are given as examples of the practice of paternalism as a characteristic manner by which the medical profession organizes its dealings with patients. They are not case studies. For the term case study implies that the principle under examination is something accomplished on a singular basis. Here the opposite is asserted.

These four particular illustrations were chosen because they represent paternalism as an institution with the greatest clarity. The first illustration is quoted from Beauchamp and Childress' Principles of Biomedical Ethics. The second illustration comes from an interview conducted with the physician director of a neonatal intensive care unit. The last two illustrations come from the author's own clinical experience. In each case the names of the patients and physicians involved have either been changed or withheld in order to preserve their anonymity.

The number of illustrations does not have any special significance. It was sufficient to show both that paternalism does exist as an institution and to provide an impressionistic glimpse of the manner in which it is accomplished. They are not to be construed as "proof" however. They are only illustrations and hopefully they will open up to our vision new ways of understanding an old game.

Illustration 1.

A doctor aged sixty-eight was admitted to an

overseas hospital after a barium meal had shown a large carcinoma of the stomach. He had retired from practice five years earlier after severe myocardial infarction had left his exercise tolerance considerably reduced. The early symptoms of the carcinoma were mistakenly thought to be due to myocardial ischaemia. By the time the possibility of carcinoma was first considered, the disease was already far advanced; laparotomy showed extensive metastatic involvement of the abdominal lymph nodes and liver. Palliative gastrectomy was performed with the object of preventing perforation of the primary tumor into the peritoneal cavity, which appeared to the surgeon to be imminent. Histological examination showed the growth to be an anaplastic primary adenocarcinoma. There was clinical and radiological evidence of secondary deposits in the lower thoracic and lumbar vertebrae.

The patient was told of the findings and fully understood their import. In spite of increasingly large doses of pethidane, and of morphine at night, he suffered constantly with severe abdominal pain and pain resulting from compression of the spinal nerves by tumor deposits.

On the tenth day after the gastrectomy the patient collapsed with classic manifestation of massive pulmonary elbolism. Pulmonary embolectomy was successfully performed in the ward by a registrar. When the patient had recovered sufficiently he expressed his appreciation of the good intentions and skill of his young colleague. At the same time he asked that if he had a further cardiovascular collapse no steps should be taken to prolong his life, for the pain of his cancer was now more than he would needlessly continue to endure. He himself wrote a note to this effect in his case records, and the staff of the hospital knew his feelings.

His wish not withstanding, when the patient collapsed again, two weeks after the embolectomy - this time with acute myocardial infarction and cardiac arrest - he was revived by the hospital's emergency resuscitation team. His heart stopped on four further occasions during that night and each time was restarted artificially. The body then recovered sufficiently to linger for three more weeks, but in a decerebrate state, punctuated by episodes of projectile vomiting accompanied by generalized convulsions. Intravenous nourishment was carefully combined with blood transfusions and measures necessary to maintain electrolyte

> and fluid balance. In addition antibacterial and antifungal antibiotics were given as prophylaxis against infection, particularly pneumonia complicating the tracheotomy that had been performed to ensure a clear airway. On the last day of his illness, preparations were made for the work of the failing respiratory centre to be given over to an artificial respirator, but the heart finally stopped before this endeavor could be realized. (Beuachamp and Childress, 1979: 263-264)

This illustration underscores the nature of institutional paternalism as a shift in the locus of control of patient determination from self to other and as a substitution of values, medical for individual patient values. The informed wishes of the patient were clearly disregarded. To be fair to the hospital and staff this was not done out of a desire to harm the patient or to cause him greater or prolonged suffering. Rather it was done because it was their established policy to do so and the policy was thought to guarantee what was best for the patients.

It should be stressed that the hospital's solution to the "management" problem was not one decided singularly on the facts of the case. There was no apparent reason to disregard the patient's informed and expressed will in this particular case. The patient was rational, fully informed as could ever be possible. He was a physician and clearly understood the significance of the information provided. He also knew its portent. From the case provided it appears that he expressed his will while lucid and not under the stress of an emergency procedure. He told the registrar after he had recovered from the procedure.

In spite that the facts of the case stress the respect of patient wishes and patient autonomy, the values of the hospital were substituted for those of the patient. The patient's value of not prolonging his life by means of CPR when cure was impossible and suffering was a

reality, was denied. His autonomous will was ignored. It was not done because any singular facts of the case changed the usual outcome. It was done because it was the normal practice of the hosptial to override the autonomous will of patients in such situations, paternalism was an institution.

Illustration 2. An interview provided by Phillip Roan, M. D., the director of a neonatal intensive care unit at a major city hospital on the structure and ideology of his unit. He said:

> Parents are included to the hilt. They do not, however make decisions. There is a regard for how they are oriented, how they think, and how they feel. But they don't make decisions. If parents want to pull the plug and we don't agree we don't respond to the customers' order. If they want extraordinary treatment and we don't agree we'll go ahead and give it to them. We're dealing with a tragic situation here. . . .
>
> We consider the parents' feelings as an active input factor. The goal of all this is parental well-being as the situation involves it. There's no autocratic business at all. This is our idea of how to treat parents so they will come out better. . . . The whole thing is an area of expertise that is restricted to us. People always assume you talk of expertise on the basis of professionals, that it precludes any input. That's not true. . . . We don't present to parents and have them make decisions that's all.
>
> You spare most parents an agony when you don't put on them the responsibility for the continued life or death of their baby. The most comforting thing is to be able to say everything was done for that child and it still died. You find it very difficult for mother to acknowledge a sick baby because that's like a death warrant. You can't have her making the decision, that's serious!
>
> . . . . . .
>
> I don't subscribe to the approach where you describe the situation to an intelligent, articulate parent and let him decide. I can't see me working with parental decision as a final factor.

> I realize that I might be wrong. There's less chance of me being wrong than the next guy, but I might be wrong.

Although this illustation involves pediatrics, an area which has not been stressed in this paper, this illustration was deemed significant because it showed how parents are systematically precluded from having any real determination of the limits to treatment of their children. This illustration also excellently portrayed all the legacies used to justify paternalism. The benefit language is used, the appeal to sole expertise or singular knowledge base, the opined ignorance of parent-clients and finally an outright refusal of parents or clients as powers in the therapeutic setting. And, of course, this is not a singular case. Rather, the physician involved is describing the ideology of a major unit. This illustration also exemplifies paternalism as an institution in that Dr. Roan was the chief instructor of a unit which was a mandatory rotation for all the residents in pediatrics and obstetrics-gynecology of a major state university. His policies were course materials for these residents and were established as their normative standard.

But one of the most curious aspects of this interview was that the lack of parental influence in the treatment process of their children was not derived from benefit language with the child as the referent, but with the parent. This supports a view where the parent is the client-patient and thus fits into the primary definition and discussion of paternalism shown in this thesis. It removes the limits of the special area of pediatrics and established paternalism as a more general institutional practice. Parents' wishes are only honored in so

far as they fit in with the general medical model: too much treatment rather than too little. Added treatment of course gives the physicians added authority.

Illustration 3 Office interaction between Dr. Richard Mace and Lydia, a sixty-five year old, white, middle-class female with chronic heart disease. Current complaint: hip problem.

Lydia: "Dr. Riley put this pin in my hip. . . ."
Dr. Mace: (interrupts) "Well, you need it."
Lydia: "Do you believe in them bone marrow tests?"
Dr. Mace: "Yes"
Lydia: "You remember that medicine you got me on honey?"
"They make my stomach burn, OOOHHH!"
Dr. Mace: "So if it burns don't take it."
Dr. Mace: "You know that the bone doctors say that it's important that you get out and walk. Would it help if we got you a walker?"
Lydia: "I'd rather walk with crutches than a walker."
Dr. Mace: "Oh well, whatever you want, just keep walking."
Lydia: "It hurts."
Lydia: "What do I do when its rainy and bad?"
"Won't I fall if I go on them walks regular?"
Dr. Mace: "No you won't fall."
Lydia: (Cackle) "But I'm getting old honey!"
Dr. Mace: "You're not getting old you're just getting started."
Dr. Mace: "You take the prescription here, its for your hip medicine. If there's no improval in two or three weeks give us a call."

Dr. Mace leaves room.

Dr. Mace to author: "You know these old people, their bones get so bad they break and then they fall. The old people, they worry about it the other way around. I let people do what they want without telling them the risks. I manage people like that if they're critical. They should do what they enjoy, if it aggravates their condition, well, its possible, but their quality of life is better if they do what

what they want to. They're happier that way."

In this illustration of an interaction in an office visit the practice ideology applied determined the manifestation of paternalism experienced. The physician applied the active-passive ideology of medicine. He considered himself to be the sole significant power in the medical setting. He saw himself as dealing with a physical problem; he had a desired therapy, walking, and he merely sought to get the patient to implement that therapy. He made no attempt to deal with the underlying reasons for the existence of the patient's problem, to detail how his therapy would help or to outline the risks involved.

The physician resisted opined patient questioning of the medical model or authority, "Well, you need it." He resisted information disbursement. He assumed patient ignorance and that assumption structured the quantity and quality of information he let out. He gave the patient a prescription for medication without providing its name, only vaguely alluding to its purpose and did not provide a drug schedule. Further, he did not tell the patient what to look for or what would constitute "improvement." He left the patient completely out of the therapeutic interaction in spite of the fact that she was obviously interested. She referred to previous procedures, medications and expressed a question which was never answered with regard to therapy. The physician provided almost none of the information requested. Thus he acted paternalistically.

He also assumed that the patient wanted to walk although there was no information to support this conferred in the interchange. On the basis of his assumption rather than a direct patient statement he

he proceeded to assess values and determine the patient's quality of life. This is the height of paternalism. Not only would he keep her ignorant of her own affairs, but would override her competency and authority and dare to determine for her her own quality of life. If Lydia became injured, well, it was just a risk she would have to take according to his assessment of what was in her best interests.

Later, talking to the author, the physician indicated that this type of paternalism was a standard practice for him. It was a way of organizing his relationships with patients in general rather than a simple response to any one set of circumstances. In this illustration, paternalism as an institution functioned to keep a competent woman on the outside of the therapeutic decision-making, allowing her to provide no more than her body. It kept her ignorant and ignored her will in favor of <u>assumed</u> benefits for her.

<u>Illustration 4</u> Interaction during an office visit between Dr. Richard Mace and Mr. Jenkins, a forty-seven year old, white, working-class, male chiropractor. Discussion centers on Mr. Jenkins diabetes, why he is not following orders. Mr. Jenkins is in the process of trying to tell Dr. Mace that his diet is inadequate and can not be adapted to his work schedule.

Dr. Mace: "Well Mr. Jenkins, have you got your food diary with you today?"
Mr. Jenkins: "Well, no Dr. Mace, I don't. . . ."
Dr. Mace: (angry, interrupts) "Why <u>not</u>."
Mr. Jenkins: "You see, I just can't eat the regular meals. My schedule won't allow it. I <u>understand</u> what I'm supposed to do. I'm not psychologically trying to deny these things, but my schedule just won't make it work."
Dr. Mace: "You and I have to be real straight with each other. If you can't eat your meals on

a regular basis we can't treat your diabetis. I can't do you any good if you can't do the very minimal thing we ask."

Mr. Jenkins: "I'm not being rebellious, you have to understand that. I'm trying to eat on a regular basis. I have breakfast mastered. But. . . ."

Dr. Mace: (angry, interrupts) "You haven't done any of the things I asked you to do."

Mr. Jenkins: "I'm not intentionally evasive, I know that you are here to help me and I am seeking help. But my schedule just won't allow me to eat regularly."

Dr. Mace: (angry) "You mean to tell me that your schedule is so hectic you can't even take a normal break for lunch or dinner?"

Mr. Jenkins: "Yes, I'll never know when I'll have patients. I'm trying to get back into practice you know, and I have to work when I can. If I were a housewife, or if I had a wife who did it for me it would be different."

Dr. Mace: "I need that information and then I will work something out. If your schedule is so hectic that I can't do something for you then I'll tell you. I just want a food list containing everything you eat."

Mr. Jenkins: "I know, o.k. sir."

Dr. Mace walks out of the room, Mr. Jenkins still wanted to ask him some questions and is forced to follow him down the hall.

Dr. Mace: "See ya in two weeks."

This illustration portrays the power and value struggle that are at the heart of paternalistic practice. Dr. Mace was operating within a guidance-cooperation treatment model in which he saw the patient as unruly and attempting to usurp his power. He interpreted the patient's non-adherence as a personal affront to his authority as a physician. He reacted rudely and with anger. He interrupted the patient, refusing to listen until compliance was obtained. He stressed the patient's incompetence to judge when medical treatment was or was not applicable. "If your schedule is so hectic that I can't do anything for you then I'll

tell you. I just want a food list. . . ."

Mr. Jenkins, on the other hand, was trying to move the interaction to a mutual participation model. He tried to reassure Dr. Mace that he was not questioning his authority. "I'm not being rebellious." He tried to give a reasonable explanation of why his practice was not amenable to regular hours. Yet at the same time Mr. Jenkins gave veiled implication of his own power in the therapeutic setting. He acknowledged that he had to seek help before the physician gained any authority.

Dr. Mace did not want to hear about Mr. Jenkins' practice or any talk of power or patient competence. He resisted the mutual participation model, effectively pulling rank on Mr. Jenkins and implicitly threatening not to treat him if he continued not to comply. He insisted that the locus of control in the setting lay with him and that it was the values of the medical model that were significant, not Mr. Jenkins' own. He justified this usurpal of patient power and substitution of values with benefit language. However, the message thinly veiled came through as "Conform or be ill, we are in control here." As insulin is a controlled prescription drug available only with physician script, the threat made good. Mr. Jenkins was forced back into the role of a meek patient in the guidance-cooperation model. "I know, o. k. sir."

CHAPTER 4

ETHICAL DILEMMAS WITH PATERNALISM AS AN ORGANIZATIONAL INSTITUTION

At the beginning of this thesis paternalism was defined as,

> . . . interference with a person's freedom of action or freedom of information, or the deliberate dissemination of misinformation, where the alleged justification of interfering or misinforming is that it is for the good of the person interfered with or misinformed. (Buchanan, 1978: 362)

This definition was only applied to paternalism as an organizational institution, that is, paternalism as a characteristic or persistent element of the organization of medicine that is widely sanctioned and which structures the interrelationships of physicians and patients. It was also noted that this definition did not include instances of the so called weak paternalism.[4] It is held that in cases of exceptional severity or irreversibility the state, and subsequently its agent, the organization of medicine, may restrain self-regarding action in order to ascertain whether the action is voluntary or not. The further provision was made that the voluntariness principle is not to function as a substitution of value judgments, but is merely to ensure that the agent's actions are autonomous.

The reference group to which the definition may be correctly applied was also established. It includes only those persons who have attained adult years, (eighteen years old); have sufficient maturity; are

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[4] Joel Feinberg, "Legal Paternalism," The Canadian Journal of Philosophy, 1 (1971), 105-24.

not mentally or emotionally impaired and are in control of themselves and acting in a self-determined manner. The conduct in question must be substantially self-regarding. The state gains the right to interfere with individual activity when that activity impedes or denies the attainment or enjoyment of the liberties of other citizens guaranteed by the state. Such interference is not considered to be paternalism.

The definition, history and organizational influences of institutional paternalism have all been detailed. What remains is to determine why paternalism as an organizational institution is problematic ethically. This task shall be taken up in this chapter.

Paternalism functions so as to deny two things to the individual: information, and the ability to act on the basis of that information. These two attributes are in fact the basis of any claim for moral responsibility in action. For an individual to be held fully morally responsible for an action two things are necessary. First the agent must be aware of her/his actions and must be cognizant in some sense of their possible outcomes. Second, the act must be free. The agent must not be under duress. The contrary of the act must be a real possibility for the agent.

As individuals are kept uninformed they are not aware of their conditions or of the options available to them. Because they are unaware of these they are unaware of the possible results of their actions. In so far as individuals are not informed, underinformed, or misinformed, their choices are being subtly made for them and the contraries of their actions are no longer open to them. In so far as paternalism accomplishes these things it functions to remove moral

responsibility from patients.

Paternalism by definition restricts or denies the expression of individual autonomy. Autonomy is defined by Beauchamp and Childress as,

> . . . a form of personal liberty of action where the individual determines his or her own course of action in accordance with a plan chosen by himself or herself. The autonomous person is one who not only deliberates about and choses such plans but who is capable of acting on the basis of such deliberations. (Beauchamp and Childress, 1979: 56)

A paternalistic act destroys autonomy by denying the individual ability to act in a self-determined manner and by denying the application of the individual's own plans or value judgments. In effect it functions as a change in the locus of control from the individual patient to the organization of medicine, both collectively and in its individual expression in particular physicians. It also acts as a substitution of values, or more accurately the replacement of values by non-values. G. Dworkin described paternalism saying,

> Paternalism might best be thought of as the use of coercion to achieve a good which is not recognized by those persons for whom the good is intended. (Dworkin, 1972: 69)

Paternalism as an institution replaces individual patient values with the values of the medical model and those of particular physicians.

What is the problem with the negation of the moral responsibility and autonomy of patients as an institution of medicine? Moral responsibility and autonomy are related concepts. They are both necessary elements of what it means to be a moral entity. Yet they should and

shall be dealt with separately in this discussion, first moral responsibility and then autonomy.

Ethical Problems Created by the Denial of the Moral Responsibility of Patients

When we remove moral responsibility from individuals we take away their status as adults. (Rawls, 1971: 505-506) The ethically relevant differences between adults and children are: knowledge base, maturity, and on the basis of these, moral responsibility for themselves and their actions. The question that must be asked here is whether this removal from adult status is justified. In order to answer this, two further questions will be required. First are individual patients possessed of a sufficient data base from which they are able to make rational, goal-oriented choices with regard to future treatment? Second, are patients mature enough as a class to justify retaining their adult status?

There is a pervasive organizational (medical) stereotype of patients as incomprehensibly ignorant and incapable of understanding any significant medical explanation. However, after a thorough search of the literature, the author did not find conclusive, objective or frequent support of this stereotype. Rather, the bulk of the more recent studies indicates that patients have a fair understanding and appreciation of what is told and adequately explained to them. (Baksaas, 1980; Hulka, 1976; Roth, 1963 both) Studies also indicate an overwhelming desire on the part of patients to know what is wrong with them and what can be done about it. (Baksaas,1980; Egbert, 1964; Kimble, 1980; Reynolds, 1978; Roth, 1963, both)

It is the opinion of the author that the data of some studies are invalid because of bias introduced by the choice of research methods. That is, some published studies "stack the deck" against patients in the their methodology. This is not done intentionally, but may be the result of a lack of sensitivity to the various nuances that comprise the contemporary medical reality. Yet, the data of these studies remain suspect.

What attributes of these studies produce this situation? There are characteristics of such studies which place patients at a unique disadvantage from the outset. The first is the assumption that patient ignorance is due to inadequate patient intelligence rather than insufficient attempts to provide patients with information. Some studies fail to ascertain if patients were ever actually provided with information or not!

The second trait revolves around the failure of the studies to investigate the manner in which the information was exchanged and the way in which this affects patient understanding. Was the patient sedated or under the influence of any other psychotropic drugs when the explanation was given? Was the information given at the beginning or the end of the interview? Was the information presented orally or in written form or both? Was any explanation provided along with the information? In what kind of language were the information and/or explanation given? What was the ratio between the amount of information provided and the time it was provided in? With what frequency was the information presented? All these factors affect patient understanding. Failure to deal with them in the methodologies of the studies predisposes

the investigations to make patients culpable for aspects of the therapeutic milieu actually controlled by physicians.

The third factor which facilitates a bias against patients is the portrayal of a direct correlation between patient compliance and patient comprehension. Just because patients do not adhere to medical advice does not mean that they failed to understand it. Patients often do not adhere because they do not agree with medical advice or because it fails to produce the desired results for them. Patients also vary their therapy modalities or drug regimens to produce more individuated treatment plans. Alterations in treatment are also designed to effect goals better suited to the patient's perceptions of her/his needs and less restricted by the demands of convenience to the physician. (Hayes-Bautista, 1976: 234) Research that fails to take these factors into account portrays patients as ignorant rather than unconvinced or self-directing and thus inaccurately describes them and does them a disservice.

Patients actually have a much broader general medical data base than either physicians are aware of or that patients necessarily exhibit. How did patients come to posess this knowledge? There are four primary factors which have augmented lay knowledge of medicine. First is a heavier emphasis on medicine and medical topics in the informational mass media. Newspapers, magazines and educational television programming all provide space and time not only for medical discoveries, but for the nature and treatment of common medical problems. Second is a heavier emphasis on medicine in the general culture. This includes more general television programming, literature, cinema and theater. Medical problems have become a topic for general discussion on a wide variety

of levels. Even such non-scholarly treatments as those found in the entertainment industries provide increased familiarity with different visions of the medical model.

The third factor contributing to lay knowledge is today's increased usage pattern of the medical arts and sciences. More people go to physicians more frequently and for a wider sphere of disorders and problems than they did in the past half or quarter of a century. (Cary, 1980) This provides the most significant amount and quality of information to patients. Patients have a broader general medical data base because they have more experience with physicians in a wider variety of contexts. Finally, the younger set of patients has an increased medical knowledge base due to broader and more specific education in the school system. More young adults have a better exposure to information about the operation of their bodies through such classes as general biology, sex education, etc.

Patients do not exhibit this understanding in the medical setting for a variety of reasons. Most significant among them is that they are not encouraged to do so. The general patient role is passive. Physicians monopolize most of the time in the therapeutic setting. They often do not even allow time for or encourage questions, let alone a display of patient knowledge. Many patients are not comfortable with the expression of the more detailed codes and patterns although they understand their meanings and uses. (Krause, 1978) Finally some patients do not express their knowledge or profess limited knowledge as a tactic to get more information directly from the physician. They may have information on a subject already, or it may have been explained

previously by allied health professionals, but the patients really want more information of greater depth or at least another repetition to ensure that they got the full story. This is a phenomenon recognized by physicians only in long term or chronic health care facilities, (Roth, 1963) although its occurrence is more pervasive.

The general level of medical information provides the foundation for the assertion that patients have a sufficient data base from which they are able to make rational, goal-oriented choices with regard to treatment. That is they have the wherewithal to understand the information relevant to their states. This information must be provided them however. It must also be provided in a language that they can be expected to understand. Many physicians make use of the private language or jargon of medicine which immures meaning. The use of a private language is also a device for the maintenance of power. By using language that the patient will probably not understand, the physician structures the nature of what is available for the patient's consideration. In so doing he structures the patient's considerations themselves. Such a practice lends new meaning to the phrase "patient management."

Finally, the information provided must be presented in an objective manner. It is of no use to request information so that the patient can make her or his own choice if the physician is going to bias it so that the result is determined initially. That is not informing but persuading. The use of these tactics allows physicians to comply with the letter of the laws of informed consent while abrogating their spirit. It is of no small import that in so doing they maintain their status as the singular powers in the medical setting.

Arguments have been made which would tend to support the belief that patients have a general level of information which provides a background from which they can make rational, goal-oriented choices with regard to their treatment. It has also been shown that patients can understand information relevant to their conditions and treatment options if the time and effort is taken to present them in the "common tongue." This statement is not without controversy however. It is widely held that such efforts on the part of physicians would take too much time. It is also argued that physicians have a responsibility to heal and not to inform or teach. These contentions shall be analyzed here and as the time-argument is the one used more frequently it shall be dealt with first.

We should begin by noting that the use and classification of time is always relative to two things: what is expected to be accomplished and who it is expected to be accomplished by. If we are satisified with the physician's status as the sole power in the therapeutic interaction then perhaps time spent on patient desires or oriented toward providing the patient with information, (and thus power), will always be too much time from the viewpoint of the medical model. But if the patient is to be more than a child s/he will have equal authority to direct the course and the content of the interaction, so the time spent in information exchange would not be too much.

A slippery slope or camel's nose argument is often used against this type of reasoning. The individuals so inclined argue that once patients have to be provided with the information necessary to make their own decisions they will become unhinged and demand the equivalents

of a medical education. They argue that patient demand for information will become unreasonable and that consequently physicians will no longer have time to heal. Images of beleagured doctors pouring over pharmokinetic texts with tyrranical patients are conjured for the enjoyment of the onlookers.

Yet it should be asserted that these types of fears are basically unfounded. For most people have been so inclucated with the disproportionate value of a physician's time that they will be reasonable. If patients are truly interested they will ask for references rather than "plague" their physicians. "Plague," by the way, is simply a manner of responding to an inconvenience or potential threat that suggests a stratified relationship. It suggests that the physician is better or has more value than the patient. The whole camel's nose argument becomes fantastic when one recalls that the physician is ultimately protected from the unreasonable patient by retaining the option of denying her/him service.

As far as the healing/informing-teaching issue is concerned, if one takes a historical vantage, then the statement that it is the responsibility of physicians to heal and not to inform or teach is probably true until most recently. As has been shown earlier, assertions of the duties or responsibilities of physicians to their patients, or affirmations of patients' rights, have been singularly notable by their absence until the last half of this century. Indeed, until the 1960's patients were only protected from the most grievious wrongs done to them, experimentation without consent, etc. Further, any considerations from the physicians that the patients have garnered have been colored

by the paternalistic benefit language in the tradition of the Hippocratic Oath. Acceptance of patients as equal powers in the therapeutic setting is not yet complete.

However, the rights of patients to be informed of any and all data relevant to their treatment were secured by the state in Canterbury v. Spence. This duty was not seen by the court as subsidiary or subordinate to the duty to heal but coextensive.

> The Canterbury Court recognized that the physician's duty to inform a patient is as much a part of medical practice as are diagnosis and treatment. (Wilcox, 1980: 66)

This right was not limited to surgery or drastically invasive medical procedures but to medical care as a whole. It is secured not only in Canterbury v. Spence but in the body of Anglo-American law since that time. Lord Justice Edmund Davies said,

> . . . the necessity for consent is not in principle confined to surgical operations. It extends to every other form of medical treatment, for it is technically an assault even to administer a drug secretly and against the patient's wishes. (Davies, 1973: 5)

In the eyes of the law beneficence arguments were insufficient to justify patient loss of control. The essence of Anglo-American law was seen to begin with the concept of a pervasive right to self-determination. From there it was established that each individual is to be considered master of her/his own body. The physician's judgments of patient benefit were deemed insufficient to override the patient's expressed wishes even in the case of life prolonging treatment. Further, the law would not permit substitution of the physician's judgment for that of

the patient by any trick or deceptive art. (Katz, 1978: 771) In fact, noted jurists and legislators indicated that it was precisely when a restriction of freedom was made on the grounds of beneficence that individuals should look best to protecting their liberties. Louis Brandeis made an observation with reference to government encroachment on citizen's liberties but the point is equally applicable to the physician-patient relationship,

> The makers of our Constitution. . . sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the government, the right to be let alone - the most comprehensive of rights and the right most values by civilized men. . . . Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent. Men born to freedom are naturally alert to repel invasions of their liberty by evil-minded rulers. The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning, but without understanding. (Childress, 1979: 21)

It would seem that the first question has been answered. Not only do patients as a class possess a sufficient data base from which they are able to make rational, goal-oriented choice with regard to treatment, but their access to the actual information necessary to do so is entitled by law. Their adult status on this basis is thus justified and its negation by the medical profession as an institutional practice is morally and legally reprehensible.

Now the second question must be answered. Are patients mature enough as a class to justify retaining their adult status in the medical setting? Maturity is a complex concept and a difficult thing to ascertain. Definitions of it are hard come by so a description shall

instead be proposed. Let it be asserted that maturity might involve a serious outlook on matters; a sense of responsibility or relative importance, and the ability to use careful consideration. It will be argued that patients as a class are in possession of all of the above attributes with regard to health.

The importance that individuals place on health and the responsibility they feel in obtaining and maintaining it is shown by many things. It is shown by the fact that Americans spent eleven cents of every dollar of individual post-tax income on medical care in 1979. (Kimble, 1980: 62) The New York Times Best Seller List in the 70's also indicates the importance of health to all of us. The list was dominated by books on health, fitness and health eating. (Kimble, 1980: 63) Finally the growing popular interest in such things as running; participant sports; smoke-enders societies; weight reduction groups and classes; self-help medical books, courses and lectures; wholistic medicine; health foods and environmental sanctity, all testify to the overwhelming importance individuals give to health as well as their sense of responsibility toward attaining it. We are a nation of people who are healthier than we have ever been and very interested in not only maintaining that state but furthering it.

It has also been established that patients as a class have a serious outlook on health and a sense of responsibility to maintaining it. They also seem to have an appreciation for its relative importance. But are patients as a class able to use careful consideration with respect to health care? The answer to that question is yes. Experience has shown that patients as a class make reasoned judgments about their

health care on the basis of both their value systems and the information they have obtained. The care with which they approach these judgments is illustrated by the types and quality of information they desire. One study showed that up to 89 percent of the patient population wished to have a more detailed explanation of the relation of their disease to their broader life activities. Eighty-three percent of the patients in one group wanted more information about the way in which the drugs they took worked on their bodies. Up to 85 percent of the entire patient population wanted to know more about the potential side-effects of treatments and drugs. (Baksaas, 1980: 410)

It can be argued then that patients as a class are mature. They have a sufficiently serious approach to health and considerable appreciation of its importance. They also use careful consideration in decisions involving health care. As they are mature they are entitled to their adult status on this ground. Because sufficient patient knowledge and maturity have been established, their status as morally responsible individuals has been justified. The onslaught that paternalism as an institution constitutes is therefore unjustified, illegitimate and ethically reprehensible.

Paternalism is also ethically unjustifiable for its negation of the status of patients as morally responsible adults under the formal principle of justice. The formal principle of justice states that equals should be treated equally. With institutional paternalism there is a group of responsible adults who are being treated differently from the rest of the population, for an illegitimate reason. They are being treated as non-adults because they are patients. It has already been

shown that status as a patient does not deny status as an adult. It has also been established that when patients are no longer rational or capable of self-determination due to extreme disease conditions, they are to be assisted.

It should be stressed that the diminished-capacity argument has been over used by physicians as a vehicle of power over patients. Patients have diminished capacity in states of illness because they are kept uninformed due to assumed psychological effects of disease. In fact what patients fear most in serious illness is not the ravages of disease, but the ravages of the system, the loss of control.

Another argument against paternalism as a denial of patients' status as morally responsible adults is that it involves the application of treatment to an uninjured area. Patients are physically sick not morally sick and the patients dealt with in this thesis are not mentally ill. Consequently, to remove their moral status and "operate" on it when they have a physical malady is to misdirect treatment. Patients have committed no crime or sin nor have suffered any moral fall which would justify a moral treatment or punishment. To apply such a cure is to recreate the exorcisms prescribed for epileptics or the drownings to cure witches.

Ethical Problems Involving Paternalism as the Denial of Patient Autonomy

Paternalism as an institution also functions to deny patients autonomy. Why is this problematic ethically? Autonomy has been established by many different philosophers and theologians as a

prerequisite for morality. Fletcher; Kant; Mill; Nietzsche; Rawls; Sartre, and Wolff all assert the necessity of autonomy for status as a moral entity.[5] Denying status as a moral entity is in a very real sense to deny individuals their humanity and to leave them ripe for abuse.

The quarrels of some of the above mentioned philosophers with a systematic negation of autonomy will be detailed. However, it would be beyond the intent of this section and needlessly involved to recapitulate the views of all the philosophers named. It has been decided instead to reproduce only Fletcher; Kant; Mill, and Rawls. They are of especial importance and singularly widely read. Their influence is perhaps the greatest. They will be dealt with chronologically.

Kant is trenchant about the moral absoluteness of individual autonomy. His view makes impossible any action by others to limit or negate this autonomy as well as any such self-inflicted action. It also disallows the usurpal of power by the individual's own passions. Kant argues against paternalistic interference on two of the major foci of his Groundwork of the Metaphysic of Morals: the first statement of the categorical imperative and the formula of the end in itself.

The first statement of the categorical imperative is as follows:

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[5] Joseph Fletcher, Morals and Medicine (Boston, Massachusetts: Beacon Press, 1954). Immanuel Kant, The Groundwork of the Metaphysic of Morals, trans. H. J. Paton (New York: Harper and Row, 1964). John Stuart Mill, On Liberty, ed. David Spitz (New York: W. W. Norton Company, Inc., 1975). Friedrich Nietzsche, On the Genealogy of Morals, trans. Walter Kaufmann and R. S. Hollingdale (New York: Vintage Books, 1969). John Rawls, A Theory of Justice (Cambridge, Massachusetts: Harvard University Press, 1971). Jean-Paul Sartre, Being and Nothingness, trans. Hazel E. Barnes (New York: Pocket Books, 1956). Robert Paul Wolff, In Defense of Anarchism (New York: Harper and Row, 1970)

> That I ought never to act except in such a way that I can also will that my maxim should become universal law. (Kant, 1964: 70)

Paternalism as an organizational institution is inconsistent with the categorical imperative because it involves a contradiction in terms. Kant would not think it possible to hold as a universal law that rational, adult beings should be treated as children and loose their right to information and self-determination in order to be treated for health problems. For to do this would be to will that rational persons, who are by Kant's definition, those who have the power to act in accordance with their own ideas of laws or principles, (Kant, 1964: 25), should become irrational. That is, they should no longer have this power when they are placed within the medical system. Such a contradiction cannot be universalized.

Paternalistic intervention also contradicts the categorical imperative because the goals it asserts cannot be established as unconditioned principles. That is they are not goods by virtue of any natural outpouring of the function of reason. They are not absolute goods but only goods within one particular system and its individual view of health. Consequently, these goals are material maxims dependent on individual desires and not universalizable.

Kant also argues against paternalistic practices on the basis of the formula of the end in itself. That is the principle which states,

> Act in such a way that you always treat humanity whether in your own person or in the person of any other, never simply as a means, but always at the same time as an end. (Kant, 1964: 96)

Paternalism does not treat rational individuals as ends in themselves and their values as significant but rather subordinates them to the particular view of health and the value system purported by a single group of individuals. Kant indicates that in order for persons to be treated as ends they have to be able to accept the values that are being pressed for them. Patients most certainly cannot do that here. Kant also argued that only rational agents can have unconditioned or absolute value and that it is wrong to use them as a means to an end whose value is only relative. (Kant, 1964: 33) As the particular idea of health purported by the medical model is only a relative good the paternalism required to enforce it is reprehensible for Kant.

J. S. Mill is equally emphatic about the moral sanctity of individual autonomy. In fact, he asserts that there is only one condition in which the judgment of the individual acting in a self-regarding manner is to be overridden. That is in the case of the individual attempting to sell herself/himself into slavery. It should be apparent then that Mill would not allow the other imposed bondage that paternalism as an organizational institution constitutes.

Mill maintains that social and political control over individual action is only legitimate if necessary to prevent harm to other individuals affected by those actions. (Beauchamp and Childress, 1979: 57) He writes in his essay <u>On Liberty</u>,

> The object of this Essay is to assert one very simple principle. . . . That principle is, that the sole end for which mankind are warranted, individually, or collectively in interfering with the liberty of action of any one of their number is self-protection. That the only purpose for which power can be rightfully exercised over any

> member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because in the opinion of others to do so would be wise or even right. These are good reasons for remonstrating with him, or reasoning with him or persuading him, or entreating him, but not for visiting him with any evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is of right absolute. (Mill, 1975: 10)

Mill did not support paternalism as a means for the substitution of values and never as a means for change in the locus of control. Paternalism as an organizational institution in medicine would be in direct contradiction with his views. As external enforcement of one set of values upon free individuals engaged in self-regarding conduct, it would be morally reprehensible.

Joseph Fletcher argues against paternalism on two grounds. He argues against paternalism in its function to deny patients knowledge and he argues against it on the basis of its denial of patient freedom of action. Fletcher indicates that it is morally wrong for a physician to deny a patient facts or to withhold information when a patient is interested in them. He believes that a patient has a right to this data because the facts of the patient's case belong to the patient and not to the physician. The physician is entrusted by the patient with what he learns but as the facts are the patient's to deny them is stealing and is morally unlawful. (Fletcher, 1954: 60)

Fletcher also reasons that paternalism is unjust because it denies patients freedom of action. Fletcher believes that our stature as moral entities is proportional both to our freedom to choose and to the control we exercise over our alternative courses of action. He argues that without this freedom we are in the realm of conscience more mannequin than human. Without freedom we are not responsible, are not moral agents and are not personal beings. (Fletcher, 1954: 35)

John Rawls holds that liberty may only be restricted for liberty's own sake. (Rawls, 1972: 244) He seems to indicate that paternalism is only valid as a social insurance policy that we take out and which applies when we are not rational or not ourselves. (Rawls, 1971: 249) He argues that paternalistic intervention is always to be guided by the individual's own settled preferences if known or by the original contract position. (Rawls, 1971: 249)

Paternalism as an organizational institution does not fulfill Rawls' requirements. For paternalism as an organizational institution, as a characteristic of persistent element of medicine which structures the relationships of doctors and patients, was and is <u>not</u> guided by the settled preferences of individual patients. It is an institution which has a history of imposing its values on patients against their will, not one of seeking to ensure action in accordance with patient preference. Further, if the values of paternalism were <u>really</u> those of the patient then there would be no need for paternalism as it has been defined in this thesis. There would be no need for interference with a person's freedom of action or freedom of information. Paternalism as an organizational institution is also incompatible with Rawls' views in

that it does not limit interferences to instances when the individual is irrational or unable to exercise self-control.

A few words should be said here on the author's conception of paternalism as a social insurance policy. Such a concept would be acceptable to the author if two things were assured. First, that patients would actually have to contract for a policy on an individual basis with the organization of medicine. Second, that the insurance policy would only take effect when the individual was incapable of self-control. It is of paramount importance that the insurance policy should only operate when the individual is unable to exercise autonomous control. It is an insurance policy not a correction policy. Its purpose is to guarantee that each individual's desires and goals are carried out when they are unable to speak for themselves.

In addition to the arguments proposed by these four philosophers and their systems there is another which speaks against the denigration of autonomy that is paternalism as an organizational institution. This is the Greek concept of moira. (Newton, 1977: 643) Moira involves the idea of individual spheres of control or just domains. For the Greeks moira wasn't a diety but the principle of just distribution superior to all the gods. Hesiod indicates that it was by virtue of moira that the gods received their dominions or allocations of authority and control or moirai. Newton defines moira saying,

> A moira was primarily a jurisdiction, an appointed area of free choice and action for its holder. (Newton, 1977: 643)

It can be argued that each human being upon the attainment of adult years and manifestation of soundness of mind has a sphere of dominance or

authority established by a natural principle of just distribution older than the gods. Each individual has a moira. In the author's system this moira would be self-regarding action. Within this domain the individual should be free to exercise self-control in accordance with their preferred value systems uninhibited by individuals or society.

A fall or a crime would be necessary to justly remove or reduce a person's moira. Yet with paternalism as an organizational institution no such fall can be documented of either individual patients nor patients as a class. The absolute sanctity of individual's moirai is violated in order to add power to others. Further, the degree of violation depends upon arbitrary factors unrelated to the capacities or actions of the individual. The degree of interference is affected by such things as the practice ideology, type of medical specialty and the manner in which the physician is reimbursed. Not only is great injustice done, but its extent and application is capricious and arbitrary with respect to the individual patient.

The Internal Incoherence and Inconsistency of Paternalism

There is a third type of argument against paternalism as an organizational institution. It involves an internal criticism of paternalistic reasoning and reality and shall be detailed at this time. This argument indicates that the reasoning supporting paternalism as an organizational institution is internally incoherent. It also shows that the reality of paternalism as an organizational institution is inconsistent with the goals that paternalism professes , the production and preservation of the benefit of patients.

Paternalism is widely justified by the use of one of three arguments: the argument from the prevention of harm; the contractual version of the argument from the prevention of harm and the argument from the inability to understand. (Buchanan, 1978: 377) All these lines of argumentation are illegitimate being either invalid, unsound, or both. The argument from the prevention of harm is by far the most commonly used argument. In fact it is visible in Chapter 3, Illustration 3. The standard form of this argument is as follows:

> 1. The physician's duty - to which he is bound by the Oath of Hippocrates - is to prevent or at least minimize harm to his patient.
> 2. Giving the patient information X will do harm to him.
> 3. (Therefore) It is permissible for the physician to withhold information X from the patient.
> (Buchanan, 1978: 377)

This particular argument is both invalid and unsound in its manifestation here. Premise 1 is true. Yet one should recall that the Hippocratic Oath is thoroughly paternalistic. It can not be appealed to with the status of an independent or objective ethical principle.

Premise 2 is false. Not only is premise 2 false on an institutional scale, but even were it to be true, it would be inadequate to logically entail the conclusion. Thus the argument is invalid. A suppressed premise is required to render the argument valid, that providing the information will do more harm to the patient than the withholding of it will do.

There is a great deal of information to support the author's statemtent that premise 2 is false. Studies show that the withholding of information from patients relates directly to increased patient

suffering both physically and emotionally. One study shows that when information concerning the preparation for anaesthesia; the duration of the operation; the degree and type of pain to be expected afterwards, as well as techniques for its relief were provided to patients rather than withheld, patient need for pain relievers was reduced by half! (Egbert, 1964: 827) Not only did patients require less drugs when they were informed but they experienced shorter recovery periods. Surgeons, who did not know which group of patients was informed and which was not, sent the informed patients home an average of 2.7 days earlier than the patients in the control group. (Egbert, 1964: 826) This study found that failure to provide even the frightened or hysterical patients with information prior to their operations exposed them to increased psychic stress during the recovery period. (Egbert, 1964: 827)

Other studies show that patient anxiety and emotional suffering is increased by failure to inform. Even when the news is bad most patients prefer to have it and do better with it than without it,

> As to the diagnosis itself, clearly patients feared the unknown much more than they feared the truth about their illnesses, however serious these might be. (Reynolds, 1978: 1675)

The powerlessness that failure to inform produces in patients is also harmful to them. One study states,

> The absence of power is strongly conected with feelings of helplessness (or impotence) and is a precipitation to . . . depression. Therefore, it would seem reasonable to suggest that patients' depression may be lessened or even avoided if the health care system facilitates some sense of control, giving them power in decisions, and helping them acquire some knowledge about their future experiences

> by providing them with relevant and appropriate information. (Schain, 1980: 1035)

What about the supressed premise? Would its inclusion make the paternalist's argument any stronger? It would seem not. For not only would the paternalist have to establish that the practice of informing causes harm to patients as a class, but s/he would have to establish that it causes more harm than the failure to inform does. When it is considered that the unjust denial of patients' status as morally responsible adults and the negation of their autonomy and all the concomitant injuries have to be reckoned among the harms of failure to inform, the promise of the supressed premise is extinguished.

The second form of argumentation used to justify the practice of paternalism, the contractual version of the prevention from argument, is as follows:

> 1. The patient-physician relationship is contractual.
> 2. The terms of the contract are such that the patient authorizes the physician to minimize harm to the patient, by whatever means the doctor feels are necessary.
>
> Therefore if,
>
> A. Giving the information X will harm the patient, or if the best way to minimize harm is to withhold X,
>
> Then,
>
> B. Withhold X. (Buchanan, 1978)

This form of argumentation is also both invalid and unsound. The first premise is true, but the second premise is neither descriptively accurate nor normatively correct. The legal necessity of informed consent verifies this. Further, even were condition 2 true, patients would have to enter into such a relationship, singly, freely, and with full

knowledge and that would be empirically rare. Paternalism as an organizational institution justified on this basis would be unfounded. It has already been established in the analysis of the prevention of harm argument that A. is not true. Because premises 2 and A. are untrue, the conclusion is unsound.

The third and final major form of argumentation used to justify paternalism is the argument from the inability to understand. It provides that,

> . . . the physician is justified in withholding information when the patient or his family is unable to understand the information.
> . . . . . .
> The idea is that either their lack of intelligence or their excited emotional condition prevents the parents from giving informed consent because they are incapable of being adequately informed. In such cases, it is said, "the doctrine of informed consent does not apply." (Buchanan, 1978: 386)

This argument simply has no basis for its assertions in reality. It is descriptively untrue to suggest that physicians only have a duty to inform when it is clear that the patient will comprehend. Physician duty to inform is absolute. The legal doctrine of informed consent secures the right of every competent, adult individual regardless of educational level to be informed and to make self-directed choices. In Natanson v. Kline the court established informed consent as the physician's:

> . . . obligation . . . to disclose and explain to the patient in language as simple as necessary the nature of the proposed treatment, the probability of success or of alternatives, and perhaps the risks of unfortunate results and unforseen

> conditions within the body. [emphasis mine,] (Katz, 1978: 772)

Duty to inform is not limited by patient ignorance or lack of educational development nor by patient agitation. And argumentation built upon such a hypothesis would consequently be illegitimate.

It should be clear that the arguments for paternalism as an organizational institution are internally incoherent. They are invalid and their premises have little or no descriptive veracity. Arguments from beneficence or non-maleficence have been revealed as shams. For if patient pain is increased, recovery period lengthened, status as a morally responsible adult denied, and autonomy destroyed, where is the beneficence in paternalism?

It has been established that paternalism is an organizational institution of medicine. It has further been shown why such a paternalism is problematic ethically. Paternalism as an organizational institution was revealed in its function as an instrument for the substitution of values and as a transfer of the locus of control from individual patients to the organization of medicine both collectively and in its expression individual physicians. The insult and injury to patients that such an institutional practice constitutes have been detailed.

It is hoped that the recognition of paternalism as an organizational institution in medicine will lead us to the development of new ways to equalize the stratified power and value structures which dominate contemporary medicine. At the least the recognition of paternalism as an organizational institution will make us sensitive to the fact that the professed advantages of the most pervasive type of medical paternalism

are illusory. Perhaps this knowledge will protect us in the future. In any case we may propose an answer to a question that has festered long in the minds of many. Where is the beneficence of paternalism? Well, the benefit of paternalism as an organizational institution lies where it has always been, with the organization of medicine.

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