

To the Graduate Council:

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A THEORETICAL FRAMEWORK FOR A COMBINED
SOCIAL-ETHICAL ANALYSIS

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ABSTRACT

Current normative analyses and recommendations in medical ethics do not sufficiently analyze the social context of concrete ethical problems. This results in impractical or ineffective policy recommendations or case responses which reinforce the social context which created the ethical problem. A social analysis is possible which displays how the social context directs the communication and action of physicians and patients, and in turn reinforces and further establishes these influential social factors. Such a social analysis provides a means of integrating short-term case-responses with long-term institutional policy and structural change. The latter, on this analysis, is the more ethically "complete", and unintegrated short-term responses threaten to undermine these efforts.

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Introduction

A contextually-bound, social analysis of medical interactions clarifies the philosophical-ethical issues that arise therein. The recommendations which are based on this analysis are of two complementary forms: 1) short-term responses which are normatively inadequate, and 2) long-term efforts to alter the social circumstances which constitute the ethical problems. Contemporary discussions in medical ethics typically assume some sort of social "picture." These assumptions direct the recommendation resulting from the analysis. Policy recommendations frequently do not accomplish their objectives when implemented. Case analyses fail to respond to the social circumstances which resulted in an ethically problematic case. The case analysis frequently reinforces these social circumstances because it needs to assume their stability in constructing a response. Recognition that these disparities are due to the focus and implied social "analysis" of the different approaches draws attention to the necessity of social analysis in applied medical ethics. The confusion which intentional models of ethical analysis generate when applied to policy issues further suggests the desirability of the move from a psychological to a sociological understanding of human behaviour. Drawing on work in my Master's Thesis (Burgess,

1983), I have illustrated the problem with the issue of informed consent (Chapter I).

I recommend an ethnomethodological approach to understanding physician-patient encounters. Following the work of Sue Fisher (1979, 1982, 1983, 1986), I suggest that a complete analysis must recognize and account for the effects of institutional and cultural factors on these encounters. As most poignantly argued by Jeff Coulter (1979), the methodological assumptions of such a social analysis is a reasonable response to some current problems in the philosophy of mind (Chapter II).

Once again drawing from research conducted with Sue Fisher (cf., Fisher, 1983, 1986; Fisher and Groce, forthcoming; Burgess, 1983, 1986), I have presented three paradigmatic cases for analysis (Chapter III). The social analysis of these cases illustrates how the context of physician-patient interactions directs the communication and decisions that are likely to be produced therein.

Clarification and criticism of the notion of informed consent is aided by the social analysis. The abstract goals of "patient's best interest" or "freedom from physician's influence" are not practical or meaningful. The layered social analysis displays that some of the ethical concerns which informed consent has been meant to respond to cannot be dealt with in this manner. Careful social analysis clarifies the limitations of the doctrine, and

suggests more effective recommendations. The implication of the overall social-normative analysis is that ethical recommendations can and must be constructed as complementary efforts designed both to help concrete individuals and to change the practice of medicine as well as patient and physician "attitudes." The structural level of analysis has shown that these latter, more comprehensive goals are difficult to achieve because they challenge broader societal practices and political agendas (Chapter V). The integration of ethical analyses and recommendations with a social analysis enhances the clarity of the philosophical discussion as well as the defensibility and effectiveness of the recommendations.

Chapter I

Importance of Empirical and Contextual Analysis

The thesis of this chapter is that different types of medical ethical analyses (i.e., case-, issue-, policy-oriented) present disparate responses to similar problems due to their different foci vis-a-vis the social context. Since each type of analysis has much to recommend it, we might reasonably expect that there might be some way to unite these different analyses. In particular, I think that the psychological-intentional model of analysis of ethical actions cannot unify these normative analyses, nor is it the best method of understanding institutionally-situated action. A contextual-social approach, discussed in Chapter II, more adequately fulfills these purposes and results in more applicable and effective recommendations.

Current discussions in medical ethics can be distinguished in different manners. One distinguishing characteristic is the particular approach. There are case-illustrated philosophical discussions, issue-oriented discussions, case-by-case analyses, issue-oriented case discussions and policy discussions. A second means of distinguishing the different approaches is to consider the type of intervention or social change that are recommended.

While some suggest that individual physicians or patients act differently, others take a wider focus, and recommend that the profession or institution should form policy to change the problematic behavior, or that laws should be enacted to enforce the ethically required change. More extreme are views suggesting that the problems in health care are reflections of those of society in general and so effective responses will take the form of social change on the largest scale, social revolution (i.e., Navarro, 1973, and Waitzkin, 1983, both suggest that ethical and social problems in the delivery of medical care must be responded to with a change in the capitalist economy). These two different ways of characterizing medical ethics discussions cut up the literature along similar lines; case-studies generally suggest individual changes in behavior while issue-oriented discussions are more likely to produce policy.

It is my contention that the reason the discussions happen to divide in such a manner is due to different forms or "scopes" of social analysis that are either implicit or explicit in the approaches. Starting with the most "philosophical," there are discussions which can be characterized as case-illustrated philosophical analyses. These are primarily concerned with utilizing the controversial ethical issues that arise in biomedical practices to clarify standard philosophical discussions.

The social factors relevant to the discussions are those which are demanded by philosophical considerations. Metaethical discussions and the like will occasionally utilize such examples. Charles Fried, in discussing and evaluating use of the self-defense exemption to the rule of non-maleficence, uses the following example:

IX. A retarded and sickly child is the only available donor of a kidney for an otherwise normal sibling. The donor would surely not survive the removal of his kidney. (Fried, 1978: 49)

The role that the example plays in the discussion is to clarify our moral intuitions on the use of force to avoid personal harm in situations where the "defense" is not against an attacker in the usual sense. Fried also uses the case of organ transplant, the withholding of treatment and scarce medical resources to illustrate his argument (Fried, 1978: 52). The conclusion of his discussion is not so much a reference to how such cases should be decided or handled as much as a clarification of the role intention plays in the general applicability of categorical norms (Fried, 1978: 53). The social picture presented in these discussions establishes the ethically relevant criteria needed to illustrate the borderline issues and to argue for important distinctions in the formulation of general ethical principles and theory.

The use of such cases as examples is a recognition

that medical practice presents us with difficult ethical dilemmas. The medical-ethical case is used for the philosophically practical purpose of illustration and argument. The accompanying social picture, which is the reason why the medical cases are so useful, presents the ethical questions in a limited context. This limited, and familiar, context is useful because it focuses our attention on those factors which must be considered in the application of moral principles to the case resolution. The focus of the discussion, however, is on ethical principles and theories. The cases considered are a means of clarification. The social picture is not based on a social analysis, but rather the case is chosen precisely because it illustrates the social factors needed to make the argument. While the general ethics discussion may enlighten the reader as to how certain ethical principles might apply to medical cases, such is not the purpose of the writings and this effect is secondary and unintended.

A second approach in medical ethics literature is an issues-oriented approach which does have the purpose of exploring how ethical principles and theories apply and assisting in resolving ethical problems that arise in medicine. In an introductory anthology, edited by R. Munson (1983), J. Gay-Williams, considers the issue of euthanasia in a brief issue-oriented discussion (Munson, 1983: 156-162). Using arguments from varying theoretical

perspectives, Gay-Williams maintains that euthanasia, defined as "intentionally taking the life of a presumably hopeless person," is immoral. Gay-Williams rejects the passive/active euthanasia distinction, claiming that passive euthanasia is not euthanasia proper, since it is not deliberate or intentional taking of life. Arguing from a natural law perspective, Gay-Williams indicates that we have an essential tendency to self-preservation. This is sufficient, it is argued, to show that euthanasia is wrong. Shifting to a discussion of self-interest, Gay-Williams argues that, since the acceptance of euthanasia might undermine the drive to survive and is too dependent on very limited capacities to predict the outcome of disease and medical developments, it is immoral from the perspective of self-interest. Finally, arguing from "practical effects," the author claims that acceptance of euthanasia could result in an overall decline in the quality of medical care and sets society on the slippery slope of allowing society to contain and kill off those who are disapproved of and labelled by mental or medical health officials. The entire argument is backed entirely with references to theoretical and ethical distinctions.

Another example of what I am referring to as an issue-oriented approach is the well-known article by R.M. Veatch called "Models for Ethical Medicine in a Revolutionary Age" (1972). In this article, Veatch draws out

the social and ethical implications for different conceptions of the relationship between physician and patient. He refers to different possible models as 1) the engineering model, 2) the priestly model, 3) the collegial model and 4) the contractual model. Veatch's arguments are based on ethical principles and concerns, as well as a discussion of the social state of affairs that is promoted by each model. He condemns the ethical abstinence of the engineering model, the ethical elitism of the priestly model and the idealism of the collegial model. The contractual model, conceived along the lines of the religious notion of covenant rather than a more legalistic conceptualization, is what Veatch finally recommends as the most desirable model for the physician-patient relationship.

There are obvious conceptions of social relations and of society in Veatch's argument. Consider his criticism of the collegial model:

for the most part we have to admit that ethnic, class, economic, and value differences make the assumption of common interest which is necessary for the collegial model to function a mere pipe dream. What is needed is a more provisional model which permits equality in the realm of moral significance between patient and physician without making the utopian assumption of collegiality.
(Veatch, 1972: 7)

In both Gay-Williams' and Veatch's arguments there is explicit use of premises that are empirical generalizations about society. Gay-Williams asserts that

society is not capable of distinguishing and enforcing different policies toward the terminally ill and those who are labelled deviant. Veatch asserts an asymmetry in medical knowledge and claims that class, ethnic, economic and value differences render unrealistic any expectation of collegiality between physician and patient. No empirical support or theoretical framework is suggested for such statements. Rather, they are assumed to be non-controversial statements about a familiar state of affairs. Neither is there reference to specific cases. The discussion is issue-oriented in that it explores the ethical implications of the acceptance of certain moral attitudes or types of actions. The outcome or conclusions of such discussions are either condemnation (in Gay-Williams' discussion) or condemnation and recommendation (in Veatch's discussion) of particular moral stances. There is no mention of concrete actions that might help to alleviate the ethical concerns expressed in particular cases. Though Veatch's conclusions may be a policy recommendation in that he suggests a particular model for medical practice (Veatch, 1972: 7), he does not give concrete suggestions of how to implement the model. It is not clear how physicians or patients can shift or grow into Veatch's model, nor what sort of institutional policies might encourage such a shift.

A third type of discussion might be characterized

as a combined issue-oriented case-study approach. Case studies are used to illustrate an ethical problem that occurs with a degree of frequency in medical practice. The cases may be used to show the development of the issue as an ethical problem rather than simply to show that the ethical problem has occurred in at least one case. The issue-oriented component of the discussion establishes the issue as an ethical issue and suggests what sort of response is ethically appropriate. The fact that the issue has been illustrated and developed through case studies has the benefit of making the recommended responses more obviously applicable or sensitive to the social factors surrounding the occurrence of the ethical problem.

One example of this approach is found in Veatch's Case Studies in Medical Ethics (1977). Interspersing ethical discussions and case studies, Veatch works through most of the issues typically discussed in current medical ethics literature. On the issue of informed consent, for example, he presents three cases to illustrate the general issue as well as standards of disclosure, non-beneficial research on children and consent that would invalidate the result of research, as in the use of placebos (Veatch, 1977: 290-306). On the issue of informed consent for non-experimental therapy, Veatch presents a brief history of the issue's development in American medicine. He then presents a case titled "The Practice-of-the-Profession or

Reasonable-Person-Standard" (Veatch, 1977: 302-304). Veatch cites a case where a patient sued physicians who suggested and performed a myelogram which resulted in injury to the nerves in his lower back causing "diminished sensation in the front of the left leg below the knee and a weakness in the left foot" (Veatch, 1977: 304). Dr. Anderson, one of the physicians, argued from the standard of practice in the community, claiming that other physicians in the area would not have informed a patient of the remote risk of serious spinal injury. The complainant, Mr. Berkey, argued that physicians are governed by a standard of disclosing what a reasonable patient would want to know, even if the risk is extremely small.

Veatch discusses the issue of standards of disclosure, citing legal cases. He indicates that the "community standard of practice" is based on the principle of benefitting the patient. "The decisive factor" as to whether the physician should tell the patient is whether the physician thinks that the information would benefit the patient (Veatch, 1977: 305). Veatch points out that Natanson v. Kline is cited in the court argument of the case study as support for the community standard of disclosure. The court ruled in Berkey v. Anderson that the medical community standard is insufficient and that such a situation is governed "in the same manner as others in a similar fiduciary relationship" (Veatch, 1977: 305).

Veatch develops the discussion of informed consent in non-experimental therapy by citing cases which illustrate patients who 1) are said to manufacture side effects if they are informed, and 2) are surprised and upset by extra charges and use of an independent laboratory (raising the issue of confidentiality). Issues are illustrated by the cases, implications and conflicts are indicated in detail through the discussion. The discussions are drawn to a close with statements of what issues are at stake. For example, after the case where a patient is said to manufacture the side effects she was warned might occur, Veatch comments:

To reveal extremely rare risks of diagnostic procedures can produce disturbances for a patient, as suggested by this case. It shows that informed consent for medical treatment is a problem not only for major, complex medical and surgical procedures but for the most routine procedures as well. (Veatch, 1977: 306-307)

This approach has the very considerable advantage of clearly illustrating, through very concrete, usually true, examples, what the issue is that is being discussed. The use of court cases also brings the legal dimension into the discussion. I consider this approach issue-oriented because it seems primarily to raise and demonstrate the ethical issues but does not tend to recommend explicitly any concrete responses. In this sense, it is more concerned with establishing the issues as

legitimate ethical problems. The spread or scope of the particular ethical issues is also sometimes suggested, as in Veatch's comment that the one case shows that informed consent is also a problem in "the most routine procedures." In other words, even in routine procedures the same normative analysis can be applied to reveal the ethical problem. This is perhaps an implicit suggestion to practitioners and ethicists that they should be aware that informed consent is an issue that might arise even in routine procedures.

Note that the social details of such discussions are set by the scope of the cases used. Consideration of the "manufactured symptoms" case was limited to similar cases; those that were routine procedures and which had a small chance of side effects. In the case of the suit over the lack of the patient's knowledge of a rare side effect, the considerations were broadened to bring into the discussion legal rulings on the legal status of the physician-patient relationship and its implications for disclosure standards. But these legal considerations serve mainly to aid in pointing out the ethical issue. The scope of social observation or analysis in these discussions is limited to consideration of how such ethical issues occur in certain social settings and to establishing that there is reason to consider them as legitimate ethical issues. Perhaps there is an implicit assumption that, as responsible

moral agents, physicians will act on the knowledge to change their behavior in a manner that will at least acknowledge the ethical issue. If so, then this too makes certain social assumptions about physicians' character, behavior and the social setting in which they operate.

More specifically, such implicit assumptions would suggest one form of recommendation. If physicians are at least as moral as most of us and are likely and able to act on their new knowledge of the ethical side of their medical practice, then an ethicist simply needs to establish the issues. There may, however, be good reasons to doubt that the mere indication of a moral problem will affect the behavior of a moral agent. Perhaps this assumption is not made by those engaged in such discussions but they are merely setting the ball rolling for more effective change. If such is the case then further discussion is obviously needed with an emphasis different from that of these discussions. The second social assumption, that simply desiring to change the situation empowers physicians to make effective change in their practice, may also be naive. Whether such is the case is an empirical question yet to be answered.

More practical and yet probably more limited in its scope is an approach taken in ethics grand rounds in teaching hospitals. In an attempt to get staff and residents to be more aware of the ethical issues in medical

practice, many faculties of medicine have sponsored case discussions where the emphasis is the ethical rather than the medical issues. These discussions may be more practical simply because of the fact that they occur in a situation where many of the participants are clinicians who want to know how to respond in such a situation. So in a case discussion of the "manufactured symptoms" the discussion that Veatch included as part of the case presentation would be likely to occur. In that discussion a resident suggests that the proper response is to withhold information about such side effects and the staff physician responds that such is not an option since "patients and their lawyers" have ruled out such action. Though likely to be in greater detail, such a discussion is of the type that occurs in the case presentations. Professional responsibility, legal liability and patients' interests are all weighed in an informal discussion or by the commentator. The main question usually addressed is "How ought a medical practitioner act in this and similar situations?" So the level of intervention is primarily that of appealing to the individual practitioner to behave appropriately.

The scope may be more limited than issue-oriented case discussions such as Veatch's, in the sense that time limitations may prevent similarities to other cases and related ethical issues from being indicated and illustrated. And the same social assumptions as were

pointed out for the previous approach seem to be operative here as well.

A final characterization of an approach to medical ethics discussions is what I will call policy discussions. Policy discussions usually, though not without exception, occur in the context of a policy making group which has some sort of institutional authority. Policy making bodies are convened to consider concrete responses to recognized problems. Hospital committees and medical professional groups engage in policy-oriented discussions regarding such issues as "no-codes" and the termination of treatment. Organ donor contracts, printed on drivers' licenses represent a means of implementing particular patients' wishes and is the result of policy discussions of ethical aspects in organ transplantation. The writing and legal status of living wills is a possible legislative response arising from policy discussions of euthanasia (cf., U.S. President's Commission Report, 1982: 155-166 for discussion of legal and ethical ramifications of "instruction directives" and designating proxies). Such policies are more overtly political in the sense of either establishing formal policies or of summoning support to appeal to other legislative or policy setting groups to make changes in their policies or laws.

Policy discussions outside such policy setting groups tend to focus on issues of allocation that are in

need of a response on the level of a social policy. For example, Ethics and Health-Care-Policy, edited by Veatch and Branson (1976), presents discussions of health care delivery policies by different authors. The ethical issues are justice, the "right" to health care, distribution of scarce resources and research efforts (e.g., the totally implantable artificial heart), and non-medical community participation in health care decisions (threatening professional autonomy). Such issues clearly need some discussion of social systems within which the issues must be considered. As such they explicitly bring in considerations of such social theories and issues as social justice (Outka), distributive justice (Fletcher), contract theory (Green), liberalism (Callahan, Steinfels), and technology assessment techniques (Walters). Disagreements are sometimes over the social analysis used (e.g., "The Right to Health Care and the Anxiety of Liberalism: A Reply to Daniel Callahan" by Peter Steinfels).

Another example of policy discussion is found in an anthology edited by T.A. Mappes and J.S. Zembaty (1981, 1986; cf., Capron 1974: 340-438; and page 49 of this chapter for a more complete list). Alexander Capron discusses the function of informed consent, concentrating on extreme therapies such as transplants (Mappes and Zembaty, 1981: 74-78). The general roles of informed consent are described as 1) the promotion of autonomy, 2) protection of the

patients' or subjects' status as persons and 3) avoidance of fraud and duress. Capron emphasizes that a formal requirement of disclosure increases patients' or subjects ability to exercise informed choice. He then enumerates six elements of informed consent set out by the federal government for the protection of human subjects (U.S. Department of Health, Education and Welfare: The Institutional Guide to DHEW Policy on the Protection of Human Subjects 7, 1971, as amended in 1974):

1. A fair explanation of the procedures to be followed, and their purposes, including identification of any procedures which are experimental;
2. A description of any attendant discomforts and risks reasonably to be expected;
3. A description of any benefits reasonably to be expected;
4. A disclosure of any appropriate alternative that might be advantageous for the subject;
5. An offer to answer any inquiries concerning the procedures;
6. An instruction that the person is free to withdraw his consent and to discontinue participation in the project or activity at any time without prejudice to the subject.

. . . No such informed consent, oral or written, . . . shall include any exculpatory language through which the subject is made to waive, or appear to waive, any of his legal rights, including any release of the organization or its agents from liability for negligence.

Following Capron's article is a legal opinion by Judge Spotswood W. Robinson III in the Canterbury v. Spence (1972) case (Mappes and Zembaty, 1986: 90-94). Robinson argues that a physician has a duty to inform

patients about dangers that "are material" to a patient's decision. He refers to a "reasonable person" standard for determining what dangers are material to the decision. Two exceptions are suggested. One exception is where "the communication of the risk information would present a threat to the patient's well-being" (Robinson, 1972: 788). The other is where in an emergency situation (i.e., life threatening) the patient is unable to give consent (Robinson, 1972: 789). Explicitly condemned is withholding information so that patients will not refuse therapy that the physician deems necessary.

Policy discussions are more practical than issue-oriented discussions in that they conclude with some form of concrete recommendation. The discussions in the Veatch and Branson volume (1976) are the most general in that they critique and make explicit use of social theories and theories of social justice and analysis. Since they are not restrained by an institutional mandate to make recommendations that will be effective within an existing system, they can be more critical of current systems than any of the other analyses can be. The Institutional Guide to Department of Health, Education and Welfare (DHEW) Policy may also be fairly open in terms of requiring change, if deemed necessary, in the policies of institutions and perhaps even legislative change. Judge Robinson's comments must remain within the legal tradition, since that is the

institution and authority within which his opinion is sought. Yet all of these discussions have in common that their recommendations are policy; they suggest that certain practices within either institutions or society must be constrained by ethical considerations. And, in each case, the arguments used to support the recommendations are either based upon the explicit use of a form of social analysis or are made within an assumed institutionalized social framework.

What all the policy discussions have in common is a recognition that there are ethical issues which need to be responded to at a policy level. This is at least an implicit recognition that these ethical issues are not easily dealt with at the level of physician-patient relationships. Social factors such as limited access to medical information and resources and conflicts of interests within the health care system serve to limit the effectiveness of appeals to individuals to act more ethically once educated as to the existence of the ethical issues. Policy recommendations, including those which suggest the need for significant large scale social change, are attempts to respond to this need.

The same ethical issue may be approached through any of these different ethical discussions. Informed consent, for example, may be a topic of discussion in a simple case presentation, a case-oriented issue approach, a

straightforward issue-oriented approach, or in a variety of policy discussions. But the type of approach taken also seems to influence the type of recommendation that results from the ethical deliberations. Each approach is useful, whether for the immediate resolution of a case, illustration of an issue, normative analysis of underlying ethical issues, or for policy recommendations. But variation in the breadth of focus on social factors influences the recommendations which are likely to result. I will now discuss what these recommendations have in common as a first step to unifying the social foci of the different types of discussions.

Social Change

Concrete ethical problems always occur in a social setting. That is to say that, in order for the problem to come to public attention, it must be observable. It is true that some ethical theories hold intentions or motives to be crucial in determining the ethical status of an act. But the illustrations, cases and issues discussed in medical ethics are subjects for discussion because they are observable. Attitudes and motives may be ascribed in order to provide an explanation for the behavior--whether as a reason or as an excuse. Nevertheless, the fact remains that concrete or "encountered" ethical problems are observable

actions or some statistical representation of them (in allocation discussions). Since they are raised as problems, the likely response will be a recommendation that is a means to change the situation. In other words, the encounter with an ethical problem is an encounter with concrete social circumstances. A recommendation that is based on a normative analysis will either endorse the particular circumstances or will make some suggestion as to how the situation should be changed.

It might be objected that this entire discussion is irrelevant to those who adopt an ethical theory which bases some or all of its ethical judgments on the moral agent's intentions. Kant's requirements that we always treat persons as ends and act out of a sense of duty would be an example of such a theory. Perhaps one of the most popular of such judgments, based on natural law deontology, are those based on the principle of double effect. This is a principle that is appealed to in such cases as a medical procedure required to save the life of a pregnant woman which will result in the fetus' death. The important detail which makes the principle of double effect applicable is that there are two conflicting moral claims: the mother's and the fetus' lives cannot both be saved. Ethical theories such as Catholic natural law considers any evaluation of one life as more important than the other to be unethical but recognizes that in such situations some decision must be

made. The principle of double effect may be appealed to in this case to justify operating on the mother even though it results in the fetus' death.

Munson (1983: 33) succinctly specifies the necessary conditions for an action to be morally permissible under the principle of double effect:

1. The action itself must be morally indifferent or morally good.
2. The bad effect must not be the means by which the good effect is achieved.
3. The motive must be the achievement of the good effect only.
4. The good effect must be at least equivalent in importance to the bad effect.

If the act is done with the intent of saving the mother and is not a direct act of killing the fetus or a case of using the death itself as the means to saving the mother's life, though it does in fact kill the fetus, the act may be morally justified on this principle.

Craniotomies are ruled out since they directly kill the fetus. The removal of a pregnant woman's cancerous uterus is permissible even though it does result in the death of the fetus.

While they differ from ethical theories which do not focus on intention, intention-oriented ethical theories help in similar ways. That is to say that they establish whether or not certain actions are moral and determine which actors are morally culpable or praiseworthy.

Recommendations for future behavior will rule out those procedures which violate the conditions of double effect and approve those which meet them. In this sense the recommendations which come from intention-oriented ethical theories do not differ in form from those which originate in other types of ethical theories. If the recommendation is addressed to individual moral agents, it will be an exhortation to use the principle of double effect in those cases where it is applicable to determine the ethically appropriate course of action. In this case it is personal behavior that is to be determined by this moral principle. If the recommendation is directed to policy considerations, it will give criteria for membership in a class of actions which will then be approved or disapproved. The procedure of removal of a pregnant woman's cancerous uterus, mentioned above, might be an approved policy, perhaps after approval by an ethics committee which will attempt to determine whether the four conditions mentioned above are met. Prohibitions such as the one against euthanasia in "The Ethical Directives for Catholic Hospitals" (Munson, 1979: 35-36; cf., Encyclopedia of Bioethics, Appendix, 1978: 1756-1757) would be an example of a forbidden procedure and

an official definition of what particular procedures are to be taken as members of that class:

The direct killing of any innocent person, even at his own request is always morally wrong. Any procedure whose sole immediate effect is the death of a human being is a direct killing Euthanasia ("mercy killing") in all its forms is forbidden The failure to supply the ordinary means of preserving life is equivalent to euthanasia.

It is important to notice that even these intention-oriented analyses make recommendations that certain acts are approved or forbidden. General recommendations will always take the form of specifying types of behavior morally condemned or accepted and criteria for membership in the relevant class. As such these recommendations take the same form as those which are based on ethical theories which place less or no emphasis on intention. While the normative analysis may make use of intention in determining what ethical behavior is, the ethical recommendations are expressed in terms of permissible and prohibited behaviors. Such behaviors are social in that they are observable and involve other persons. In fact the actions are usually approved or prohibited on the basis of the social relationship between the actors (e.g., the prohibition of direct killing is a prohibition against an action toward another person as well as against an intention or attitude). In this sense all

ethical recommendations are recommendations that direct social behavior, whether or not they suggest appropriate intentions or attitudes.

There is also a practical reason to prefer analyses which apply normative principles to actions rather than intentions. It is notoriously difficult, if not frequently impossible, for observers and doctors to have infallible, or even dependable, knowledge of motives and intentions. This may be due to the abstract concept of "intention" not having a psychological referent in many instances of intentional behavior (see Chapter II). But this analysis is designed to respond to publicly identifiable ethical problems, with recommendations whose effectiveness is measured by the elimination or reduction of (ethically condemned) behavior. If some persons act in ethically unobjectionable manners on motives which we might disapprove, that is a matter of character and virtue with which I am not here concerned.

Any recommendation based on ethical analysis will be either to change the situation analyzed or to maintain it. If the ethical analysis results in approval of the action, then either no change will be recommended, or change to encourage recurrence of the action. If the ethical analysis results in condemnation of the action, then the recommendation (if any) will be to change the situation to avoid recurrence of the action. Of course, based on the

limitations of certain forms of analysis as discussed earlier, some analyses may treat certain social features as unalterable. Such analyses may conclude of morally condemned actions that nothing can be done to avoid their recurrence. The analysis here defended (the social-normative analysis) is, in part, a response to this inadequacy.

The focus on ethical action to the exclusion of intention may be a result of this analysis' orientation. If someone acts in an ethically appropriate manner for motives which we might condemn (i.e., fear of punishment, disrespect, etc.) the ethical concern over the motive is not likely to arise. It is when the motive manifests itself in terms of unethical behavior, or when a disclosed attitude is judged to be likely to lead to unethical behavior, that the motive or attitude is criticized. Recommendations which promote ethical behavior, and prevent unethical behavior, are effective in so doing without considerations of the ethical status of actors' motives and attitudes. The change recommended may be either that individual actors consider certain details in determining their proper course of action or that certain moral policies be adhered to. In this sense, most recommendations based on ethical analysis will take the form of recommendations for social change.

Limiting the discussion to applied ethics, it is reasonable to assert that any recommendations will take the

form of social change. Social change is taken here to have a broad definition that includes the various levels of intervention that have been discussed in the first part of this section. To be more specific, whether recommendations take the form of exhortations to individuals that they modify their behavior, claims that professional groups or institutions should change their actions or policies, or suggestions and calls for legislative changes or a form of social revolution, they are all recommendations for social change.

Medical ethics discussions have often left the impression that policy discussions, though normative, are quite different from typical ethical or normative issues. For example, Ruth Macklin (1981: 513) claims that:

Policy issues are surely normative ones, but they may include political and economic, as well as moral considerations, arising out of vested interests or prior commitments.

Some political theorists have argued that political theory and political philosophy cannot operate without making normative assumptions or judgments (Jagger, 1983). It is far from clear that any recommendation based on a normative analysis is exempt from "vested interests or prior commitments" or that any argument for social or political change is complete or convincing without backing the normative elements with ethical argumentation. The

different levels of intervention all recommend social change. They are essentially recommendations which are made and implemented within social settings and so require the consideration of political and economic vested interests and "prior commitments."

Consider the issue of informed consent. A physician's resistance to the requirement that he or she fully inform a patient of the risks and alternatives might be based on concern that the patient might reject medically required treatment. Such a concern may be embodied in a moral argument to the effect that the responsibility of the physician is to take care of the patient's health needs (cf., Veatch, 1977: 305). Or perhaps the underlying worry is that the patient is not fully rational in rejecting or considering the information, since the background medical education is lacking (cf., Ingelfinger, 1972). But the physician's resistance might also be based on prior commitments to such values as health or to treating all similar medical cases similarly. Patient choice will possibly disrupt such consistent treatment or perhaps prevent the physician from treating some illness. In other words, a prior commitment to treating illness may be partly or fully the basis for the physician's doubt of the ethical or practical wisdom of informed consent (cf., Robinson, 1972: 789).

An example of the influence of political

commitment on ethical analysis and subsequent recommendations can be found in the use of "edge of the wedge" or "slippery slope" arguments in such issues as euthanasia or abortion. On such issues the argument claims that legislatures and those who implement policies on "killing" are incapable of making the kind of subtle distinctions that are required to keep the accepted moral policy from sliding "down the slope" to include killing those who are not the intended benefactors of the policy but for some reason are socially undesirable (cf., Kamisar, 1958; Ramsey 1978: 217, 225).

What sort of ethical recommendation might be exempt from such prior commitments or political or economic interest? A brief catalogue of the issues typically considered in biomedical ethics texts might be a good place to start. Ronald Munson (1983) has the following categories or titles in his table of contents:

- Abortion and Infanticide
- Treating or Terminating: The Problem of Birth Defects
- Euthanasia
- Paternalism, Truth Telling, and Confidentiality
- Medical Experimentation and Informed Consent
- Psychosurgery and Behavior Control
- Genetics: Control, Counselling and Research
- Competition and Allocation (for resources)
- The Claim to Health Care

Mappes and Zembaty's anthology adds the following to the list:

- Patients' Rights and Professionals' Obligations
- Health, Disease and Values
- Involuntary Civil Commitment
- Suicide and the Refusal of Lifesaving Treatment

Apart from the explicitly political topics (i.e., behavior control, involuntary civil commitment, competition and allocation of resources, the claim to health care, and patient rights and professional obligations) any of the issues are of the sort that can be discussed abstractly, apparently excluding vested interests and prior commitments of an economic and political nature. That is to say that these issues can be analyzed in the manners earlier described as issue oriented, case-study or a combination of the two. As observed earlier, such analyses also tend to produce recommendations that either establish the issue as an ethical issue, perhaps in the hope that practitioners will pay heed, or construct particular responses that the practitioner can use in similar cases without requiring changes in the medical setting or policies.

It is also obvious that such issues frequently involve discussions of social policy and practices, attempting to develop responses that are sensitive to the social contingencies and the variety of opinions on the values and appropriate means. So particular case studies on

informed consent or withholding information, in observing that the physician is the person with the information that the patient needs or is threatened by, recognizes a common social fact about physician-patient relationships: There is an asymmetry in knowledge which gives the physician a degree of authority and power over the patient (cf., Fisher, 1979, 1982, 1983; Todd, 1982; Friedson, 1970a).

Case-recommendations which are directed to intervening in concrete interactions focus on indicating how practitioners can change their behavior, or more generally, what general rules they should follow. Social change at "higher" levels of intervention, i.e., those that require changes in policies or institutions, are not considered in case-studies since they are simply not the focus of such analyses.

Perhaps the most comprehensive policy discussion, the President's Commission for the study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982: 115-164), discusses increasing public access to medical information, reviewing medical school selection criteria and curriculum, nursing practice and legal means.

The significant point here is that no matter the level of intervention to which a recommendation is directed, since the recommendation is for social change it can ignore the social factors, since they determine the recommendation's relevance and effectiveness. It is obvious that abstract normative ethical theory (i.e., metaethical

accounts of the good, theories of justice, etc.) can be constructed without reference to concrete social situations, finding instead that hypothetical examples can control for relevant similarities and avoiding troublesome dissimilarities. Once the concern shifts from abstract philosophical issues to the construction of effective recommendations, however, this theoretical distance cannot be maintained. The fact that an ethical problem is perceived reveals that the problem exists in a social setting, not merely as a private psychological event. If the normative analysis confirms that there is an ethical problem, then the recommendation will be directed to change the situation. Since the recommendation is an attempt to make a relevant social change, it must be sensitive to those ethically relevant social factors which will affect the normative analysis. Even this amount of social sensitivity is insufficient. The recommendation ought also take into account those social factors which will mitigate or enhance the effectiveness of the recommendation. Otherwise, unforeseen consequences are likely to follow the implementation of the recommendation which may create more problems than the recommendation resolved.

Recommendations aimed at affecting the most concrete or "micro" level often ignore those social factors that are not immediately relevant to the ethical analysis of implementation of the recommendation. To do this may

invalidate the accuracy of the analysis or the effectiveness of the recommendation. On the other hand, recommendations typically directed toward changing social structures, or creating new ones (e.g, Institutional Review Boards and Hospital Ethics Committees), neglect some of the more concrete social factors and result in ineffective recommendations.

Consider, for example, the ethical issue of informed consent. All the ethical discussions agree that there are circumstances that demand medical intervention without fulfilling the requirement of informed consent, such as an emergency with an unconscious unidentified patient or when the information itself presents an obvious threat to the life or mental health of the patient (cf., Robinson, 1972). Most ethicists reject the withholding of information by the physician for the reason that the patient, if fully informed, might reject what the physician perceives to be medically required treatment (Robinson, 1972; Capron, 1974; Zembaty, 1979) Once this normative analysis has been made, the resulting recommendation must be directed at some particular level or levels. Some analyses seem to leave the recommendations implicit, such as Veatch in his Case Studies in Medical Ethics (1977: 306-307). This analysis concludes that informed consent can be a problem in the most routine of cases. Some commentators suggest that the physician is reasonably assumed to be the expert on such social and

medical factors as the remote risks of major and minor effects that are not the therapeutic goal as well as possessing the knowledge and experience within which the proportion of risk can be assessed (Ingelfinger, 1972; Alfidi, 1975). Physicians may then be said to be the best judges of what ought to be disclosed to each particular patient. Extending this line of reasoning, Veatch suggests that only through compassionate and ethical physicians will patients get what is in their best interests (Veatch, 1981: Chapters 5 & 9). This suggests that the level of intervention is quite concrete, perhaps the education of physicians as to the ethical dimensions of such issues.

Other recommendations resulting from the normative analysis direct attention toward legislative and policy recommendations. An example of this type of recommendation would be the United States Department of Health, Education and Welfare's Institutional Guide to DHEW Policy on the Protection of Human Subjects (1971) which lists elements of informed consent to be included and a prohibition on exculpatory language. Judge Spotswood W. Robinson III's opinion in the Canterbury v. Spence case (Robinson, 1972) which sets out the previously noted exemptions to informed consent is also such a policy oriented recommendation. The effect of such recommendations may be to guide institutional ethics committees and hospitals in constructing forms for informed consent, as well as giving concrete guidelines to

practitioners who must present the information to patients and subjects and receive informed consent.

Yet both of these approaches, at least in isolation, have significant deficiencies. The lower level of intervention, that of educating and emphasizing to physicians that they have this responsibility, neglects the social fact recognized in the policy oriented recommendations: Physicians as a group have prior commitments that may color their view of when it is appropriate to withhold information for the patients' own good. In response to this factor, the policy recommendations spell out in more detail the sort of information to be disclosed and what reasons are legitimate to justify paternalism (when it is appropriate). But the policy recommendations must also depend on the physicians to make the judgments as to when the particular patient qualifies as one of the specified exceptions. Furthermore, the simple disclosure of the information on forms or verbally by practitioners does not guarantee comprehension by the patient. An inadequate policy response to this problem is to require review of forms and educational materials to assure that medical terminology is translated. There may also be a requirement that patients or subjects be given time away from the medical setting to consider their decision and to formulate questions. Nevertheless, the emotional and psychological burden of an ill patient may be

relevant in a particular case and such issues must inevitably be decided on a case by case basis. This is of course a strength of the lower level recommendations over the higher level or policy recommendations. The former emphasizes the individual practitioner's responsibility while the latter may seem to pre-empt professional autonomy and personal responsibility by stipulating the particular obligations. Clearly the best type of recommendation is one which sets out what the particular obligations are and the basic means that are to be employed but also encourages the practitioner to use considered judgments as to how best to achieve the designated ethical value. But even the ethical goals that the recommendation is meant to serve may depend on the social analysis. Some ethical discussions recognize this in the observation that ethical issues are dependent on the particular descriptions of action.

Consider the issue of moral agency or responsibility. In a case of a person accused of murder what must be determined is whether or not the person acted freely and intentionally to commit the crime. The prosecution might present the account that the accused had been harassed and threatened by the murdered person and had planned the murder ahead of time. The defense might agree that the defendant had been harassed and threatened by the victim but had acted out of fear and that the act was one of self-defense in that the defendant perceived herself to be

in danger. The prosecution's account encourages us to consider certain factors to be the defendant's motive while the defense claims that the same factors are morally relevant in a completely different sense; they excuse the defendant from her otherwise unacceptable behavior. The difference in the two claims has to do with the role that the particular factors played in the action being judged. In this manner certain factors that on one account play a role of excusing otherwise morally questionable actions (self-defense) may, on another account, be combined with other factors to establish moral culpability (premeditated murder).

The above account of the different roles that certain factors can play focuses on the psychological impact of harassment and threats on the accused. The "other factors" referred to in the above discussion are the crucial points to be established. In fact, what must be claimed by the defense is either that there are some morally acceptable cases in which threats and harassment relieve a person of the prohibition on killing, or at least that such conditions render the individual morally excusable since she is unable to act as a fully autonomous person in these circumstances. The first account is generally referred to as some form of a self-defense argument and the second as a "crime of passion" (or temporary insanity).

Such accounts of the circumstances surrounding a

morally questionable action are also relevant in more general discussions. The general form would be one which considers whether the social setting of particular moral concerns renders moral agents less autonomous (e.g., whether "captive populations" can give valid informed consent). In specific cases we consider the plausibility of the psychological account; whether or not the factors in the case affected the accused in the manner described. The ethical issue is whether the psychological effects of the social setting alter the person's moral responsibility. If the psychological account is accepted as plausible in the particular case, then it must be admitted that such an account has a more general applicability in all similar cases. Similar cases are those in which the relevant factors are present. But it is not clear whether what will be accepted (say by jurors) as the relevant factors are the psychological account (i.e., what one claims to have "felt") and/or a description of the social setting and in a manner that makes the action forgivable (i.e., that it would be understandable or forgivable in "these circumstances" to kill and not only that one felt threatened).

The ethical requirement, based on universalizability or some version of the principle of justice, is that we treat all moral agents with equal respect. It would be prejudicial to do otherwise. Consequently we must find morally relevant differences

between the judgment in those cases where a fully autonomous person kills another who poses no threat to the murderer or anyone else. *Ceteris paribus* we ought to treat all murderers similarly. Self-defense is the judgment that the killer acted on the reasonable belief that she was in danger of temporary insanity, or even of continuous or permanent insanity, and this is a recognition that the killer was incapable of exerting rational self-control. What counts as reasonable belief must be more than the testimony of the killer; the social context is relevant as evidence for or against such a claim.

In the murder accusation, the factors are the harassment and threats of the defendant from the deceased and particular observable or verifiable signs that the defendant's reactions to the victim's behavior are best explained by one theory rather than another (the prosecution's argument rather than the defense's). Acceptance of such an account in the particular case sets precedent for a similar line of argument in other (similar) cases. In other words, the account must be accepted as plausible in general. The normative claim in the particular case can be expressed in a universalized moral statement: In cases of harassment and threats resulting in the killing of the offensive person the killer may be excused of his or her actions if it can be established that the act was the only way to protect himself or herself from serious harm. Or

perhaps a less controversial form would be that the charge not be murder (i.e., reduce the charge to "manslaughter") if it is established that the killer acted irrationally out of passion due to the victim's threats and harassment. Legal issues of what is sufficient to establish the legitimacy of such claims in particular cases turn on the concept of "reasonable doubt" as determined by a jury. Ethical discussions, however, do not have recourse to such a procedural response. Rather we must attempt to specify what conditions would justify accepting this account of the action over one which would find the defendant fully, or somewhat, responsible for killing the victim.

Since the crucial consideration for moral discussions such as the one above is whether or not the killer is autonomous, any account which excuses the agent from normal moral obligations must explain how the actor's autonomy was either threatened or infringed upon in a manner sufficient to justify the act of killing. Ethical claims paralleling the "crimes of passion" legal excuse are that the killer's autonomy was restricted in such a way as to relieve the person of moral responsibility for the killing. So the entire discussion of when the killing is justified in the face of threats and harassment by the victim will turn on what are unacceptable amounts of infringement and restriction of autonomy. Descriptions of threats (infringement) and of non-autonomous acts of passion will

have to be accounts of observable behavior in order for the ethical judgments to be applicable. So while the ethical claims are based on judgments of particular instances of the psychological impact of certain behaviors on the killer's autonomy, the universalized ethical statement will, for practical purposes, need to be based on verifiable accounts of social behavior.

This is tantamount to claiming that ethical judgments are about classes of social behavior. Such a claim is clearly controversial. Surely it is true that a description of the behavior may meet the conditions we would typically accept as indicative of a loss of control without the killer's autonomy necessarily being impaired in such a way as to reduce the moral culpability. It is precisely such facts which give credibility to act utilitarianism. But does such an exception to the rule invalidate the rule? A more detailed account of what is entailed by the general ethical rule is in order.

Choosing only one of the above conditions, it may be claimed that a certain level of harassment and threats relieves the harassed and threatened individual of responsibility for the killing of the threatening and harassing person. The reason for the suspension of the usual attribution of responsibility is that the necessary condition for moral responsibility has been interfered with--the killer is rendered less or non-autonomous by the

killed person's threatening and harassing behavior (insanity plea). In other words, the conditions under which the killing has taken place render the killer incapable of engaging in the sort of moral deliberations one is morally obligated to engage in before acting in such a blatantly immoral fashion. Assuming that ought implies can, then one can only be held responsible for that which is within one's capabilities. The killer cannot be held responsible for failing to do that which was not possible. Of course there may be other reasons for punishing the killer, such as discouraging such acts in general or the symbolic value of promoting negative consequences for such behavior. It may also be claimed that the killer's autonomy was impaired, not incapacitated, so perhaps it would be appropriate to reduce the punishment but not to remove it. Universalizability, fairness or a principle of justice all seem to demand that similar cases be treated similarly. So we must, in all fairness, determine what details count as the morally relevant conditions which demand similar treatment.

Conceptually, the important fact is the impairment or reduction of autonomy. So in any case where there is a similar effect on autonomy we must treat the agent as we do in this case. But it is also likely to be true that different individuals can endure different levels of harassment and threats before their autonomy is affected. This in fact does seem morally relevant for each case. In

other words, holding constant the "level" of threats and harassment, we can imagine that there is a spectrum of personalities which will vary from those persons who are quick to anger to those who are rarely excitable or reactionary under such circumstances. A rule or policy which considers autonomy of persons to be impaired under specified levels of threats and harassment will not be sensitive to these various levels of tolerance for such behaviors. But a policy which is based on consideration of individual levels of tolerance will hold different persons to have varying levels of responsibility under similar circumstances. Clearly these different policies will differ in judging those cases where the killer is seen to have high levels of tolerance and thus to have been more autonomous in the act of killing. The issue then becomes one of whether it is fair to hold some persons more responsible than others in similar circumstances. This is , in a way, to penalize the tolerant individuals for being so tolerant by expecting more of them. Conversely, this policy would reward, or at least not hold responsible, those who are especially quick to anger for their nasty disposition.

If one accepts the more particularized version (that an individual is responsible according to his or her disposition and consequently the actual effects of the threats and harassment on autonomy is what is of moral significance), then other even more particular details also

seem important. The tolerant individual's level of tolerance may have been affected by such conditions as lack of sleep, other encounters with abusive persons, etc. The explosive person may also be unusually tolerant on the particular day due to surrounding circumstances. If what is of central moral concern is the actual effect of the threats and harassment on the individual's autonomy, it seems that such factors also play a significant role. In other words, even the most tolerant of persons have bad days when they are quick to anger. So the estimate of how autonomous the act of killing was would need to be based on an evaluation of the net effects of the threats and harassment on the particular individual's autonomy considering how generally tolerant of such things the person is and on whether there are any other circumstances that might alter this estimation of the person's autonomy. Provided that we accept that the focus is to be on how autonomous the person was in killing, these considerations do not seem to be unreasonable.

On the other hand we might adopt the moral policy that individuals should only be held responsible for fully autonomous acts in the absence of a certain level of threat and harassment. This might seem an easier policy to enforce and would not hold persons responsible for the particular level of tolerance that they have grown to have. It is at least highly plausible that varying levels of tolerance for different personalities are due to environmental or genetic

differences beyond the control of the individual. It may therefore be fair to hold this standard. But even this policy does not free us of all social-psychological considerations.

First of all we must determine that level of threats and harassment over which it is unreasonable to expect an individual to exercise full autonomy. Should this be a minimal or median standard? That is, should we hold all moral agents responsible only to that standard we can expect of the least tolerant or autonomous of us? Or should we hold the least tolerant responsible to a standard that most of us can live up to? (This issue will be discussed in connection with the reasonable person standard in the next section). Second, how do we determine whether or not the designated level of threat or harassment was present? Clearly this latter question is one which must be settled by a close examination of the circumstances in which the threats and harassment took place. What if the killer imagined them? They are then present as an impairment of the killer's autonomy so it seems that they are relevant to the determination of the level of moral culpability. At the other extreme it is possible that the threats and harassment were expressed by the victim but that the killer did not hear or understand them. Such a situation can hardly be construed as an impairment of the killer's autonomy. If the expression is non-verbal then their presence is still more

difficult to ascertain and their effect masked. Yet all of these examples have one thing in common: They show that there is no impairment of autonomy if the killer did not comprehend the threats and harassment. Certainly it seems to beg the question if we simply assume that the killer heard them since he or she did kill the victim. But how do we tell that the killer acted in response to the threats and harassment? Far from settling any of the ethical issues involved in this issue, this discussion has demonstrated that there are complex psychological and sociological questions involved in setting the ethical policy and in applying it to particular cases. If such confusion can arise in the enforcement of a reasonably simple ethical prohibition, it may be even more difficult to determine the ethical ends and appropriate means of bringing them about in the socially complex realm of medical ethics. Having recognized the need for social analysis to guide recommendations for social change, I now turn to a particular illustration. Informed consent is one such policy that presents a complex of ethical and social dilemmas.

Informed Consent

Informed consent is fundamentally an attempt to respect the autonomy of patients in the process of medical

treatment or research. It is basically a requirement that patients or subjects be given the opportunity to consent to (or dissent from) treatment based on relevant information. Patients are autonomous agents whose choices must be honored. Capron lists six functions of informed consent (Capron, 1974: 364-376):

- a. To Promote Individual Autonomy.
- b. To Protect the Patient-Subject's Status as a Human Being.
- c. To Avoid Fraud and Duress.
- d. To Encourage Self-Scrutiny by the Physician-Investigator.
- e. To Foster Rational Decisionmaking.
- f. To Involve the Public [in Promoting Autonomy as a General Social Value and in Controlling Biomedical Research].

Notice that none of these is, strictly speaking, a medical goal. The requirement of informed consent of patients or subjects is a restriction of medical practice. It is a requirement that medical practitioners have patients' agreement prior to its execution. And the consent must be "informed." That is to say that it must be based on information that gives the patient a basis for rational decision. In this manner, individual autonomy is promoted. Unless there are strong reasons against it, there is a presumption in favor of patients having control over what happens to their bodies and lives.

Requiring that patients and subjects of research be told about procedures and give consent prior to treatment

is also a means of protecting them. Research with little or questionable therapeutic benefit is not obviously in the subjects' interests so it is only with their knowledgeable consent that their participation can ethically be accepted. This is due to the fact that they are put at some degree of risk in the procedures and so their protection is best served by their being informed of such risks. It is also possible that certain researchers or physicians may act unethically and treat patients/subjects in a manner that is clearly not in their interests. Informed consent is one means of making such an occurrence less likely. By protecting patients' autonomy in the decision regarding participation, their "status as a human being" is protected. Thus it is expected that attempts at fraud or duress, or any similar unintended effects, will be less influential in the presence of informed patients and subjects. This too is achieved primarily through maintenance of patients' autonomy.

Capron's last three functions are more abstract or general. If the medical profession is expected to present information to patients and subjects, it is reasonable to expect that the professional will take care not to be embarrassed by its less scrupulous or thorough members. This "self-scrutiny" is to promote reflective rather than non-reflective habitual practice. In this sense it promotes physicians' increased autonomy. If patients are to consent

from an informed basis, rather than from a simple trust in the profession or their physician, then it is also expected that both practitioners and patients/subjects will give a significant role in the decisions to the relevant factors. This ought to promote decisions that are as rational as possible based on the available information (Capron's "e"). If such information did not play a significant role, it would be more likely that decisions to treat or do research would be based on less rational grounds such as hunches, whims and desperation. Finally, it is expected that informed consent will involve the public in promoting autonomy in general and in controlling biomedical research. At the very least this function is thought to be accomplished through patients/subjects as members of the public, becoming more autonomous in their medical care and in the selection of the sort of research and risks for which they will agree to be subjects. So these six of Capron's functions of informed consent reduce to various means of promoting autonomy, both that of patients and physicians.

Before discussing the form that informed consent must take to begin to fulfill this function, there are limitations that are important to recognize. "Therapeutic privilege" is the ethical justification given for withholding certain information from patients. This is not valid in the case of research subjects because the reason that is given for treating without consent is always

"therapeutic." It is said to be in the patient's best interest to withhold the information. "Presumed consent" is when it is in the patient's interests to proceed without consent rather than to wait for consent. This action is usually justified in cases of emergency treatment of unconscious patients. When time is not so limited, "proxy consent" allows a responsible person to consent in behalf of unconscious or clearly incompetent patients. Beauchamp and Childress suggest that the paternalistic act of withholding information is justifiable in the case where the medical practitioner considers the information to be harmful to the patient (Beauchamp and Childress, 1979: 74). Judge Spotswood W. Robinson III, in his opinion in Canterbury v. Spence, expresses this concern:

The second exception obtains when risk-disclosure poses such a threat of detriment to the patient as to become unfeasible or contraindicated from a medical point of view. . . . The critical inquiry is whether the physician responded to a sound medical judgment that communication of the risk information would present a threat to the patient's well-being. (Robinson, 1972: 789)

In other words, it is permissible to withhold information from a patient when, on the basis of a sound medical judgment, the information itself constitutes a serious risk to the patient's life or health. The most crucial, and ambiguous, terms in this doctrine are "sound medical judgment" and "risk" (i.e., there will be a range of

information which might be construed as imposing a risk to a patient who is critically ill on the account that maintaining a "will to live" is crucial to recovery and any significantly bad news may adversely affect this desire).

If this is an act of justified paternalism, then it ought to stand up to the general requirements for acts of justified paternalism. Jane Zembaty argues persuasively that paternalism is justified in those cases where the end result is a greater promotion of autonomy than if the non-paternalistic action(s) was taken (Zembaty, 1986). This is in keeping with John Stuart Mill's argument that one ought not be allowed to sell oneself into slavery for the reason that the loss of autonomy is permanent while the prohibition on the particular action is only a temporary infringement on autonomy. But Mill also argues that in other cases a person's physical or moral good is insufficient grounds for the suspension of the value of autonomy (Mill, 1962: 135). Zembaty's and Mill's discussions indicate that the justification of withholding information from a patient must be based on the long-term promotion of autonomy, not the promotion of the patient's health. In other words, since the paternalistic actions are prohibited on the grounds that they violate the person's autonomy, it seems that they may be justified in those cases where they actually promote the person's long-term autonomy more than the non-paternalistic options. Nielsen (forthcoming) has

supported a similar position. He (unlike Zembaty) does not accept paternalism as justified if the person is currently autonomous, rejecting on empirical grounds the ability to objectively predict the effect of information on another's autonomy. For Nielsen, paternalism is only justified in those cases where the person is incompetent, where incompetent is defined as not being able to make rational decisions (if such is a case of paternalistic action at all). While Zembaty has attempted to make room for at least a minimal acceptance of paternalism in medical practice, Nielsen carefully circumscribes such practices to those cases where the patient is clearly not capable of exercising autonomy.

The treatment of those incapable of giving informed consent is usually given a different justification from that of paternalism. This is because of a wide acceptance of a definition of paternalism along the line of Dworkin's:

[Paternalism is] the interference with a person's liberty of action justified by reasons referring exclusively to the welfare, good, happiness, needs, interests, or values of the person being coerced. (Dworkin, 1972: 65).

Mappes and Zembaty, following Feinberg's discussion (Feinberg, 1973: 7, Chapter 2), consider coercion to include

only intentional use of threat and of harm, so they redefine paternalism:

Paternalism is the interference with a person's autonomy justified by reasons referring exclusively to the welfare, good, happiness, needs, interests, or values of the person being constrained. (Mappes and Zembaty, 1981: 12)

But such a definition excludes the possibility of paternalism in the case of those who are not autonomous (cf., Culver and Gert, 1982: 130; Beauchamp and McCullough, 1984: 84). That is to say that one must be autonomous in order for one's autonomy to be interfered with. If one is unconscious, irrational or under some severe form of constraint, one's actions are not autonomous. In the case of not informing a patient who is not autonomous it could not be said that the medical practitioner is being paternalistic, since the patient's autonomy is not present to be infringed upon. In such cases it is preferable to get informed proxy consent (Nielsen, forthcoming; Robinson, 1972). And in emergencies, other ethically relevant concerns such as promoting the patient's welfare and health are generally seen to take precedence over getting substituted consent or waiting for the patient to become competent.

The exceptions to informed consent are typically justified either on the grounds that the patient is not currently competent and therefore there is a long term promotion of autonomy, or that the patient's immediate need

for medical treatment outweighs the value of delaying treatment for the patient to return to competency or for professionals to find a proxy. Since the latter emergency exception to paternalism and informed consent typically saves a person's life or at least promotes a quality of life by preserving certain physiological functions (e.g., cardiopulmonary resuscitation may prevent brain damage; immediate treatment may avoid loss of limb, etc.), it may be reasonably claimed that this action also promotes long term autonomy. So the doctrine of informed consent, and the exceptions to it, are directed toward preserving and promoting patients' and subjects' autonomy. This may reasonably be referred to as the main goal of informed consent.

Why is it that patients' and subjects' autonomy needs to receive such protection? Konold (1978) has pointed out that ancient medical codes and prayers tended to be paternalistic in nature. He indicates that even the most historically persistent of these codes, the Oath of Hippocrates, counsels the physician to refuse certain patient requests and to judge what confidences to keep (Konold, 1978: 164). More recently, the "Nuremberg Code of Ethics in Medical Research" was developed to govern medical research and to provide ethical and legal standards to judge the Nazi practice of human experimentation (U.S. Defense Department. Nuremberg Code, Trials of War Criminals Before

the Nuremberg Military Tribunals, 1974). In 1964 the World Medical Association adopted the "Declaration of Helsinki" to guide physicians involved in biomedical research on human subjects (World Medical Association, 1975). These international concerns about the ethics of research centered around the issues of voluntariness and information to be provided the subjects. These concerns have been echoed in efforts by professions and governmental bodies within numerous countries, including the U.S. (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1978) and Canada (Medical Research Council of Canada, 1978). In addition to the avoidance of such atrocities as occurred in the Nazi experiments, these efforts are a recognition that medical research has a goal different from the typical therapeutic goal that characterizes the relationship between medical practitioner and patient. The fact that the research is aimed at the production of medical knowledge which may benefit future patients may seem to justify the particular subject bearing certain risks. But this decision cannot be made for the subject. Even the inherent paternalism in most therapeutic relationships cannot justify the medical researcher acting in behalf of a subject, since not therapeutic benefit but the gain in knowledge and potential benefit to future patients would be the basis of the decision to participate.

This documentation of responses to the perceived

problem of informed consent in research on human subjects points to the obvious conflict that may arise in research, where the goal is not unambiguously the patient's health. Since the research goal is seen to provide a conflict of interest sufficient to require informed consent, it may provide a model for understanding the same requirement in therapeutic treatments. It may be that establishing the ethical issue will help to clarify the reason why the issue has received so much public attention. This may need to be supplemented with a description of the changes in general "societal" perceptions, which will follow the ethical discussion.

Judge Robinson has already been quoted in conjunction with legitimate limitations on the doctrine of informed consent. But Robinson also rejects a particular justification for the withholding of information:

The physician's privilege to withhold information for therapeutic reasons must be carefully circumscribed, however, for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity for even the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself. (1972: 789).

This legal statement represents quite well the ethical concerns expressed in the doctrine of informed consent. The

autonomy of the patient is seen to be a principal concern in the therapeutic relationship, as in any other relationship.

The fact that the physician has information that is material to the decision as to how to treat a patient becomes important in that the patient needs the information to make a rational decision. The presumption includes the patient's agency; it is expected that the patient is ideally the one deciding to accept or reject specific treatment options, under the guidance of the physician's knowledge and recommendation (cf., U.S. President's Commission Report, 1982: 36-39 on joint decisionmaking is critical of this presumption).

This ethical description is noticeably at odds with the picture of the doctor-patient relationship depicted in the early codes such as the Oath of Hippocrates, where the physician is encouraged to decide what is in the patient's interests and keep within the profession knowledge pertinent to such decisions. But the shift of context for informed consent from the rather obviously relevant area of research into the therapeutic relationship is also due to social perceptions which have brought this issue to public attention.

The shift in attitude toward physicians has been noted by many authors writing on informed consent. Mappes and Zembaty (1986: 48) claim that the shift is from an assumption that physicians were best placed to act in

patients' best interests to one which assumes that patients should be actively involved in these decisions. They list three factors responsible for this change. First, the physician-patient relationship has become more impersonal as the practice of medicine becomes more technological and specialized. Secondly, the increase of illness due to the medical treatments that the profession has used (iatrogenic illness) has led some to question the "activist" orientation of many physicians. Third, physicians are increasingly gaining a reputation of being of a particular socio-economic class, with implied educational biases, and thus are suspected of having significant value differences from a large proportion of patients.

Robert Veatch, in the introduction to his well known article, "Models for Medicine in a Revolutionary Age," indicates that ethical issues in health care are gaining in publicity partly due to the growing acceptance of a "right to health care" (Veatch, 1972: 5). Medicine has only recently been able to make significant differences in people's health and the concept of justice is being extended to physical and mental well-being (Veatch, 1972: 5; World Health Organization, 1958). This is lending credence to the right to health care and thus to the impetus behind increased patient participation in health care decisions at both the level of informed consent and allocation of resources. Barber argues that in this age of "citizen and

civil rights," medical research and treatment has become a sort of social problem. He indicates that what is considered a social problem is variable since it is defined as "a social condition that a sizable group comes to define as both bad and improvable or removable" (Barber, 1980: 2).

Pellegrino and Thomasma, in considering the philosophy behind medical practice, recognize that societal deference to technology and those educated in it has resulted in a loss of control of the "values and purposes of that technology." (Pellegrino and Thomasma, 1981: 255). They also observe that a particular patient's illness may result in a loss of the "ability to speak about his values." (Pellegrino and Thomasma, 1981: 254). They continue:

Especially in tertiary care settings, we have observed that the values of the patient in decisions decline and the values of the institution or the health care team rush to fill that vacuum. (Pellegrino and Thomasma, 1981: 254)

While Pellegrino and Thomasma emphasize patients' illness as the source of this loss of autonomous voice in health care decisions, there are sociologists of medicine who argue that it is the institutionalization of health care and the cultural authority of the physician which together account for this loss. Though we will return to these discussions later, it is relevant in this context to point out that such social analyses have been based on historical

accounts (Stevens, 1971; Starr, 1982; Conrad and Kern, 1981; Freidson, 1970b), as well as on empirical research into current medical practice (Fisher, 1979, 1982, 1983, 1986; Ehrenreich and Ehrenreich, 1970; Waitzkin and Stoekle, 1976; West, 1980, 1982).

Whatever weight is given to these explanations, the social climate has supported a concern for patient participation in medical research and therapy. One of the chief outlets for this concern is the issue of informed consent. Informed consent is an ethical issue in its own right as has been shown by the earlier discussion of autonomy and paternalism in the withholding of medical information. What has yet to be discussed is what the precise goal of a doctrine of informed consent should be and how such a goal could be accomplished in the complex social context that makes up the delivery of health care.

Capron's six functions of informed consent have already been discussed. But a relevant distinction can be drawn between function and purpose or goal. A medical treatment may be given for a purpose or to achieve a particular therapeutic goal and yet may have other effects, desirable or not, that it may be said to "function" to bring about. Thus one of the functions of certain radiation therapies in the treatment of cancer has been the increased incidence of certain iatrogenic osteosarcomas. Or a codeine prescription for the relief of pain may also function to aid

in relieving (or creating) gastro-intestinal problems. In an analogous manner, informed consent is meant to be a means of preserving patient autonomy by requiring informed participation of patients in health care decisions. But it may also serve to increase a general respect for autonomy and rational decisions. Or it may function to increase public input into research. But these are not necessarily or obviously the best means to accomplish these ends; they are simply unintended though not undesirable results.

The goal of a doctrine and practice of informed consent is the promotion of patient autonomy in the receipt and delivery of health care. But what state of affairs is to be promoted as an expression of such an abstract goal? It seems that many discussions of standards of disclosure, comprehension, whether consent must be written or oral, and other procedural issues all differ on the point of what is to be achieved by informed consent. Indeed, Veatch seems to recognize this in his discussion of standards of disclosure. He argues that the acceptance of a "medical community of practice" is based on the principle of benefitting the patient (Veatch, 1977: 305). This is because the decisive factor then becomes whether the physician thinks the information would benefit the patient. He cites the court ruling in Berkey v. Anderson as supporting the conception of the physician-patient relationship on the model of other similar fiduciary relationships and thus

supportive of the "reasonable person" standard of disclosure (cf., pages 11-13). This would emphasize the goal of allowing patients access to information in order that they may make their own decision, rather than so they can be informed as to what they are consenting to. Beauchamp and Childress (1979: 73-74) suggest that such a goal might be better served by an "individual patient standard" where the particular patient's concerns and beliefs are taken into consideration to determine if any additional information not required by the reasonable person standard ought to be provided in this case.

In arguing for a standard of disclosure that includes purposes of research, as well as risks and options, Ramsey (1970: 24) has suggested that the patient/subject becomes a "joint adventurer in the common enterprise of human medical progress" (cf., U.S. President's Commission Report, 1982: 36-39 on joint decisionmaking). This is a recognition that medical research cannot progress without the participation of human subjects nor of medical researchers. Thus both groups play indispensable roles in the advancement of medical science through research on human subjects. But since it is the subjects of research that bear the risks on their persons, it is reasonable that they share with the researcher in possessing such information as is relevant to the types and probabilities of risk. Ingelfinger argues that informed consent of such a type

practically requires that the patient receive not only pertinent information but also a medical education that allows for proper interpretation of the information imparted (Ingelfinger, 1972). He concludes that the requirement of informed consent in experimental therapy only serves to notify patients that part of their treatment is an experiment. He continues:

Beyond this accomplishment, however, the process of obtaining "informed consent," with all its regulations and conditions, is no more than elaborate ritual, a device that, when the subject is uneducated and uncomprehending, confers no more than a semblance of propriety on human experimentation. The subject's only real protection, the public as well as the medical profession must recognize, depends on the conscience and compassion of the investigator and his peers. (Ingelfinger, 1972: 466)

It is not clear what particular level of education that Ingelfinger thinks patients or subjects would need to have in order for the practice of informed consent to be more than an "elaborate ritual." But it does seem clear that Ramsey and Ingelfinger have drastically different pictures of what can reasonably be expected from a practical application of the doctrine of informed consent.

Veatch has rejected the "collegial model" of physician-patient relationship on the basis of its unrealistic estimate of the similarities between physicians and patients as social classes (Veatch, 1972: 7). He suggests a "more provisional model" which he characterizes

as a contractual relationship where patient and physician work toward a common goal; patient health. This seems to be a middle ground between Ramsey and Ingelfinger, insisting on patient participation but admitting that physician understanding and comprehension may remain more extensive.

Each normative analyst criticizes the current practice of consent and, using ethical principles, suggests an altered practice. But their rejection or expectation of "collegiality" or of "joint adventurer" or of a "contractual relationship" and other descriptive accounts are based on some practical estimate of what is realistic. Some, such as Ramsey, may be more optimistic about the educability of subjects, or may consider the practical constraints inconsequential in the face of the ethical arguments. To see how a social analysis might unify or critique these diverse approaches, it is helpful to describe the social circumstances which ethical analysts might be trying to achieve.

All of these descriptions of the problematic state of affairs and the improved picture that is to be brought about by informed consent are quite vague. It seems that at least three different goals or "social pictures" may be defended.

A) The first starts with a critique of the current situation as problematic because patients tend to agree to procedures whose details, effects and options are not well

known to them. This is ethically problematic because most patients are autonomous agents who ought to make decisions based on rational grounds. The lack of relevant information and the rationality of the consent is therefore questionable. Such consent may partly be based on trust in the medical professional. But this trust is problematic in two ways. First, it is an unreasonable burden to place on the medical practitioner and is irresponsible of the patient. Second, such an attitude allows value differences between patients and physicians to go unnoticed even though they may affect decisions. The goal of an applied doctrine of informed consent is to alter this state of affairs so that patients' consents are based on relevant information, their physicians' advice and their own values. The crucial change is that the patients become aware of exactly what is being consented to and the implications of such a treatment. The patient will then be given the opportunity to agree with the physician's advice from an informed basis, rather than such agreement being based simply on a trust which may be rather naive (note that the standard of disclosure--reasons and risks of treatment--serves as the rationale for physician choice of medical options). (Cf., the U.S. President's Commission Report, 1982: 50, for a discussion regarding the fact that some apparent trust may be due to patients' failure to know or believe that they have the prima facie right to self-determination.)

The practical recommendation which follows from this analysis and goal is the provision of information and time for deliberation to the patient. Agreement, either verbal or written, to the procedure would basically be an indication that the patient has received the information and agreed to the treatment. The change is that where the patient formerly trusted the medical practitioner to deliver health care productive of patients' best interests, now the patient is to be educated as to the reasons for the physician's choice and consent on that basis.

A criticism of this analysis and response is that it produces informed consent only in that patients are now given a better understanding of proposed treatments and the reasons for them but are not really given more control or choices. Such consent is based on the receipt of information by the patient and the patient's trust of the physician to perform in a manner productive of the patient's best medical interests. But the requirement of informed consent is based on the ethical importance of autonomy. As such the emphasis is on the patient's self-determination. In order to fulfill such an ethical goal it is not enough that the patient's consent be based simply on an understanding of the reasons and implications of the procedure recommended by the physician. The moral doctrine of informed consent is an attempt to assure that the patient

has chosen the procedure over other options, not that the patient has chosen the physician and his or her choices.

B) So a second goal, to be distinguished from the first which aims at serving patients' best interests, is one which attempts to change the social picture so that patients' interests are served. The difference between these two goals is the shift of emphasis from preserving the authority of the medical professional to determine what is in the patient's best interests, to one which treats such determination as a judgment of interests which only patients are ethically qualified to make. So any recommendation must determine what social change will either guarantee or increase the likelihood of this occurring and by what means the change can be brought about.

The distinction between these first two goals have been made in such discussions as have been referred to above (Veatch, 1977: 305; Robinson, 1972: 789; Ingelfinger, 1972). Authors such as Ingelfinger do not suggest that the social picture as it currently stands needs to change much, perhaps because the patients' medical interests are still served. So while he criticizes the unrealistic hopes of others as to what informed consent can achieve, he does not argue for any new or different measures. Robinson, on the other hand, suggests that physicians are legally bound to provide patients with information and opportunity to decide for themselves among options, rather than that they simply be

informed as to the reasons for, and implications of, the recommended treatment. Veatch, a much more prolific writer and offering an analysis of the situation that is perhaps more sophisticated, is more difficult to tie down to one position. Through what appears to be exhortations to physicians and patients, Veatch seems to encourage a change in attitude which is to "permit equality in the realm of moral significance between physician and patient without making the utopian assumption of collegiality." (Veatch, 1972: 7). In his discussion of Berkey v. Anderson and Natanson v. Kline, Veatch also seems to agree that informed consent is to promote the goal of patient choice rather than patient's best interest (Veatch, 1977: 306). But neither of these discussions make concrete recommendations that both courts and physicians, and perhaps ethics committees, use the reasonable person standard of disclosure, rather than that of the practice in the community.

C) The third possible goal or desired social picture treats the ethical issue of informed consent as "a tip of the iceberg." Informed consent as an ethical issue points to the existence of a larger problem in health care practice, the difference in power between physician and patient. Power can mean many different things, but in this analysis it indicates the reduction of patients' ability to choose for themselves. All commentators admit that physicians possess the skill and knowledge which patients

need when ill. The problem of informed consent arises because patients may be treated without the respect for their autonomy that is their ethical "right." Initially this was seen as problematic because patients' interests were not always served, as in research and experimental treatments. The first goal of protecting patients' best interests were not always served, as in research and experimental treatments. The first goal of protecting patients' best interests addresses this concern. More recently, the concern has spread to allow patients the right to refuse treatment that physicians recommended, granting the patients the right to determine what is in their best interests. This is a better defined and more rigorous normative analysis of patient autonomy. But the social analysis of the delivery of health care has raised the question as to whether such a goal is realistic. Veatch considers the "assumption of collegiality" to be "utopian." Further recognition of this fact is implicit in Robinson's denial of therapeutic privilege for the good of the patient (in the physician's opinion), and in Ramsey's ethical goal of making subjects "joint adventurers" in medical research (Ramsey, 1970: 24).

The third goal of informed consent differs from the second on the basis more of social analysis than of normative analysis. Both positions maintain that the ethical goal is to place patients firmly in control of

determining what is in their best interests. Achieving this goal in the delivery of health care will require more than setting disclosure standards and informed consent procedures. The third goal differs in its targeted social picture by recognizing with Veatch that the current social situation in the delivery of health care is one which makes the assumption of collegiality, which grants physician and patient equal moral voice, terribly unrealistic. But rather than give up such a social picture altogether, the third goal is precisely to actualize this picture. Informed consent is then seen as part of a program whose goal is to alter the social circumstances of the delivery of health care in such a way as to promote patients' increased autonomy. In order to begin such an ambitious task it is important to understand and identify those factors in the delivery of health care which are involved in the suppression of patient autonomy. Informed consent is an excellent place to start since it too is aimed at the promotion of patient autonomy. But the typical practice of informed consent, while based on the normative concern for patient autonomy, is clearly too limited an approach for accomplishing even the second goal; that of allowing patients to determine their own interests rather than expecting physicians to do so for them (cf., U.S. President's Commission report, 1982: 46. The Commission's survey found that 72% of the public wanted to share

decisions with physicians while 88% of the physicians surveyed believed patients wanted physicians to choose for them.).

The encouragement of patient autonomy through the doctrine of informed consent is a very abstract, or not obviously applicable, ethical maxim. In attempting to break this concept into smaller more manageable and applicable ones, the issues of standards of disclosure, competency, undue influence, rationality and comprehension become the focus. As has been argued, such concepts, especially if they are to play important roles in practical recommendations, are difficult to define and controversial in their application. But even if such concepts were agreed upon and their import determined for the concept of autonomy in the context of informed consent, any recommendations resulting from the normative analysis would need to utilize some socially determinable markers to employ the suggested parameters. Thus some form of social analysis is necessary in any applicable determination of moral responsibility and criticism of current situations. Consequently this discussion will now turn to consider what form this social analysis needs to take and how the ethical analysis relates to the social analysis.

For the purpose of determining a relevant framework for social analysis, I now turn to the work of discourse analysts, especially Sue Fisher and Jeff Coulter,

to construct a framework for social analysis. Fisher's work is based on a layered analysis which analyzes medical interactions and distinguishes levels of social analysis with constraining social factors. Coulter's work continues the argument that a sociological-contextual approach (like Fisher's) is superior to the psychological-intentional models.

CHAPTER II

Social Analysis: A Method

The task of this chapter is to describe and defend a framework for social analysis. In order to be helpful, the social analysis needs to provide a basis for understanding the genesis of the concrete actions to which normative analysis applies. It must supply both the details relevant for normative ethical analysis and the details relevant for the social construction of effective recommendations. Furthermore, the assumptions upon which the social analysis is built must be at least reasonable, and preferably the most reasonable of all the alternatives. This chapter will describe a form of social analysis, called discourse analysis. The discussion will then turn to the assumptions on which this analytic framework is based.

Social analysis has traditionally had a variety of foci, any of which would be fruitful to explore. In finding a place to start, I choose to begin with the fact of meaningful communication. It seems an undeniable fact that social activities and communication occur. Starting with this fact, we can ask how participants in the social world successfully perform these activities. One approach to this task is represented by reality reconstruction. Generally, the emphasis in this approach is to get an "insider's view"

of the particular social activity, which may be any observable behavior. This qualitative approach proceeds by observation and interview, perhaps aided by a familiarity with traditional sociological concepts and what has been written about the activity being studied. What is studied or observed is the significance that interactions and acts have for the participant (cf., Blumer, 1969: 4-5). Herbert Blumer called this approach "symbolic interactionism" because it focuses on whether participants see something as real, as evidenced in their interactions, rather than on whether what they treat as real is accurate or "true" (Blumer, 1969: 4-5). The reliance on sociological traditions and literature need not cause a bias; it is a means of avoiding random observations with the likelihood of personal bias. The analytic concepts gleaned from this background understanding are to be taken as "sensitizing concepts" which may be revised in the field as they are reinforced or contradicted by observation (cf., Glaser and Strauss, 1967).

The focus is on the interaction of persons in order to find the significance of the whole event or of particular elements. Secondly, the use of background understanding is to suggest what to look for, but is not taken as a pre-established "rule." Both data-based and theoretical sociology provide conceptualizations as to how the social world is "cut up" and how it "works." These conceptualizations may be treated by a symbolic

interactionist as sensitizing concepts. The traditional focus on demographic information is a good example of this. One might suppose on the basis of common knowledge, theorizing and perhaps some studies, that female patients would respond differently than male patients. Rather than setting out to prove this as a hypothesis, one could begin to observe and record interactions to see if such is the case. If we were to find a pattern that is generally supportive of the generalization but had exceptions, it might then be interesting to look more closely at the exceptions to see what they have in common. Perhaps an alternative, or complementary, analytic element might provide further clarification of the pattern of action. For example, Bernstein and Kane (1981) found that differences in labelling was correlated with patients' sex and expressiveness. While non-expressive women were more likely to be diagnosed as having a psychosomatic disorder, expressive men and women were about equally probable to be so labelled. Note that an exception is only visible against a background of a general rule. So the general rule may not be falsified as much as shown to be an incomplete depiction of how "things usually go." It is not that patients' sex was found to be irrelevant, but rather that the action is more complicated than the broader rule can depict. In the example, if women are generally less expressive than men in medical interactions then the general rule holds that women

as a class are more frequently diagnosed as psychosomatic. The latter general rule, though failing to explain as well as the two-factor correlation, nevertheless may accurately describe a pattern, directing attention to a possible problem (sexism in medical practice) and the manner in which it occurs.

Sociology and the "Mundane"

Sociologists who study everyday activities focus on the mundane rather than the extraordinary (Schwartz and Jacobs, 1979: 235). This focus on everyday activities, such as giving and obeying commands or maintaining a personal space in a public place (Goffman, 1963: 3-32), is an innovation in both sociology and philosophy. Both disciplines have longstanding rationalist traditions for which theoretical concerns set the boundaries of the discussions. While common knowledge of the world has played a role in both disciplines, the focus of most discussions has been on theoretically interesting issues such as reconciling mind and body dualism or identifying social norms and their effects on groups of people in society. Neither tradition gave much insight into how different individuals were able to get along in spite of such large scale "problems." For the "person in the street," neither the mind-body problem nor the influence of social norms ever

entered into practical considerations which might be used as examples by the theorists. My hand just does rise when I so choose and a desire to marry and have children in a stable social and economic situation seems to be a personal desire, not an external social norm. The theoretical issues seem to disappear when the focus of analysis is how these everyday activities are possible. Nevertheless, this "micro"-analysis requires further theoretical work on what explanations best account for the actions.

Ironically, the focus on everyday activities and how they are "accomplished," or successssfully executed, yields two problems. Descriptions of what must be postulated to underlie these activities in order to explain how they are accomplished must account for many of the implicit beliefs and shared social activities common to the actors. These elements of the everyday activities of people may not be recognizable as constitutive of their actions by any one but social scientists. So to make the claim that these beliefs and activities were second nature to the participants, it is important to describe them in a manner that might at least be recognizable and verifiable by anyone who participates in those activities, though their role vis-a-vis the activities might not be recognized by the participants.

The second problem that arises out of the focus on detailed description of how the mundane activities of

everyday life are carried out is that the role of these social features described as underlying the activities, making them practically possible, is likely to be considered trivial to the participants. Discussions of the accuracy or the influence of the social factors postulated as underlying their practices would seem incredible to the participants. If asked why she used a certain behavior (i.e., avoiding eye contact, terse responses, backing away) to keep her personal space, the observed woman might well wonder what the interviewer was talking about; at least she might simply assert that it is just what she does in some cases without thinking about it; or she might explain why the other interactant made her uncomfortable. If a history lecturer were asked if he believed that the world existed during the period of history he was lecturing on, he would likely think we were joking or taunting him. The focus and detail needed to carry out the research required to understand these mundane activities leads us to describe much of the context or "beliefs" which are even more trivial than the interaction studied, from the participants' point of view. The description of these elements are quite possibly not recognizable by the actors without considerable explanation as to what we are trying to portray.

Schwartz and Jacobs (1979: 214) describe such participants' knowledge, or Garfinkel's "social facts" as:

1. Features of the society that members knew, discovered, used and (above all) talked about in the context of daily activity.
2. Features of the society which were "accomplished" by practical reasoning in everyday life.

These "social facts" are what members use to perform and rationally account for their everyday activities. Commonly understood features of the social order are rarely made explicit, since they form the basis of rational explanation and action. Activities and explanations or accounts are based on such implicitly and explicitly acknowledged features. That is what makes the activities intelligible and reasonable. This common sense of social structures forms the basis of all social activity. These "social facts" are real in that they have social consequences. Awareness of them allows members to use practical reasoning in successfully performing their everyday activities. Shared knowledge of them makes members' actions reasonable to other members and is the basis of cooperative action and conversation. One of the central questions for ethnomethodologists is, "What is the relationship between social structure and practical reasoning in everyday life?" (Schwartz and Jacobs, 1979: 214).

The relation between implicitly understood practices and practical, everyday communicative actions, is an important issue for ethnomethodologists. Theoretical sociologists and social-political philosophers have created a wide range of social theories, norms and descriptions of social structures to account for the functioning of societies and groups within them. Qualitative sociologists, phenomenologists, existentialists and some Wittgensteinian philosophers are more interested in how particular people live their everyday existence. The element of truth in the theoretical approaches is that there do seem to be certain shared social forms which are expressed, and direct the activities of people (though not deterministically). The generalizations that accurately depict patterns of everyday activity express social facts which shape our actions and communication in a manner that can be described in this general form. The founder of "cognitive sociology," Aaron Cicourel (1973) is concerned with an empirically-based understanding of how these methods are acquired by individuals and then used to create the world within which practical activities are manageable. Practitioners of Cicourcel's cognitive sociology, together with those of linguistics and sociolinguistics, have made various attempts to specify what is necessary to account for how it is that we come to have such complex abilities (cf., Chomsky, 1966; Lyons, 1970).

Other sociologists have started with the fact that we have the ability to carry out social activities and conversations and then they set out to describe how particular events are accomplished. Conversational analysts such as Harvey Sacks and Emmanuel Schegloff concentrate on elements within the conversation itself to explain the outcome or the joint participation of the actors in producing a common understanding of the situation. They consider such elements as the patterned occurrence of utterances and they attempt to construct the rules which describe them (Schegloff, 1968; Sacks, Schegloff and Jefferson, 1974; Schegloff and Sacks, 1974). Frankel (1983: 45), another conversational analyst, describes the practical value of making explicit such elements of the interaction in medical settings:

The value of an interpretive view in medicine is that it radically transforms the nature of the physician's participation in the health care encounter from an objective, dispassionate giver of advice to an interactional partner who actively participates in the social construction of illness, its treatment and outcome.

The description of the function of certain rules of conversation shows that the physician plays a role in shaping the conception of illness, treatment and prognosis which becomes the topic and outcome of the encounter. The focus is not specifically linguistic. Rather, the analysis of the interview is an examination of how the outcome and

conception of illness and treatment is not something stipulated but created between the participants. This is a functional view of the use of language and the role of the participants, although language and meaning are not the focus of the analysis.

Discourse analysts extend this focus on the structural and constitutive elements of everyday activities to examine an entire language event, discovering that the conversation is not entirely produced by elements found within the conversation. Rather, as members of a culture, participants bring with them a collection of values, beliefs and accepted practices. Through these "social facts", and in the context of the conversation, a conceptualization of appropriate outcomes and means is formed by the participants. More specifically, discourse analysts have argued that such an event is constrained specifically by the "institutional order" within which it is located. The mundane activity of medical treatment includes as part of its structural and constitutive elements shared knowledge of the institution of medicine; i.e., how patients and physicians must act in order to facilitate treatment. The practical reasoning displayed in such interactions reveal interactants' understanding of the "expected" or "proper" structure of the discourse. Such "structuring" also facilitates the achievement of institutional goals. For example, the discourse in classroom lessons (Mehan, 1979)

and in medical interviews (Fisher, 1979, 1982, 1983; Fisher and Todd, 1983) are found to be arranged to facilitate the accomplishment of institutional goals.

Shared knowledge of the need and method to accomplish concrete tasks within social or institutional settings is the locus of the relation between more abstract norms and rules and concrete action. Such a connection is precisely where discourse analysts argue institutional roles and authority come into play in the shaping of discourse and subsequent concepts and outcomes.

The discourse analysts' awareness of institutional goals and authority is part of their professional familiarity with the relevant literature. But postulation of the presence and influence of such abstract concepts depend for support on their power to explain the concrete action of each interaction, and the common patterns across interactions within particular institutional settings. Thus the analysis of social action can be seen as having different layers or levels of concreteness or abstractness with respect to the analytic concepts.

Levels of Analysis

Some discourse analysts have analyzed interactions as being constrained by and reflecting elements of the social world which are shared either between the two

participants or by a wider social group. The discussion of such an approach follows. My framework is heavily dependent upon the work of Sue Fisher (1979, 1982, 1983, 1986; cf., Knorr-Cetina and Cicourel, 1981).

Fisher(1983: 140-141) suggests that an "ethnography of speaking" (Hymes, 1962) ought to record and analyze naturally occurring talk, "displaying it as socially produced." This places the interaction in a perspicuously described context which provides the grounds for its understanding as well as for seeing its function. Such sociolinguistic studies have been done as complete studies of language use (cf., Labov, 1972; Schutz, 1973, Shuy, 1983). Labov and Fanshel (1977) found that therapeutic discourse, as distinct from everyday conversation, displayed an asymmetry in the discourse, which influenced the exchange of information between the actors. Fisher further indicates the similarity between the asymmetry that Labov and Fanshel discuss and the "competence gap" discussed by the social critics Waitzkin and Waterman (1974). The latter claim that this asymmetry is the result of socioeconomic factors which cause the participants to enter the medical interview with different needs and resources. Eliot Freidson (1970a, 1970b) has also noted this asymmetry, explaining it in terms of an imbalance of knowledge between professional and client. Fisher refers to Shuy (1983) as demonstrating that the difference between normal conversations and medical

interviews affect the patients' participation and understanding of the information and interview. Cicourel (1973, 1975), among others, has also claimed that the method of information exchange affects how the information is understood. These apparently competing analyses of the interactional asymmetry may be arranged into a complementary framework.

Beginning with her earlier work (1979), and carried through her later analyses, Fisher suggests that there are at least three levels of analysis which can be distinguished. As we shall see, there are the interactional, organizational and structural levels of analysis. It is important to understand that none of these levels of analysis is "experienced" or found as different types of social factors in the social world. Rather, they are of varying degrees of generality; some may be unique to one or a few particular interactions, others may be common to most interactions of a certain type due to their being placed in a particular setting (i.e., medical), and still other factors may be common to an entire society or a sector.

This type of approach may be a means to bridge what some have called the "micro-macro" gap in sociology (Habermas, 1970, Cicourel, 1975; Mehan and Wood, 1975; Fisher, 1982; Fisher and Todd, 1983: 11-12). At the "macro" end of the spectrum are social theorists who construct

theories of societies and how groups within them function, examining such things as social norms and deviant behavior (e.g., Marx, 1964; Parsons, 1951; Waitzkin and Waterman, 1974; Krause, 1977; Conrad and Kern, 1981). Within medical sociology, recommendations are large scale, such as Waitzkin and Waterman's (1974) claim that injustices in the delivery of health care can be addressed only by reconsidering the capitalist structure of the medical system and the society (cf., Navarro, 1973). This roughly corresponds to Fisher's structural level of analysis. At the other end of the spectrum are interactionists who set out to increase our understanding of the everyday practice of medicine; how the medical interviews occur and are understood by the participants (e.g., Davis, 1963; Roth, 1963; Millman, 1977; Bosk, 1981). More specifically, they are concerned to produce a description of how the participants, say Davis' (1963) disabled patients, produce a definition of the situation and self (in the example, definitions that deny or reject the disabilities). An extension of this type of work includes that of Garfinkel and Cicourel who encouraged empirical study of how individuals within interactions contribute to an understanding of the action for both participants (Garfinkel, 1967) or how language is used to "create and sustain the social world" (Cicourel, 1973). These analyses roughly correspond to Fisher's interactional level of analysis.

Situated between these two ends of the spectrum are sociologists such as Freidson (1970a, 1970b, 1973), Goffman, (1961), Mehan (1979), and Bellah (1970). Discussions at this level of analysis, called the "organizational" level by Fisher, consider how the organization of particular professions or settings influence the interactions. For example, Eliot Freidson (1970a) describes the rise of the medical profession's autonomy in terms of the influence of funding agencies, social and legal action and educational requirements (cf., Stevens, 1971; Starr, 1982). As a consequence of this organizational development of the profession of medicine, and in particular its autonomy, the practice of medicine is shaped in a particular manner. The specialized medical knowledge that the professional possesses, and of which the patient is in need, sets up an asymmetry. Other professional choices also influence the physicians' behavior toward patients. If the setting is a fee-for-service practice, the interaction is more likely to be client-oriented than in a group practice, where the setting is colleague-centered (Freidson, 1970a).

Fisher labels her three levels of analysis "interactional," "organizational" and "structural" (1979, 1982, 1983; Fisher and Todd, 1983: 3-13). She emphasizes that the analysis is not that there are disparate levels of influences, but that the different levels of analysis must be seen to reflexively support one another in a manner that

is indistinguishable in the interactions. Together they comprise the social facts of which the interactants are either tacitly aware or to which they have access (see discussion on page 101). A complete analysis of paradigmatic cases which illustrate a pattern common to medical practice (in general or, more commonly, in particular types of settings) will describe this reflexive relationship between interactional, organizational and structural levels of analysis. The relationship is reflexive in that the interactions are both constrained by and reflect or recreate the organizational and structural factors. This is, as it were, a two-way street, where structural and organizational factors guide, but do not determine in a strict sense, how the interactions proceed; what purposes they serve and what treatment outcomes are likely. But since these social factors enter the interaction through the shared social world of the interactants, they are not external constraints as much as tacitly understood shared beliefs, or better, practices. As such, these factors are recreated in each interaction by the participants, serving as a hermeneutic context which enables the actors to engage in functional communicational activity. They are shared methodological beliefs and activities which are learned common patterns of behavior.

Sociologists like Fisher are concerned with understanding communicative action within particular

settings and how the setting differs from other activities such as natural conversation in less institutionalized contexts. The non-deterministic reflexive relationship among:

1. concrete actions, including recurring patterns across different interactions (interactional level of analysis);

2. factors described as unique to particular professions or settings (organizational level of analysis); and

3. factors described as common to the society (structural level of analysis), provides us with a model within which a comprehensive analysis is possible.

It may be that we are not likely to be capable of identifying or classifying all the factors, though in the social analysis that Fisher suggests, it may be that we can identify the more important ones.

Consider briefly how such an analysis would apply to medical interactions. The interactions observed and recorded may be characterized at the interactional level in terms of the recurring patterns of communication, including control of topic, number of interruptions, contribution to outcomes, etc.. Paradigm cases may be chosen as illustrations of the patterns, though no one element of the pattern is intended to be construed as a necessary or universal factor. Some analysts, at this level of analysis,

have found that the health-care provider shapes the patient's conceptualization of illness and its treatment (Frankel, 1983: 45). Paget (1983) has argued that practitioners emphasize and de-emphasize patients' fears and conceptualizations through subtle interactional nuances. Attempting to understand why the professional has a preferential role in defining and clarifying even non-medical concepts leads us to the organizational level of analysis. The unquestioning acceptance of the physician's authority is common to both physicians' and patients' life experiences. Though there is evidence of this acceptance of professional authority in the interaction, it is construed as an organizational factor because it is a general feature of the organization of medical practice and the profession (cf., Fisher, 1979, 1982; Fisher and Todd, 1983; Fisher and Groce, forthcoming). Throughout her work, Fisher argues that the institutional authority of the doctor structures the discourse, shapes the flow of the information and influences the process of medical decision-making. Not only do the professional and institutional affiliations of professionals vest them with authority, but since practitioner and patient share a common social world, the view of the practitioner-patient relationship is shared. Consequently patients are, in these instances where persuasion is required, often easily persuaded that their best interests are served by the physician's

recommendations. The emphasis on institutionally situated events allows for the consideration of such non-local factors on the production of meaningful discourse and agreement on outcomes.

The institutionalization of medical practice did not occur in a vacuum. In fact the practice of medicine for profit and its network of ties with other profit-oriented organizations such as pharmaceutical companies, establishes conflicts of interest with patients' best interest. Knowledge of this is also common to both patients and physicians, yet rarely does a suspicion of profit as a motive find expression in a medical interaction. Conspicuous in its absence from the content of the discourse, such a well known structural factor is a taken-for-granted feature of the context of medical (and other) practices. Perhaps there is also an assumption that professionals' good intentions are a sufficient check on this factor (see discussion of profit-motive on pages 94 ff). The dispensing of drug samples and the typical use of brand names rather than the generic ones are cues that point to the influence of pharmaceutical companies on medical practice. These are analyzed as structural factors because drug samples and prescription by brand name reflect a monopolistic, profit-seeking enterprise which is common to a society as a political and economic entity. Though finding unique expression in medical interactions,

structural factors could be expected to show up in any interaction within that society. Once again, it is appropriate to refer to this as a "level of analysis" because it is an attempt to describe the social factors which serve to "ground" the communication and its meaning for the participants. The profit motive is not an element of the interaction, but rather explains why practices or actions in the interaction occur as they do.

Consider the example of the influence of pharmaceutical companies' profit motive on the prescription of a drug to a particular patient. In the interaction, we may find a physician prescribing by brand-name a drug which she believes will help the patient. Presumably the patient will take the prescription and have it filled. Both patient and physician find this activity intelligible and consistent with their mutually perceived goals of efficiently treating the patient's ailment. The patient within the context of physician-patient encounters, does not typically question why he needs the physician's authorization to purchase a needed drug. Both are familiar with the social arrangement of prescribing controlled substances, and this seems to help make the entire activity intelligible. They also share a conception of the physician's ability to competently diagnose and prescribe. This also helps to make the exchange intelligible. Pointing out these institutional arrangements would likely seem trivial to the patient and

physician. Conversely, the patient may not fully accept the legitimacy of this arrangement; but, since he has no recourse outside of the system, nevertheless considers the observation moot.

This description of the institutional context makes explicit some of the tacit understanding which enables physician and patient to engage in intelligible and efficient communication. It describes the institutional conventions on which the communication depends for its intelligibility. As a social analysis of the institutionally-located interaction, these details help account for the actors' ability to accomplish the apparent goals of the exchange, as well as for why it was accomplished in this manner rather than in another manner (e.g., the physician could suggest that patient buy a drug, but does not give a prescription, or suggests the drug by a chemical or generic name). Such details having been made explicit, two questions guide further analysis. First, a social and empirical issue, is whether this particular institutional arrangement currently exists (in the example, whether and how much influence pharmaceutical companies have on medical practice). This leads us into further social and historical exploration. Note, however, that the "reasons" or social factors which shape institutional contexts (e.g., profit, efficiency, distribution of labor) may be quite different from the goals which actors within the institution

are pursuing (i.e., health in general or particular health needs). The second issue arises from this social analysis of the *raison d'etre* of the institution (i.e., the delivery of health care) in comparison to particular goals of physicians and patients within it (e.g., inexpensive treatment, conservation of time). The issue is whether the social factors which shape the institutional context of medical practice have a neutral, complementary or antagonistic effect on the achievement of the particular actors' goals. This question directs further social analysis to the examination of social factors which may shape the context of the interaction in a manner that is antagonistic or complementary to the goals of the physician and patient. Furthermore, the context so evolved may also set physician and patient at cross purposes, though there is still the common institutional goal of patient health. This might be manifested by a patient's desire to receive inexpensive and effective medical care, which a generic prescription might most efficiently accomplish, and a physician's desire to treat efficiently and safely, combined with an incomplete knowledge of the drugs which are alternatives for the brand-name drug. The explicit discussion of these details sets the stage for the analysis

of normative issues (i.e., informed consent, deception, etc.).

The profit motive of pharmaceutical companies can reasonably be said to stimulate a considerable amount of advertising and educative activities. Since it is physicians, not patients, who prescribe drugs, they are included in the companies' target population. The goal of these activities, including seminars, informal "education" and dispensing free samples, is quite clearly to influence general prescribing practices. The larger companies dispensing brand-name drugs, engage in the most aggressive research and advertising endeavours. Practicing physicians who have severely limited time to read about new pharmaceutical advances, will of course find it easiest to depend on those drugs with which they are most familiar and have had experience. In this manner, the profit motive of pharmaceutical companies results in promotional activity which shapes the prescribing habits of physicians. The institutional context, as has been discussed, sets the stage for physicians to prescribe as they see fit and for patients to comply without considering those institutional constraints on the options.

This influence on the context which constrains and socially legitimates the interaction is antagonistic to the patient's interest. Patients could reasonably be assumed to want the least expensive of identical treatments.

Brand-name prescribing does not allow for this. A patient might also benefit from some difference in drugs which has not been made a sales point of a brand-name drug. Having grown dependent on this source of information, a physician may be unaware or inadequately informed of such a therapeutic advantage. Thus the indirect influence of the pharmaceutical companies on particular therapeutic interactions may actually be antagonistic to patients' interests.

Methodological Assumptions

The assumptions which form the basis for this analysis may be controversial. The idea that understanding communication must be done by means of a contextual-sociological process rather than an intentional-psychological one is widely debated. It is not my purpose to enter into this debate here, but rather to briefly indicate the philosophical bases for my approach. The role of intentions in ethics has a long history; but, as was discussed in Chapter I (pages 38-48), it presents us with considerable difficulties. Though seldom discussed, there is good reason for a shift toward a social basis for understanding ethics, primarily due to the increased explanatory power and sensitivity vis-a-vis understanding communication and social behavior. This was argued (in

Chapter I) to be relevant to both the analyses and recommendations of applied ethics. The crucial assumptions of this analysis are as follows:

1. Communication and social action can best be analyzed by specifying the actors' intersubjective understanding of the context of the action (rather than analyzing intentions, motives, beliefs etc. on an intentional-psychological model).

2. The effectiveness of such an analysis is due to the fact that the performance of everyday activities is based on common practices and tacit presuppositions (not on cognitive structures or systems of rules, or even responses to interactional stimuli).

3. These common practices and beliefs "structure" discourse and action (in a non-necessary, non-determinative predispositional manner).

4. From a sample of similar interactions we can deduce the "structuring" elements, buttressing our observations with literature review, information about the setting, and the testimony of the interactants (rather than searching for conscious or unconscious beliefs).

5. Some of these structuring elements serve to promote class or institutional goals, in some instances directing discourse or action contrary to one or more actor's desires or interests (rather than such social

factors being influential only when they are known by the actors).

I will discuss the philosophical bases for these assumptions, drawing heavily from Jeff Coulter's book, The Social Construction of Mind (1979, esp. Chapter Two).

Alternative Accounts of Human Behavior

There has been considerable effort devoted to finding referents for mental ascriptions such as intention, motive, and thought or for the processes of intending, remembering, understanding, thinking, etc. Mentalists, including contemporary cognitivists, assume that there must be such mental states or processes which can be typified and provide insight into human behavior. Behaviorists have assumed that such efforts are in vain due to the "privacy" or introspective nature of any access to such phenomena. They have focused on operational definitions of such ascriptions. The analysis of intentional action, remembering, knowing, etc. is then to be based on observable patterns of behavior which justify these ascriptions. Conceptual analysts have tried to describe the logical grammar of mental concepts. This too has led to a priori theorizing, resulting in general concepts, which are frequently inapplicable to some mundane contexts of use. It is this de-contextualized characterizations of the

"psychological phenomena", shared by these theorists, which Wittgensteinian analysts have rejected.

As Wittgenstein endeavored to illustrate, philosophical problems result when we consider mental predicates out of their context of everyday use. Rather than looking for conceptual or referential "common ground" of mental predicates, we are advised to observe their non-problematic usage in mundane contexts and search for how interactants make sense of them in context. This, as Coulter (1979: 36, 37) indicates, lays a foundation for a social-organizational approach, rather than a psychological-mentalistic one.

Consider Coulter's discussion of the analysis of the mental predicate "understanding." Some cognitive psychologists have characterized understanding as a mental "click of comprehension" (Coulter, 1979; R. Brown, 1968; Bransford and McCarrell, 1974). Ryle (1973: 163) has criticized this account. He indicates that this is rarely the case phenomenologically, and is defeated as a legitimate claim should the claimant fail to provide evidence of comprehension. There are public criteria for the claim to understand which are supplied by the context of use. Each context provides such practically "sufficient" criteria "and no experiential or mental process can in itself fully constitute understanding nor count as a determinate criterion" (Coulter, 1979: 38). And, as Coulter indicates,

Wittgenstein takes a similar approach; "but for us it is the circumstances under which he had such an experience that justify him in saying in such a case that he understands" (Wittgenstein, 1958: paragraph 155).

What is rejected by this account, and what behaviorists and cognitivists have in common, is the attempt to fix a referent for "understanding" in general, independent of any context of use. As Coulter (1979: 39) explains:

The criteria for understanding, for having understood, cannot be private, inner mental or experiential states or processes, but must be scenic.

Coulter goes on to explain what he means by insisting that the criteria for understanding must be "scenic." Most practical contexts do not allow or require the continual checking and rechecking for fulfillment of the criteria for understanding. Rather, social interactions typically occur in such a manner that the context and flow of communication or action provides practically "sufficient" grounds for the assumption or questioning of actors' understanding. Decontextualized or abstract discussions of understanding (or any other mental predicates) omit this context-specific element. The resulting esoteric notion of understanding bears little resemblance to the particular contextual uses of the term. For any mental-state

description, there are likely to be contexts where fulfillment of the abstract conditions for "understanding" (if they can be formulated at all), will be rejected by participants in the context as insufficient or irrelevant. And any generalized behavioral description of "understanding" will meet the same fate. It is only through a detailed examination of a particular context of use that the relevant practical criteria for understanding can be formulated. And there is no a priori reason to assume these contextual criteria to be generalizable to other contexts or to be characteristic of any "essence" of understanding.

Fodor and Katz (1971) have criticized such Wittgensteinian approaches to language and meaning (cf., Coulter, 1979: 46). They claim that the Wittgensteinian focus on context-specific elucidations of meaning cannot account for novel utterances. The rejection of semantic structures or generative rules, claim Fodor and Katz, makes it impossible to account for the construction and understanding of never-before-encountered sentences. In order to account for these, they claim that it is necessary to posit recursive encoding and decoding rules which operate unconsciously. So any account of an actor's novel utterance, and its being understood by another, must have reference to shared unconscious rules according to which the utterance is constructed by one actor and understood by the other.

Hunter (1973: Chapter Seven) responds to this line of criticism by indicating the oddness of the abstract question, "How do we produce and understand new utterances?," which is the basis of the Fodor-Katz critique and their project (cf., Coulter, 1979: 47). Either the question lacks a context for its reasonable understanding, or, in any particular context where it might be asked, it is misleading.

The question of how we creatively communicate in general has the form of a request for instruction for communicating creatively. But Fodor and Katz are not seeking instruction, they are seeking a scientific explanation. Their analysis is based on the assumption that we are capable of such communication. They must be asking for some account of our ability to communicate creatively. The question can then be rephrased to read "how do we construct utterances that express [creatively] what we have to say?" (Coulter, 1979: 47). Since they are positing a generative system of rules, Fodor and Katz must argue for actors' possession of tacit knowledge of a propositional sort. Another alternative is Ryle's "knowing-how," a tacit non-propositional sort of practical knowledge. What basis is there to prefer one alternative over another?

Coulter (1979: 48) suggests that the only evidence for the Fodor-Katz account is that speakers can do what the Fodor-Katz account explains. But the tacit and

inarticulatable nature of this propositional knowledge is suspect. As Michael Polanyi's work has made clear, tacit knowledge of how to perform tasks is very familiar to us as the non-propositional and inexpressible awareness which is possessed by people who are able to perform the practical tasks. Coulter draws on Polanyi (1958: Chapter Four) earlier in his book to illustrate just this point:

it is clear that many people know how to ride bicycles without in the least having formulable, propositional knowledge of the geometric and ergonomic alignments involved. Expressed as a principle, a cyclist must keep his balance by adjusting the curvature of his forward path in proportion to the ratio of his unbalance over the square of his speed. Clearly, knowledge of this propositional form is not available to most people who manage to keep their balance very well, just as detailed knowledge of syntactical principles is unavailable to speakers of English whose speech can nonetheless be found to accord with them. (Coulter, 1979: 21)

There is no reason to attribute unconscious propositional knowledge to account for such abilities. At least, the only reason could be that there is no other way to account for such abilities. That is not the case, as I will now endeavor to show.

Context-Bound, Sociological Analysis of Presupposition-Ascription

The alternative to unconscious propositional knowledge and semantic structures is the tacit knowledge of

"how to." Intersubjective familiarity with the context of concrete communication enables actors to understand and communicate. It is shared conventions, knowledge of the "how to" variety, which guides the communication in particular contexts. It is not a common set of propositional rules, but a shared practical understanding of the context, which enables actors to act and communicate meaningfully. The ascription of presuppositions which describe this understanding of the context makes intelligible how actors are able to perform and communicate, even creatively. The ascribed presuppositions make explicit the contextual factors which limit possible interpretations of the novel communication. Nevertheless, these presupposition-ascriptions are neither determinative nor infeasible.

Alfred Schutz (1973) maintained that any social activity is founded on a "presupposed stock of common knowledge." Everyday conversation frequently draws on context and presupposition to understand, clarify and communicate. Pointing out that the store is closed to someone who has just said "Let's go to the store." draws on the presupposition that the speaker would only want to go to the store if it were open. On the other hand, if the speaker were the owner of the store, the fact that it was closed could be irrelevant, and would not arise as a part of the conversation. Context, including location, identity of

actors, current topic or activity, time or day, tone of voice, bodily positioning, etc., furnishes "common sense warrants" (Coulter, 1979: 51) for our ascribing certain presuppositions to the speaker. Of course, if their role is to make evident the meaning of the utterance, the contextual elements are unlikely to become part of the conversation. As Wittgenstein's rules of a game, they are typically discussed only when one fails to act in the conventionally expected manner. In learning to speak, we learn how to attend to the conventions of the relevant culture and language. Tolerances for different degrees of adherence to these conventions are also learned. Sociologists such as Labov (1972) have noted this fact with respect to phonetic and grammatical "rules." Conversational and discourse analysts note these tolerances, explained by the former in terms of the role of the speaker in the interaction (cf., Frankel, 1983) and by the latter in terms of shared presuppositions of social rules and conventions which may be analyzed as a feature of the setting (eg., medical or educational settings; cf., Mehan, 1979; Fisher, 1979, 1982, 1983, 1986).

Coulter (1979: 53) brings Ryle back into this discussion to illustrate the common-sense priority sometimes given to "assignable propositions:"

Ryle's (1973: 173-177) remarks on what he terms "disclosure by unstudied talk" are pertinent here;

we do not usually think of a person's (or his utterances') presuppositions as continually and consciously self-monitored, [sic] and so tend to think of them as less subject to deceptive manipulation than the contents of avowals, and thence as more likely to reveal his real states of mind.

Coulter (1979: 54) continues to explain that our way of discovering what another "has in mind" is to be found in common conventions or practices, not in the form of propositional knowledge. The "properly sociological focus upon the psychological and subjective phenomena must consist in the technical specification" of such methods. But analysts must also be careful not to posit these socially-organized methods as rules or structures somehow located in the mind (Coulter, 1979: 61). The "attending to" such features of communication constitutes tacit "knowing how" and is no more known by actors than competent cyclists know the mechanical description of their forward motion and maintenance of balance.

For example, our linguistic activities can be characterized in terms of a sequence of turn-taking, where one utterance is expected to be tied to the previous. This provides a constraint on the ascription of presupposition. If the conversation was not interrupted by a request for clarification (i.e., if it "went smoothly"), then any presupposition-ascription must make the sequencing practically reasonable. That speakers are aware of this is evident from the use of conventions by them to mark an

utterance which might be confusing because it does not follow the usual sequencing. Schegloff and Sacks (1974) call these "misplacement markers" (e.g., "by the way", "incidentally"). Of these, Schegloff and Sacks claim that the "display of such orientation and recognition apparently entitles the user to place an item outside its proper place" (Schegloff and Sacks, 1974: 258).

Coulter (1979: 54) suggests that members' presupposition-ascription of other members are defeasible in that they may be contested or falsified. This is not, however, an obstacle on which communication falters, since the context of any particular communicational activity typically provides enough clarification for the members to understand one another. But the use of these methods, however "technically specified" are similarly context-bound and defeasible. It is for this reason that the analysis of particular communicational events needs to include a description of the setting of the communication and as accurate as possible a reproduction of the communication. Review of this ethnographic and interactional data by other analysts ought to lend credence to or challenge, the analytic claims (i.e., presupposition-ascriptions) of the analyst. (See Chapter III for illustration.)

Organizational and Structural Direction of Communication

Fisher (1979, 1982, 1983, 1986) has found it useful to distinguish levels of analysis (see pages 85-98). The presupposition-ascriptions which can be made on the basis of physician-patient communication do more than display the micro-processes of this communication. Certain activities and their ascribed presuppositions are typical, though perhaps not universal, of communicational events of a particular sort in a specified setting. In Chapter III, the communicational events examined are those of first-contact female patients with third-year residents in one particular family practice setting. As Coulter has carefully argued, the analysis by presupposition-ascription does not assert that the interactants hold these presuppositions to be true or have even consciously entertained them in the past. Rather, the conventional practices which constitute, for example, physician-patient interactions are learned as methods of achieving practical goals; and communication can be analyzed in terms of the presuppositions which make more intelligible or rational the action or communication. Historical-sociological reflection and research may lead to further understanding of why these presuppositions shaped the conventions, as well as increasing credibility of the analysis by supporting the claim that the presuppositions have been, and are, influential.

This analysis is still sociological, not psychological. It is of the context or culture that ascriptions are made, not of the minds of individuals. The analysis of mental-ascriptions in Coulter's work is scenic in that it describes a context which enables concrete individuals to intend, understand, remember, etc.. The psychological question "How do individuals intend, understand, remember, etc.?" can only be answered in this manner. To look for a psychological or mental process is to construe actors' knowledge of "how to" as requiring individualistic explanation. Thus it assumes the need for some mental machinery or unconscious set of propositional rules. As has been argued, this is neither necessary nor justified.

Since presupposition-ascriptions are made of conventions, practices and settings, they can be classified in terms of the scope of the practice or contexts to which they can reasonably and consistently be ascribed. Some practices, such as turn-taking or sequencing, seem relevant to all conversational events. Social communication which is not conversational, such as lectures and sermons, obviously does not share the convention of turn-taking. Some practices may be unique to a context, or, if they occur in various contexts, their organization in a particular setting may be unique. An example of the first would be certain diagnostic and treatment procedures: they are likely to

occur only within a particular medical setting, and thus some of the presupposition-ascriptions which explain how the procedures are "accomplished" are relevant only to those settings. This would be an example of Fisher's organizational level of analysis, as would the presupposition-ascriptions which distinguish casual conversation from conversation in a physician-patient interview.

There are also presupposition-ascriptions which are either ascribable to types of contexts (perhaps due to similarities in the activities practiced in each), or which are so common or "basic" that it is a strained analysis to consider them as interactional or organizational. Deference to professional authority on the assumption of superior knowledge is an example of such a structural factor or presupposition-ascription. Fisher (among others), building from an interactional analysis of physician-patient communication, notes that participation is imbalanced, with the asymmetry in terms of control of floor, topic, number of interruptions, etc., distinguishing the conversation in physician-patient interactions in general from that of casual conversation. An organizational feature or presupposition of the context is that the physician is the expert and needs such control to effectively diagnose and treat the patient. Other contextual features or presuppositions also help to explain this particular social

organization of the interview (e.g., that physicians need to be efficient and unencumbered by the usual conventions of conversation in order to fulfill the heavy demands on their time). The acceptance of this asymmetry is not, however, unique to physician-patient interactions. It extends to other professional-client relationships (e.g. lawyer-client, teacher-student). It may also be detected in less institutionalized communication such as parent-child or "experienced advisor-inexperienced listener" conversation. Such a breadth of convention requires extra-organizational presupposition-ascriptions in order to reasonably account for the commonality of the activity.

Howard Waitzkin (1983: 142) suggests that physicians' "relative dominance", as manifested by their special privilege in the physician-patient interaction and ascribed as an organizational feature of the context, allows them to "make ideologic statements." Waitzkin continues:

These messages reinforce the hegemonic ideology that emanates from other institutions--the family, educational system, mass media, and so forth--and that pervade a society. The same messages tend to direct clients' behavior into safe, acceptable, and non-disruptive channels; this is the essence of social control in medicine. (Waitzkin, 1983: 142-143; My emphasis--M.B.)

Although this excerpt is from a chapter in which Waitzkin engages in a "micro-analysis" of physician-patient communication of the type that I have been

discussing, I do not know whether he would agree with the present discussion. His political focus, however, is helpful in identifying structural presuppositions. "Emanating from other institutions" and "pervading a society" are "messages" which shape behavior. On the present analysis, these "messages" are the presupposition-ascriptions which analysts may make of a society and its institutions. Physicians are the professionals in medical institutions, and are allowed the dominant role in medical interactions. Their role in medical activities match broader cultural conventions of how to accomplish concrete tasks in the context of authority found in institutionally situated interactions (e.g., between physician-patient, professor-student, lawyer-client and parent-child). It is true that this presupposition of authority "manifests" itself in, or can be ascribed to, observed physician-patient relationships. But to treat it as an isolated interactional or even organizational factor is inadequate, since those aspects of the communication which justify the presupposition-ascription also occur in other institutions. As Waitzkin claims, such a widespread pattern of activity across organizational or institutional settings must be ascribed of the society rather than uniquely to the organization of medical practice. The presupposition, if it is scenic in the sense of applying to a context of action, applies to all contexts with

authoritative agents whose authority has been more or less institutionalized (i.e., has gained wide cultural acceptance).

This could be contrasted with the particular type of authority which physicians have in medical interviews. Theirs, for example, allows them to ask personal questions which no other professional authority would be as likely to ask (or to receive a cooperative response if they did ask). Were lawyers or parents to inquire about an adult's sexual, dietary and drug use habits, they would not be likely to be answered as frankly as physicians may reasonably expect. This type of authority needs to be understood in terms of the presuppositions ascribed to certain types of contexts within medical care. It is therefore an organizational factor, while the pattern of institutionalized authority in general is a structural factor. But these are distinctions in analysis, since their concrete manifestation will be interactionally and practically indistinguishable. The analytic distinction helps us understand the cultural breadth of the presupposition-ascription, and perhaps enables a more detailed understanding of its history of influence on the formation of the observed conventions.

In this manner, any concrete interaction exists within a context of practices which actors know in Ryle's "knowing how" sense, but which practices are expressive of conventions. The varying levels of analysis represent a

recognition that some conventions are "accepted in practice" more broadly than only in the particular context.

Historically, the conventions of a culture enable the conventions of institutions to be adopted for practical purposes, as the society-wide acceptance of professional dominance and paternalism enables the particular type of medical professional dominance to develop in practice.

These, of course, only "exist" in concrete interactions, but the acceptance of authority in any institutional setting (e.g., parental or political) is a convention which is likely to be manifested in similar practices in other settings. So the broader, more abstract levels of analysis indicate factors which have shaped the practices and conventions in institutionally-situated interactions. But these organizational and structural "factors" are manifested only in the concrete interactions. They are ascribed to the social context as a means of better understanding how the actors are able to accomplish their tasks and communication.

The more abstract presuppositions ascribed to interactions are restricted by their explanatory usefulness and by their being consistent with other practices and conventions manifested in the interaction. Certain presupposition-ascriptions will be inconsistent with the action or communication. For example, we could assume that physicians and patients interacted in a context in which

conventional practices would justify ascribing the presupposition that physicians practiced medicine primarily out of an effort to accumulate profit. Practices which cut into profits (e.g., referring, preventive care, discouraging unnecessary visits, suggesting less expensive treatments) would require special explanation. Furthermore, the degree of patients' trust would be inexplicable. In a context of sales, where this presupposition is more justifiably ascribed to the setting, the customer typically responds very differently than patients in medical interviews. Though profit from illness and expensive treatments may well influence some of the conventional practices in medical settings, it is not a tacitly-accepted presupposition of the interactional context for physician-patient interactions.

The preceding discussion has suggested a sociological method for understanding communication. The micro-analysis of particular interactions is to be conducted by specifying presuppositions which render understandable the communication and action in the interaction. The crucial assumptions of a social-contextual analysis (see pages 98-100) have been supported (see pages 100-117). The superiority of accounting for social action by examining actors' intersubjective knowledge of "how to" over ascribing unconscious propositional rules is supported by examining how actors accomplish practical and communication tasks. Thus any account of how participants successfully

communicate (especially creatively) must be context-bound (page 99; assumption one). This methodology is successful in explicitly displaying why the action or communication occurs as it does because that is an account of the construction of the action, not of intentional or mental states or propositional rules postulated in order to explain the action (page 99; assumption two). Participants in social action know how to do things, and that is what is explained by the social-contextual account. What is explicitly accounted for by the analysis is how intersubjective practical knowledge "structure" discourse and action: They form the conventions which enable participants to achieve communicational and practical activities (page 99; assumption three). The recurrence (or absence) of certain social factors in different interactions increases support for the claim that they are social conventions. Buttreassing the observations is accord among different analysts, as well as the factors' occurrence in other sociological, political and philosophical discussions. Analysts' presupposition-ascriptions are propositional descriptions of the social conventions and their genesis, not to be confused with actors' "knowledge" of them, which is constituted by their practical understanding of how to accomplish practical activities and communication (page 99; assumption four). The explicit description of these "social facts" also shows how these

factors may serve to undermine, conflict with or support actors' practical interests (pages 99-100; assumption five). These social factors may support individual, class, or institutional interests which particular actors might consciously oppose (or support). This last claim will be affirmed by the social-normative analysis of concrete cases (Chapter IV and V). These presuppositions are not propositional beliefs of the actors; they are propositions which describe the intersubjective understanding of the context. Therefore, some explanation must be given regarding why the actors' practices seem to justify the presupposition-ascriptions. Historical-sociological examination of the context of both the interaction and the methods whereby actors accomplish their tasks supply social factors which explain the formation and intersubjective comprehension of the methods. Many of these factors reflect prevailing social and political norms and practices. The next two chapters provide a concrete application of this methodology to recorded medical interactions.

Chapter III

Paradigmatic Cases for Analysis of Informed Consent

The following two chapters are a practical application of the preceding chapters' theoretical discussion. The present chapter (Chapter III) presents a description of the setting in which physician-patient interviews were recorded, three cases that illustrate the ethical issue of informed consent (discussed in Chapter I) and an expanded discussion of the three interviews, highlighting the details of particular interest. The next chapter (Chapter IV) is a contextual social analysis. The analytic framework is derived from Fisher's work in discourse analysis (discussed in Chapter II). These two chapters roughly duplicate the presentational approach used by discourse analysts who are concerned with showing the influence of interactional, professional and social-political factors on the communication and negotiation of treatment in the delivery of health-care (Fisher, 1979, 1982, 1983, 1986; Fisher and Todd, 1983).

Cases

The cases presented are not ones in which common medical practice would require explicit informed consent.

Informed consent is usually an attempt to assure that the patients themselves accept the risks involved in a procedure. When the risk is substantial, as in major surgery, the need for informed consent is well recognized. In routine medical procedures the degree or type of risk is usually considered negligible or minimal; thus explicit informed consent is not typically sought (cf., U.S. President's Commission, 1982: 108; Graber, Beasley, and Eaddy, 1985: 40-43). I will argue that this is partly due to the social fact that in physician-patient interactions, patients typically allow the physicians to take responsibility for the decision. Whether or not the information is given, patients usually simply take physicians' advice. That this is acceptable to both parties is based on the "presupposition" that the nature of the decision is routine as well as on the shared expectations of the participants (this will be discussed later in more detail).

The purpose of the empirical research is not to evaluate either the individual physician or the profession as a whole. Rather, it is an attempt to illustrate how varying levels of risk and influence are managed in everyday medical practice by patients and physicians. The cases are not chosen because they are exceptions to the general practice, but as illustrations of this practice whereby medical practitioners and patients do not concern themselves

with informed consent for routine cases. The issue came to my attention as a pattern in the interactions only after recording, transcribing and analyzing forty-three doctor-patient interactions.¹

Ethnographic Description

The data for this study were collected over a three month period in a family medicine model practice in a teaching hospital that serves a largely rural area. I participated in the project from its inception through data gathering and analysis.

The family practice model office is simultaneously a setting for the training of residents and a facility delivering health care. First-, second-, and third-year residents work in an arrangement that simulates a group office practice. Patients may request a particular physician when they first call or walk in for an

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The medical information used was obtained as part of a larger study conducted by Sue Fisher in a family practice residency. The research was partially funded by a Research and Development Award from the University of Tennessee in Knoxville. The data and some of the analysis originally appeared in my Master's Thesis, "Informed Consent in Routine Contexts" (the University of Tennessee, Knoxville, 1983). I also wish to thank Ablex Publishing Corporation for permission to use material published in "An Empirically Grounded Approach to Ethical Analysis and Social Change" in Fisher and Todd (eds.), The Structure of Discourse and Institutional Authority: Law, Medicine, Education, (1986).

appointment. Typically, however, an appointment is set with a resident assigned by the receptionist, and that resident is the patient's physician on subsequent visits. Another resident will substitute when the assigned physician is absent, as would occur in a group practice.

Four full-time staff physicians and some members of the local medical community are either in attendance or on call to the practice for the residents to consult. Nurses in the family practice model office are assigned to a particular resident for a month at a time. There are also professional support personnel on staff. A nutritionist, a health psychologist and a social worker are available for consultation with residents and patients. These inter-professional relationships further simulate the kind of practice the residents will experience in private practice.

The patient population is set by the National Family Practice Charter and purports to represent a population similar to that of a private practice. The charter is set up by the American Board of Family Practice and requires, for example, that any accredited residency have no more than one-half indigent patients (including medicaid but not medicare). The family practice model office also simulates the fee-for-service billing character of group practice, and pays physicians by salary.

On their first visit, new patients are given an

appointment time half an hour prior to when they are scheduled to see the physician. In this half hour the patients are individually called into an office off the waiting room where a questionnaire is administered by a clerical worker. The questionnaire asks about social and medical factors in patients' lives as well as means of payment (medicare, medicaid, insurance, personal payment). The patient information sheet is placed with a note regarding the presenting complaint in a holder on the examining room door. Before meeting the patient, the resident reads the note which lists the presenting complaint and thus also has access to social and financial data.

Generally, the residents first interview patients regarding presenting complaint and medical history and they leave the room for the patients to change clothes if the examination requires that the patient be undressed. Nurses are sent in ahead of the residents to prepare some patients (such as women scheduled for pelvic exams) and to collect samples for lab tests (drawing blood, urine tests, etc.). Following the examination, patients are asked to dress before the resident returns to close the interaction. During these breaks the resident may consult with other residents or with a staff physician. Staff may also be asked to examine the patient for a second opinion. Sometime during the day the residents dictate notes which are typed

and placed in patients' files. At a later date these are reviewed by staff physicians.

The research project from which these examples are drawn was conducted with new women patients coming to the family practice center for the first time. After bringing a new woman patient to an examining room the nurse would notify the primary researcher or myself. One of us would then approach the appropriate resident and ask for permission to video- or audio-tape the medical interview. Then we would approach the patient to explain the research project and ask her to sign a written consent form permitting the recording and observation (see Appendix). When audio-tape was used one of us would sit in on the interaction to take notes on non-verbal and impressionistic aspects of the exchange. In situations where the interaction was video-taped one of us would monitor the taping from a separate room.

The tapes were transcribed and served as a basis for analysis. These typed verbal accounts were augmented by our knowledge of the setting, non-verbal elements of the interviews, casual discussions between physicians or with us, field notes and patient files. It was in the process of reviewing the transcripts that interactional patterns regarding informed consent emerged as a topic of interest. These routine medical interviews were found to involve both patient risk and inconvenience and as such may be

interactions which should include an explicit informed consent procedure. The cases presented here are attempts to reconstruct for the reader typical interactions which illustrate this pattern and to empirically ground the ethical claims. They represent a variety of degrees of risk or inconvenience, as well as different interactional techniques. What is typical about these interactions is that the reasons for the particular treatments are not fully explicit, the patients do not ask for reasons or clarification, and the treatments are not obviously the only available ones nor necessarily the best for the patients. What is important about the interactions is the underlying practices or beliefs, not the particular details of the practice's expression in the interactions. But positing a ground or common practice underlying the interactions is a part of the analysis and so will be left for the next chapter. We now turn to the descriptions of the three cases and a summary of the relevant details for analysis.

Sheila

In the first case the patient, whom we will call Sheila, is a young Anglo woman who is from out of town. The physician is a third-year male Anglo resident. Sheila has been staying in her husband's hospital room for three weeks while he is being treated for injuries resulting from a

motorcycle accident. Her presenting complaint is a sore throat. The resident orders a strept screen and prescribes penicillin for five days, to be increased if the screen is positive.

On physical examination, the resident notes that one of Sheila's ears is "a little retracted but not red." After examining her throat he says:

- D. Okay, you may have a little strept throat, I, I'll tell you what we will do. We'll go ahead and get a throat culture// (double slash lines-- // --indicate an interruption)
- P. //Uh huh.
- D. and I'll go ahead and start you on some antibiotics. If the culture, the culture could still be _____ (unintelligible to transcriber)//
- P. //Uh huh.
- D. if it's uh, if it is _____ then you won't need to take a full course of antibiotics but if it's strept well we'll have you go ahead and take a course. You're not allergic to penicillin are you?
- P. No I'm not.
- D. Take a deep breath. Okay. Again. Just a couple more times. All right. I'll be back momentarily. The prescription, I'll go have the nurse come do a strept screen on you.
- P. Okay.
- D. At that point what we'll do is give you five days worth of penicillin//
- P. //Uh huh.
- D. I want you to go ahead and take that. If your strept screen comes back negative then you can stop taking it.
- P. Uh huh. After what, five days, or after?
- D. Five days, after five days, what I'll do is give you five days worth, one refill. If it's positive I want you to take it for a full ten days//
- P. //Uh huh.
You've taken penicillin before?

- P. Yeah, uh huh. I've had to _____.
- D. I'd like to see you again in two weeks just to make sure this is all cleared up. Hopefully you'll be all cleared up.

In the interaction the physician tells Sheila that he does not know whether her sore throat is due to streptococcus (a common bacteria which can cause sore throats and is usually treated with antibiotics), that he will not know for two days, and he gives her a five day prescription for penicillin. Sheila is to take the penicillin for two days and then call to see if she should take the other three days and fill another prescription for five more days. So we can reasonably assume that Sheila is informed regarding when the strept screen can be read (forty-eight hours), that if it is negative she does not need to continue the antibiotic, that she should be better within two weeks.

The attending physician has attempted to cover two aspects of this type of presenting complaint in his treatment plan. First of all, he starts the patient on penicillin immediately. The usual reason for this is to prevent the somewhat rare occurrence of rheumatic fever and reduce the risk of other possible complications. Secondly, he takes a culture and arranges for an opportunity to terminate treatment if the screen is negative. The unnecessary use of antibiotics is discouraged due to the slight chance of various allergic reactions, increasing

sensitization to a valuable drug which reduces its later efficacy, depressing the growth of normal bacteria and contributing to the development of resistant strains of bacteria in the population at large. So this physician has treated Sheila in a manner that shows his sensitivity to the attendant problems in the treatment of sore throats with antibiotics.

Are there any factors of which Sheila is left ignorant? Clearly the medical criteria specified above are not disclosed. Consequently there is good reason to believe that Sheila is not aware of why she has been given the particular treatment plan.

Maria

The next patient, whom we will call Maria, is a 24-year-old Mexican-American woman. She is a heavy-set, outgoing woman who during the interview discloses that she came to this area with her boyfriend and is currently living in his house. Her presenting complaint is persistent pain in her leg following a motorcycle accident. The motorcycle she was driving slid on gravel and she fell off injuring her leg. The physician is a third-year male Anglo resident of conservative religious persuasion.² During the medical

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This resident's conservative religious beliefs were common knowledge in the clinic.

history she reveals that she has had three abortions and one miscarriage and thinks that she may be pregnant again. If she is pregnant, she states she plans to have an abortion and asks the physician if they do abortions at the teaching hospital or if he knows of anywhere she can get one without having to pay in advance. He tells her that hospital abortions are very expensive and that he does not know about other places in town.³ He then has her leg x-rayed. The x-ray does not reveal any fractures or breaks. The following dialogue begins just as the resident re-enters the examining room. He is reading the package insert on the pain medication he has brought for her:

- D. Well, I'm real hesitant about medication//
P. //Yeah.
D. You're
not sure, even though, you know, you think you
may want to have an abortion//
P. //Definitely. I could
make the mistake but it's not mine.

3

There is a practice in the university hospital of referring abortions to the only licensed clinic in town--a women's reproductive health clinic. The center, in order to be licensed, had two physicians on call. In casual conversation in the family practice clinic I have heard the reproductive clinic referred to as practicing "ethically". Furthermore, abortion was frequently discussed in the family practice clinic conference room. In the discussions that we were privy to, the general attitude toward abortion was negative. This particular resident at one time said that no doctor "worth his salt" would get "messed up" with abortions.

D. You may, it looks like uh, well the medication I want to use it's not recommended during pregnancy for treating nursing mothers or during pregnancy, tell you what to do. What kind of work do you do?

P. I'm a cook.

D. A cook. Uh, where do you work at?

P. I work at Hefty's Truck Plaza on Dixon Road. (names have been changed)

D. Uh huh. Are they pretty good to you?

P. Yeah, but they won't pay me (laughs).

D. They won't pay you//

P. // Except peach pie.

D. Okay, I bet within another day or two you'll be able to get up and stand on it without a whole lot of pain, and right now I would just use extra-strength Tylenol//

P. // Okay

D. and stay with that. The x- ray is negative, if the pain persists you need to get back in touch with me.//

P. //Okay.

D. but I don't see anything there that//

P. //I just wanted to make sure that it wasn't fractured.

After emphasizing that Maria ought to consider birth control and denying knowledge of abortion clinics around town, the resident closes the interview:

D. Alrighty, I'd like to see you back if you've got time to come back in and see me//

P. //Okay.

D. otherwise if you still haven't had a period in ten days you probably ought to consider yourself pregnant and probably come back in and get a pregnancy test or//

P. //or start praying hard and heavy.

D. Yeah, or start going to Mass two or three times a day.

P. (laughs) For sure. I appreciate your time.

D. Yes maam, it was nice meeting you.

P. Same to you. I'll come back whenever I need

- to see a doctor cause I'll never have a doctor here.
- D. Hopefully 24-year-old ladies don't need many doctors.
- P. Yeah, okay. Thanks a lot, bye bye.

In this second interaction, the physician recognizes Maria's need for pain medication, yet does not provide it. The pregnancy is considered to be a contraindication for such medication, notwithstanding the patient's declared intent to abort if she is pregnant and a history of three earlier abortions. Maria is informed of the fact that her x-ray does not reveal any fractures, that the physician decided not to give her a prescription for pain medication because it is contraindicated for pregnant women. She knows that, in her doctor's opinion, the leg should feel better in a few days and that she can take extra-strength Tylenol(tm) for the pain.

The drug which the physician was going to prescribe and dispense presents a threat to the health of the fetus, not to Maria's health. The physician has said that the drug was contraindicated for pregnant and nursing women. The physician has not presented information regarding abortion which Maria requested. He has suggested that Maria consider birth control and explained that if in ten days she does not have her period she is probably pregnant and could get a test done at the family practice clinic.

So Maria is not informed on where to go for an

abortion and that the pain medication is contraindicated for the possible fetus' health, not her own (for further discussion of this case, see Fisher and Groce, forthcoming).

Vicki

The third patient, whom we will call Vicki, is a 26-year-old Anglo woman. Vicki works in a university library while her husband attends graduate school as an art student. The physician is a third-year male Anglo resident also in his late twenties. Vicki has several presenting complaints; a cyst on her tailbone, a skin rash and several moles. The moles are brought into the discussion by Vicki after the physician has examined her rash:

- D. What other problems or questions do you have?
P. Okay. Um I was wondering if you could take some moles off for me?
D. Okay. Whereabouts?
P. (unintelligible) There's one on my forehead. Right there. _____ (unintelligible).
D. Any others?
P. Um, how many can you do at once?
D. Half dozen. Well, the problem is that, ah on ah, young attractive females I don't usually take them off the face. But I can do it and probably everything will go well, but those are best done by either a dermatologist or a plastic surgeon. But I'll be glad to do it. We can do one in another location and see how it goes, and if you feel comfortable with it and I feel comfortable with it we'll do the one on your forehead.
P. I would not be afraid to have you do it all. First of all I can't afford anybody else.
D. Okay.

- P. But it's like (unintelligible) I would not be ashamed to have a scar.
- D. Okay. Well it shouldn't leave a scar//
- P. // Okay.
- D. unless they infect or something like that. Okay? So what else would you like?

After discussing Vicki's presenting complaint, taking a medical history and doing a physical, the physician explains what he is going to do about the cyst:

- D. Okay. Uh, if it's all right with you I want to have one of our old doctors come look at this mole on your forehead and get his opinion on it. I was telling him about it, you know, describing it and uh, you know, as I was saying family practitioners normally don't take moles off faces, faces just because of, uh, mal, you know, they have to go up on your malpractice insurance and things like that, that we normally handle by people who do it all the time, however, I have removed them off people's faces without any problems before. It's just that we are being conservative and protecting ourselves when we do so. But I wouldn't hesitate at all to take that one off.
- P. Okay.
- D. But I'll get him to look at it and get his opinion on it, okay?
- P. Okay.

The staff physician enters the room, lists Vicki's three complaints and examines the moles:

- SD. Okay, uh, if you remove it you're gonna will have a little scar but it probably won't be but about an inch or more, you'd have a scar that'll match this little line right here//
- P. //(laughs)
- SD. parallel, that way it'd be easy to hide it. Now see what you got here. Has that been there for a long time you say?

- P. Uh huh. Can you get rid of that? But I was never sure what it was (interval)
- SD. We're reluctant to cut on women's faces.
- P. Well I'm not very vain on my face.
- SD. Well, we are (laughs)

The family practice resident works through his lunch hour and a noon conference to remove the mole on Vicki's face. After removing the one mole, he explains that he would like to remove the others later:

- D. You know what? It may be, uh, best if we do these others in a, at a different time?
- P. Why is that?
- D. Well, uhm, we've already run way over this morning, for one thing.
- P. Okay.

A few minutes later the resident refers to the difficulty the nurse had in getting the proper instruments set up:

- D. Next time I'd like to use, make sure that I have the exactly instruments I want, too.

Finally, as he closes the interaction, the physician makes special arrangements to check on the incision and remove the stitches on his day off:

- D. But I'll tell you what. I may just, I may just come in Monday since I'll be in town. What appointment will be best for you Monday?
- P. Anytime before four.
- D. Why don't we make it early in the morning. I'm actually on vacation but I'll come in just to make sure that this is okay.
- P. All right.
- D. And don't be grossed out by the fact that the

- incision is little longer than you might have expected but I opened it a bit like that so that it would be, leave less of a scar.
- P. I won't be.
- D. You're not too particular are you?
- P. No I'm not. I was planning on taking the stitches out myself. I//
- D. //Well, on this one I'd like to see it, on the others I might go along with that idea, okay?
- P. Uh huh.
- D. This one is on your face. I can't have that, you know. Turn around.
_____ (unintelligible).

Vicki has come in for, among other things, the removal of moles. The resident has introduced himself as a doctor, indicated his discomfort with removing moles from women's faces and his preference to at least do a less conspicuous one first. He has said that it is better to go to a dermatologist or surgeon but that he is capable and willing to do it. In fact he has taken moles off other people's faces at prior times. He explains that family physicians do not routinely do such removals because it would increase their malpractice insurance. He also informs the patient that he would like to have an "old doctor" (staff physician) give a second opinion before proceeding. The surgical room does not have the proper instruments, the operation takes longer and the surgical scar is longer than the resident apparently thought it would be. He makes special arrangements to come in and remove the stitches and examine the incision even though he is on vacation.

Vicki asked the family practice resident to remove

her moles--all of them. The reasons she gave were that she could not afford to have anyone else (a higher level specialist is implied) do it and that she was not concerned about having a scar. She is told that this particular physician has done such removals before and is not hesitant to do hers, though he might prefer to do a less conspicuous one first. She has been told by the resident that the removal should not leave a scar and by the staff ("older") physician that the scar will not be more than an inch long. Vicki is also informed that the physician can do about six removals at a time. After the removal, she is told that the physician has "run way over time," that the instruments were not exactly the ones he wanted, that she should return to get the stitches removed and to have the other moles removed.

This third-year resident expressed hesitancy about removing the mole from Vicki's face, consulted with a staff physician and worked through lunch hour to remove it. He has, despite his suggestions to the contrary, removed the most conspicuous mole first. After noting that dermatologists and plastic surgeons are best qualified to remove facial moles, he explained to the patient that he was capable and experienced if she really wanted him to perform the removal.

What factors are there of which Vicki is not informed? She was never explicitly told that her attending

physician was resident and that the "older" physician was a supervising staff physician. She was incorrectly informed that all of her moles could be removed on that day. It appears as if neither she nor the resident knew that the equipment would be below the standards the resident expected, nor that the removal would take as long as it did. She also apparently operated under the assumption that the removal performed by a family physician is less expensive than when performed by a dermatologist or a plastic surgeon.⁴

Similarities and Differences

In all three cases treatment decisions are arrived at by the physicians without giving the reasons for their decisions and seeking the patients' agreement. There is no opportunity for the patients to question the sufficiency of the reasons, or the choice of one among other possible options (which may also be medically sound, as discussed in the next chapter). In the case of Sheila and Maria, the decision is simply expressed in the form of a treatment, and they accept the recommendation without comment or

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The fee scale at the family practice would allow for fees for the removal of three moles in two or three visits to vary from \$30 to \$153. Local dermatologists claimed that they would complete the removals in one 30- to 45-minute appointment.

clarification. There does not appear to be any patient choice or deliberation over options or reasons in these cases. In Vicki's case, the treatment is in harmony with her presenting complaint and very specific request for a particular treatment. Though he expresses hesitancy, the resident does eventually comply with Vicki's request. What is not explicit in the interaction is why the resident does comply despite what he expresses as the usual practice and such adverse factors for him as running through the lunch hour, a noon conference, lack of desired surgical equipment and the expressed desire to do a less conspicuous one first. So in all three instances, the residents have not disclosed the reasons for their actions in treating or not treating the patients, consequently the women did not have the opportunity to agree or disagree with the reasons or choices.

In the cases of Sheila and Maria, there is not any opportunity for the women to give their consent to the treatment or non-treatment. At no point are they asked if they agree with the physician's choice. Nor are they explicitly informed of any options. They do not seem to find this at all unusual. Vicki's case seems to be different. She specifically requests a certain procedure, among other things, and is given the requested treatment. Furthermore, she is given the treatment that she requested despite the resident's expression of hesitance. So she has

taken the opportunity to request specific treatment, and her consent might more reasonably be implied.

It may be that this apparent difference is mitigated by other features of the interaction. Vicki leaves the interview with more of a sense of why family practice physicians might not remove facial moles than with knowledge of why hers were removed. This is similar to the first two cases in that there is no communication of the reasons why the physician chooses to treat Vicki instead of referring her or removing a less conspicuous mole first. Discussion of why the physicians' expressed hesitancy and yet proceeded will have to be delayed until the analysis, since it is not an explicit part of the interaction.

Another difference between Vicki's case and that of Sheila and Maria is that Vicki was obviously aware of options and her physician explicitly mentioned them. Vicki had apparently deliberated, or at least knew of the option of going to a dermatologist or plastic surgeon to get her moles removed. The resident expressed that the usual practice was to refer such cases to these specialists. In contrast, Sheila was not told that she could go untreated or wait on the screen. Maria was not told that she could take pain medication and risk her fetus. Of course, it is so rare as to seem odd for a physician to append to recommendations "or you can get another opinion or do nothing at all." Nevertheless, the explicit discussion of

the possibility in Vicki's interaction is a difference between hers and that of Sheila and Maria. It is more reasonable to say of Vicki that she consented to the treatment than it is of Sheila and Maria.

The next task is to examine the particular cases to see what consequences the treatment decisions have for the patients. This discussion will have relevance for both the sort of questions asked in a contextual analysis as well as for the normative analysis.

Chapter IV

Social Analysis

Consequences of Outcome to Patients

Each interaction resulted in the treatment of the woman. Most traditional normative analyses of cases involve a consideration of the outcome of the case, whether for the purposes of a consequentialist evaluation or to aid in deliberating whether there was any infringement on the patient's "rights" or "person." As will be evident, a social analysis examines the outcome for different reasons, such as to consider how the outcome was arrived at and what social and interactional processes were involved in shaping the treatment outcome for each woman. Note that even at this level of analysis, we need to draw heavily on our knowledge of practical effects on patients' everyday routines of advice given by the physicians. Each case will be considered individually, then they will be compared in Tables I, II, and III (pages 158-162).

Sheila

Sheila presents with a sore throat. She receives treatment that is quite routine and probably as effective as any she would receive elsewhere. The treatment plan also

shows that the resident is sensitive to the problems attending the use of antibiotic treatment. She is given a five day prescription of antibiotics, with another five days' worth to be filled if the strept screen is positive. She is to call the physician in two days to check on the strept screen. There are medical and practical consequences of this treatment outcome.

Medically, Sheila is immediately placed on antibiotic treatment, an effective method of combatting strept infection. She is likely to be less contagious and less likely to be subject to rheumatic fever, a rare side-effect of strept infections. It is possible that Sheila may recover from her sore throat earlier and with fewer complications because the resident did not wait to read the screen before prescribing the antibiotic.

If the screen is positive, Sheila will have benefitted from earlier treatment without any additional medical risks to later treatment. Since the only difference waiting for the screen would have made, if it is positive, would be a delay in starting the treatment, there is no difference in the risks of treatment itself. Treatment with wide-range antibiotics has the accompanying risks of an infrequent occurrence of allergic reaction, a possible reduction of the drug's later efficacy due to sensitization, depression of normal bacterial growth (sometimes related to yeast infections) and a societal impact of contributing to

the development of resistant strains of bacteria. The medical issue of whether or not the risks of such treatments are worth the usefulness of treatment prior to reading the screen is controversial (Lasagna, 1980).

If the screen is negative, Sheila will have been exposed to these possible negative side effects unnecessarily. The antibiotic would prove inefficacious, unless by the coincidence of another bacteria being present which the antibiotic is effective in treating. Sheila would have been exposed to all the attendant risks of the treatment.

Practically, the treatment has several consequences for Sheila which are evident only if we first understand that there were alternatives to the chosen treatment plan. The physician could have given Sheila the entire prescription to be filled at the same time, or he could have had her wait until the screen was read before beginning the ten days of antibiotics. Alternatively, he could have withheld dispensing of the prescription until he knew that she had strept. Medically, the only relevant difference between these options rests on the issue of treatment with antibiotics prior to or after reading the screen. The physician had clearly made up his mind to treat prior to the screen's being read, so this alone could not have been the only reason for the particular choice among the different means of achieving that medical goal.

On the treatment plan the physician chose, Sheila will need to call him to check on the screen in two days, and may have to return to the pharmacy to fill the second half of the prescription. If the screen is negative, Sheila will have spent money and time on the treatment plan that was unnecessary, though not as much as if he had given her a full ten day prescription. These are practical consequences for Sheila of the physician's treatment plan. The trips to the pharmacy could have been reduced to one or eliminated by dispensing one prescription, or having Sheila wait until the screen was read before filling the prescription. The extra expense and effort of taking unnecessary medication could be avoided either by not prescribing before the screen is read or by having Sheila wait two days. If the medical indications were of minimal concern to the physician, then it would probably be most convenient for Sheila if, at the time of the interview, a ten day prescription were given. It could then be filled if the screen is positive. If the medical indications were strong, so that the resident thought it important for Sheila to be treated immediately, the choice between two five day or one ten day prescription seems arbitrary, with neither obviously more convenient.

The medical indications for antibiotic treatment are controversial, though it is possible that here were some clinical indications in this particular case that might reduce the controversy for this instance. Barring this

event, unexpressed in the interaction or patient records, the treatment decision is not fully dictated by the medical factors. The decision to accept the medical risks, expenses and practical inconveniences is made for Sheila by the physician. She is neither asked for her preference, nor are the options (of non-treatment or alternative dispensing arrangements) mentioned. Sheila is uninformed regarding the fact that there are options and regarding the reasons for the physician's particular choice.

In this case the differences in treatment plans and their consequences seem to be more or less trivial. Sheila received adequate medical care and this care was not prescribed in the most inconvenient manner (Which would require that Sheila return to get the second prescription after the screen was read). But the controversial and uncertain nature of the medical indications reduces the strictness with which the treatment decision can be said to be determined by the medical factors involved in this case. Consequently, it is more reasonable to weigh the practical factors in determining the treatment plan. But such factors are not ever explicitly mentioned in the interaction. It is interesting to note that Sheila never raises these factors. The practical consequences of the treatment plan are effectively removed from Sheila's control or negotiation by their implicit treatment. This will later be discussed in terms of the medicalization of non-medical factors

(Waitzkin, 1983: 141-142), which effectively removes from patients' control aspects of their everyday life.

The fact of there being options to the treatment plan, together with the lack of clearly or strictly indicated medical treatment and the practical consequences of the treatment plan, raises the question of Sheila's silence regarding her inconvenience and expenses. Why is it that she never asks if the complicated treatment plan is necessary, if she could just fill the ten days of antibiotics at once, or if she could just wait until the screen was read? This question is one which also arises in the next two cases.

Maria

Maria presents with a sore leg from a motorcycle accident and is probably pregnant. She plans to abort and has had three previous abortions. The resident re-enters the examination room with pain medication but does not give it to Maria, telling her that it is contraindicated for pregnant and nursing mothers. Instead the resident tells Maria to take an over-the-counter medication, and to return if the pain persists (and later, "if she has time"). It is likely that Maria could have received better pain medication from a different physician who would have followed one of the options to be discussed below. This non-treatment,

referred to from here forth as her treatment-plan, has medical and practical consequences for Maria.

Medically, if pain management is a medical matter, Maria has not been given any better pain management than she could have received by self-treatment. It is possible that she really came to the physician for information on where to procure an abortion, and that her leg pain was just an excuse. If such was the case, she did not get any aid on this issue either. The resident did have Maria's leg x-rayed, so she does know that it is not fractured. If she has benefitted medically from the encounter, it is in the assurance that there is nothing seriously wrong with her leg. Even this assurance, however, may be mitigated by the resident's request that Maria return if the pain does not cease.

If the over-the-counter medication is effective in treating Maria's pain, she has received some assurance that such is all she can do and the health and life of her fetus is not at risk due to pain medication. It is possible that Maria will be less likely to do further damage to her leg by overuse since she is on a weaker pain medication and would likely feel pain sooner than if she were on something stronger.

If the over-the-counter medication is ineffective or only partially effective in relieving Maria's pain, she has only benefitted in that she now knows that her leg is

not fractured. (It would not be unreasonable to think that she may already have tried the over-the-counter medication.) The pain medication that the physician decided not to give her due to the contraindications probably would have been more effective pain relief. Had he dispensed the medication, he would have endangered the life or health of the fetus. This was not a concern of Maria's since she planned to have an abortion.

Practically, Maria may be more inconvenienced by the over-the-counter medication than if she had received the stronger prescription. She indicated that her leg hurt at work and that she would not be paid if she had to take time off work while her leg healed. So a "practical" consequence of the treatment plan is possible continued pain, possible loss of income, and perhaps the inconvenience of having to return to the clinic for further medical attention. The fetus she is carrying, and planning to abort, is protected from possible side effects of the stronger pain medication. She may possibly be protected from further injury to her leg due to over-medication of her pain.

As in Sheila's case, there are options to the treatment plan Maria received. Most obviously, the physician could have given her the medication, even though it was contraindicated for pregnant women. The contraindication is due to fetal health and in this case Maria intends to abort, and informs him of this fact. This

treatment plan would relieve her of pain more than the one chosen and would bear only the possible medical risks of threat to the fetus and further damage by overuse of the leg since she would be less sensitive to the pain. Of course, the latter is a risk she may bear anyway since she may choose to work regardless of the pain. Another means of approaching this risk would be to warn her not to overuse it, perhaps with concrete descriptions of what might be damaging. The risk to the fetus seems immaterial since Maria plans to abort.

The resident came in carrying the medication he decided not to give Maria. There are other pain medications which do not present a threat to fetal health. At no point did the resident mention this as an option. It may be that the clinic did not have any samples of such a medication, but since Maria was to buy the over-the-counter medication anyway, it is reasonable to wonder if she would not have been just as willing to purchase a more effective prescription.

In light of the fact that Maria intends to abort the fetus and that she has carried through with this intention on three previous occasions, the protection of fetal health does not seem to be a valid reason for the treatment option chosen by the resident. If the decision is based on protection from further damage to the leg, it is never explicitly stated in the interview and there may be

better ways of dealing with this possibility. The contraindication is stated in an ambiguous fashion which leaves open the possibility of interpreting it to mean that the pain medication is dangerous to Maria because she is pregnant. The options of alternative pain medication, stronger than the over-the-counter medication and not threatening to fetal health, or of taking the other medication despite its threat to fetal health, are never explicitly discussed in the interview. Neither does Maria ever raise them. Why does Maria not ask if there is anything that her physician can do for her more than simply advise her to take the over-the-counter medication, and call him if there is any problem? Once again, there seems to be good reason for the patient to question the physician's choice of treatment plan, or at least ask for clarification, but no such attempt is made.

Vicki

Vicki has presented with a variety of complaints, among them the removal of moles, one on her face. This is not a medically indicated treatment. It is one for which the medical profession is consulted due to its technical expertise and the possibility of complications which are medical in nature (i.e., infection). It is a little out of the ordinary for a patient to consult a family practitioner

for the removal of facial moles, due to the fact that plastic surgeons and dermatologists have more experience with such procedures (an exception to this may be rural family practices, where specialists are not as accessible). Informed of this fact, as well as the fact that the problem is not considered formidable by her physician, Vicki is "treated" for her facial mole.

Medically, this procedure has several risks. Some of the risks are difficult to categorize as strictly medical since the whole procedure is more "cosmetic" than medically indicated. Since the procedure is treated under the rubric of a medical treatment, and its success is the removal of a mole with a minimum of scarring, I will treat all consequences besides financial and practical inconvenience as "medical" consequences. With this clarification, the risks of this procedure are present regardless of who does the cutting and suturing. Varying levels of experience and quality of equipment are the only factors which affect the probability of the risks. The only benefit is removal of the moles, which would be the probable result of any clinical encounter around this presenting complaint (unless of course there were some sort of medical contraindications around the removal of the moles). So the only deliberation

over risks that is relevant is that of degree of likelihood.

There are several factors which seem to increase the risks for scarring and disfiguring in Vicki's case. First of all, she has come to the lowest level of experience, generally speaking, in terms of those medical practitioners who are qualified to remove moles. As the resident points out, usually dermatologists or plastic surgeons are the best qualified to remove facial moles. Secondly, she has come to the family practice model office. So within the lowest level of experience of the medical specializations, she has elected to come to the setting where she is likely to get a physician who is in training, rather than an experienced practitioner. Finally, as is revealed through the interaction, the clinical setting is not very well equipped to perform the procedure that Vicki has requested.

It is possible to argue against this evaluation of the risks. It could be claimed that family practitioners are better equipped to deal with cosmetic surgery because of their concern with the whole person. One result of such a concern would be to avoid unnecessary or ill-advised cosmetic surgery. This is not explicitly discussed in Vicki's case, and since the surgery was performed, Vicki's attendance at a family practice did not have a different result than would be likely from the more

surgically-oriented specialists. Another advantage might be that family practitioners are more likely to pick up on later infection and avoid unnecessary disfiguring. Furthermore, it could be argued that those training for medical practice are more careful, more recently schooled in new techniques. Though possible, this does not seem as likely for a family practice resident. Residents have been said to be more attentive to patient's desires and needs and under the careful scrutiny of experienced staff physicians. The supervision, however, is by a family practitioner who is not likely to have much experience in facial surgery. I cannot imagine any counter-argument to the lack of suitable equipment.

Practically, time and expense are highly variable considerations. Second to the removal of her moles, Vicki's concern seems to be expense. She gives as her reason for not going to a specialist that she cannot afford one. She also asked how many moles the physician could do at one time. This may be an expression of a concern with the inconvenience of needing to make return trips, or of having to pay for each visit. The actual effect is that she will have to make return trips for the removal of stitches, as well as to have the other moles removed. This is despite the resident's original expression of the intent or ability

to remove six at one appointment, and to reduce risks by doing an inconspicuous mole prior to the one on Vicki's face.

The options to the treatment plan are many. None of them would have removed the medical risks or had a long term effect different than the option taken. The moles would all be eventually removed and there would always be some risk of infection or disfiguring. The practical consequences and the probability of the medical consequences could all have been improved on by many optional treatment plans. Vicki could have been encouraged to reconsider whether the expense would not be any or much greater if she had gone to a specialist (cf., page 138, footnote 4). Another option would have been to do one or more removals at different sites to see if she were really comfortable with the family practice resident operating on her face. Or she could have him do all but the facial mole, going to a specialist for that one alone. Simply verifying that the proper or desired equipment was available in the clinic, and then postponing the surgery until it was, would have reduced the risk. Or another appointment could have been set for a time when the resident would have adequate equipment, time and supervision to do a larger number of moles under optimal conditions.

None of these options, except the original intention of doing a less conspicuous one first and a rather

cursory discussion of the higher level specialist, were mentioned to Vicki. Perhaps she could reasonably be expected to have thought of the latter possibility herself, prior to presenting at the clinic.

The Treatment Decisions

The question of whether or not the treatments were in the patients' interests, when compared to the obvious alternatives, is difficult to answer. This is due to two factors: First, there are different means of achieving the medical goals, and these different means have efficacies and side effects which result in controversial cost-benefit ratios. Secondly, the non-medical advantages and disadvantages, such as cost and time, are dependent on non-medical factors (income, work schedules, etc.), and are so mundane that it is not at all obvious how the women would have chosen, had they been given the opportunity.

The medical treatments which the physicians chose were more or less effective means of achieving certain medical goals for these patients. Presumably patients come to physicians to have their medical interests looked after and physicians' treatment of patients serve these interests. An examination of the alternative treatments which might serve the same medical interests gives us a basis to consider whether the treatment decision made was so

clearly the "best" that there was no need for the physician to consult the patient nor for the patient to ask for reasons or clarification. If there are other courses of treatment which might be preferred by the patient, then it is reasonable to consider why the physicians did not consult the patients regarding their preferences on the non-medical concerns, or why the patients did not inquire about these options.

If the medical cost-benefit ratio of a particular treatment is controversial in comparison to the others, then it is also reasonable to consider why the patients' opinions were not sought. In order to see the relevance of such questions, it is helpful to get a clear picture of the medical risks and potential benefits, as well as the non-medical practical advantages and disadvantages, of the different treatment options which are suggested by the medical concerns expressed in the physicians' treatment decisions. Tables I, II and III describe for each patient a few available treatment options, together with the medical and non-medical advantages and disadvantages.

Table I. SHEILA - Sore throat; suspected strept infection.

TREATMENT OPTIONS	POTENTIAL BENEFITS	ADVANTAGES	MEDICAL RISKS	DISADVANTAGES
A. No Screen, Immediate full course of antibiotic	1. Avoid rheumatic fever 2. Reduce chance of contagiousness 3. Earlier recovery than waiting for screen	1. No return trip to Dr. 2. No return trip to pharmacy 3. No need to call Dr.	1. Allergic reaction 2. Reduction of later efficacy 3. Suppression of normal bacterial growth 4. Contribute to development of resistant strains 5. Treatment may be ineffective	1. Possibly unnecessary Expense 2. Possibly unnecessary trip to pharmacy
B. Strept Screen, Immediate full course of antibiotic, to be stopped if screen negative	1. Avoid rheumatic fever 2. Reduce chance of contagiousness 3. Earlier recovery than waiting for screen	1. No return trip to Dr. 2. No return trip to pharmacy	1. Allergic reaction 2. Reduction of later efficacy 3. Suppression of normal bacterial growth 4. Contribute to development of resistant strains 5. Treatment may be ineffective	1. Need to call Dr. about screen
	<u>NEGATIVE SCREEN</u>			
	4. None of the above benefits apply 5. Cease unneeded treatment, reduce risks	No additional advantages	6. Risks borne without need for treatment	2. Unnecessary expense of ten days' antibiotics 3. Unnecessary trip to pharmacy
	<u>POSITIVE SCREEN</u>			
	6. Known effective treatment	3. Expense for needed drug 4. Avoid second (needed) trip to pharmacy	No additional risks	No additional risks

Table I (Continued)

TREATMENT OPTIONS	POTENTIAL BENEFITS	ADVANTAGES	MEDICAL RISKS	DISADVANTAGES
C. Strept Screen, Two-five day prescriptions, one to be filled and started immediately, second to be filled and taken if screen is positive	1. Avoid rheumatic fever 2. Reduce chance of contagiousness 3. Earlier recovery than waiting for screen	1. No return trip to Dr. for prescription	1. Allergic reaction 2. Reduction of later efficacy 3. Suppression of normal bacterial growth 4. Contribute to development of resistant strains 5. Treatment may be ineffective	1. Need to call Dr. about screen 2. Two trips to pharmacy 3. Need to keep track of prescription
	<u>NEGATIVE SCREEN</u>			
	4. None of the above benefits apply 5. Cease unneeded treatment, reduce risks	2. Avoid expense of 5 days of drug	6. Risks borne without need for treatment	4. Unnecessary expense of first prescription 5. Unnecessary trip to pharmacy
D. Strept screen, dispense antibiotic only if screen positive	<u>POSITIVE SCREEN</u>			
	6. Known effective treatment	3. Expense for needed drug	No additional risks	4. Second trip to pharmacy
	1. No unnecessary risks		1. Delay in treatment 2. Rheumatic fever 3. Contagiousness 4. Delayed recovery	1. Need to call Dr. about screen
	<u>IF TREATED</u>			
	2. Known effective treatment 3. (Delayed) protection from rheumatic fever 4. (Delayed) protection from contagiousness	1. Expense is for drug that is known to be effective 2. One (needed) trip to pharmacy	5. Allergic reaction 6. Reduction of later efficacy 7. Suppression of normal bacterial growth 8. Contribute to development of resistant strains	2. Trip to pharmacy 3. Return trip to Dr. if he cannot phone in prescription

Table I (Continued)

TREATMENT OPTIONS	POTENTIAL BENEFITS	ADVANTAGES	MEDICAL RISKS	DISADVANTAGES
E. Strept screen, dispense antibiotic immediately to be taken if screen is positive	1. No unnecessary risks		1. Delay in treatment 2. Rheumatic fever 3. Contagiousness 4. Later recovery	1. Need to call Dr. about screen
	<u>IF TREATED</u> 2. Known effective treatment 3. (Delayed) protection from rheumatic fever 4. (Delayed) protection from contagiousness	1. Expense is for drug known to be effective 2. One (needed) trip to pharmacy 3. Prescription already in possession of patient	5. Allergic reaction 6. Reduction of later efficacy 7. Suppression of normal bacterial growth 8. Contribute to development of resistant strains	2. Trip to pharmacy 3. Need to keep track of prescription

Table II. MARIA - Pregnant (intending to abort), with leg pain from injury.

TREATMENT OPTIONS	POTENTIAL BENEFITS	ADVANTAGES	MEDICAL RISKS	DISADVANTAGES
A. Give pain medication sample though it is contraindicated for fetal health	1. Effective pain relief	1. Less or no time off work; income maintained 2. Less impairment of other life activities 3. Save money (sample not purchased)	1. Risk to fetus 2. Possible further leg damage due to desensitization	1. Risk to fetal health or life
B. Suggest less use of leg and over-the-counter medication	1. No risk to fetus 2. Less chance of further damage to leg due to desensitization	1. May be less expensive than filling a prescription	1. Less effective pain relief	1. May need to take time off work and reduce income 2. Cost of medication 3. May be greater impairment of life activities
C. Prescribe a medication to be purchased which gives better relief than over-the-counter medication and does not threaten the fetus	1. No risk to fetus 2. Effective pain relief	1. Less or no time off work; income maintained 2. Less impairment of life activities	1. Possible further leg damage due to desensitization	1. Cost of medication 2. Trip to pharmacy
D. Refer Maria to a physician in the clinic who has no moral concern over her fetus' health and her intention to abort. This physician gives Maria the drug sample of treatment A.		(The same as for treatment A, above, except that a different physician is responsible for the decision.)		

Table III. VICKI - Facial and bodily moles; patient requesting removal.

TREATMENT OPTIONS	POTENTIAL BENEFITS	ADVANTAGES	MEDICAL RISKS	DISADVANTAGES
A. Removal of facial mole by a family practice resident with sub-standard equipment	1. Moles removed	1. Facial moles removed immediately 2. May be less expensive than some other specialists	1. Disfigurement and infection 2. Non-specialist care 3. Resident, not an experienced Dr. 4. Sub-standard equipment	1. Need to return for removal of stitches and other moles 2. Cost approximately \$30 - \$150 for all moles
B. Removal of less conspicuous body mole(s) first, return to have facial moles removed	1. Risk of disfigurement and infection to less conspicuous location 2. Moles removed 3. Increase in experience on part of resident prior to removal of facial mole	1. Some removals immediate 2. Less expensive than plastic surgeon; perhaps than dermatologist	1. Disfigurement and infection 2. Non-specialist care 3. Resident, not an experienced Dr. 4. Sub-standard equipment	1. Need to return for removal of stitches and other moles 2. Cost, \$30 - \$150 for all moles
C. Do bodily moles and suggest that Vicki call and check prices for dermatologists	1. Bodily mole removed immediately 2. Facial mole may receive higher level of expertise	1. Bodily moles removed immediately 2. May not need to return for stitches 3. If Family Practice clinic is less expensive, save money for removal of bodily moles	1. Disfigurement and infection 2. Non-specialist care 3. Resident, not an experienced Dr. 4. Most conspicuous (facial) mole has reduced risks if dermatologist performs	1. May need to return for stitch removal 2. Inconvenience of phone calls to check prices 3. Trip to dermatologist 4. Two fees: Family Practice, \$30 - \$150 Dermatologist, \$25-\$175, so may or may not save
D. Refer Vicki to a dermatologist, suggesting that they are better prepared to do the surgery and not as expensive as she thinks	1. More experienced surgeon, reducing chance of risks 2. Moles all removed immediately	1. Removals all done in one visit to dermatologist 2. May save money: dermatologists in community charge \$25-\$175 for three removals	1. Disfigurement and infection	1. None removed at first visit 2. Inconvenience of second appointment at a different office 3. Probably need to return to have stitches removed 4. Cost of both Family Practice clinic bill and dermatologists

Each treatment decision had medically sound alternatives. In each case, though medically sound treatment was given, there was at least one alternative for which it could be argued that medical and practical concerns would be better served. Yet the women passively accepted the physicians' decisions. Considering each case individually, two questions are relevant to this analysis:

1. Was the treatment decision obviously the best possible, or was there some alternative that was arguably as, or more, medically sound and practical?

2. Were the women consulted regarding the risks, benefits, advantages and disadvantages of the treatment decision?

In Sheila's case, the physician chose a treatment plan that showed his knowledge of the controversy over the prescription of antibiotics prior to reading the strept screen. In this sense he showed concern not to expose Sheila unnecessarily to the risks of antibiotics as well as over the delay in treatment if he had waited for the strept screen. He had also given Sheila some "control" over her health care by giving her the responsibility to call about the screen and either to stop taking the antibiotics or to fill a prescription which she already had in her possession. At that point, Sheila had as easy an access to the antibiotics as if they were over-the-counter medication.

What if the physician had given Sheila the entire

ten day prescription either to be started immediately (treatment A) or to be held until the screen had been read (treatment D)? If he was concerned to avoid the continuation of the treatment if the screen was positive, treatment B, which includes a screen and cessation of the regimen if the screen was negative, could have been used. In treatment C, the only difference was the inconvenience of a return trip to the pharmacy if the screen was positive (under treatment C). Treatment B had the disadvantage of added cost of six to eight days' worth of unneeded medication if the screen is negative. Sheila was not asked whether she would prefer the extra cost or the extra trip. It is at least arguable that Sheila might have found treatment A or B preferable to treatment C.

Treatments D and E would have Sheila wait until the screen is read before taking the antibiotic. These alternatives eliminate any unneeded trips to the pharmacy as well as any unnecessary cost. They also would have avoided unnecessary treatment and its attendant medical risks (and the potential benefits). While these are medical factors, they are also controversial within the profession and it is possible that Sheila had a strong preference for one set of risks and benefits. For example, it may be that Sheila had a recurring problem with yeast infections which the suppression of normal bacteria by antibiotics would exacerbate. It is reasonable to think that this might make

some difference to the determination of which treatment Sheila would have chosen. It might have been her preference, for good reasons, to avoid antibiotics unless they were known to be needed in order to recover her health. The only difference between treatments D and E was the time at which Sheila is given the prescription. The physician had already demonstrated a willingness to dispense a possibly unneeded prescription, and this was certainly a more convenient treatment for Sheila. Consequently, treatment E seems to have been the more viable and practical alternative which Sheila might have chosen better over treatment D or C.

So treatment B and treatment E are arguably better than the treatment C which was selected by the physician. Of course actual determination of what Sheila would prefer cannot be made without consulting her. Furthermore, the physician might not have agreed with Sheila's estimation of her interests. On the other hand, he might have agreed or Sheila might have been so determined as to seek other health care. This interaction, the physician's first exposure to Sheila, had no reference to Sheila's practical and medical preferences. Nor did Sheila inquire whether there were more convenient ways, or less expensive, than the option that was given by the physician. Sheila was asked whether she was allergic to the drug, and responded that she was not. Beyond this, she was not consulted about any of the medical

risks and potential benefits of treating before or after the screen was read.

In Maria's case, the physician chose a treatment plan that shows concern for fetal health which results in a compromise in pain medication for Maria. Any of the other three treatment options suggested in Table II appear to have been more practically and medically sound. This is not to suggest that the treatment chosen is disastrous or medically inadequate. It is quite possible that Maria received adequate pain relief from the over-the-counter medication. On the other hand, it may be that she had been using such medications without success and came to get something stronger. The protection which the physician gave the fetus seems ineffective since Maria planned to abort and had a history of being able to carry through with such plans. With this consideration in mind, it seems that the physician would have best served Maria's interests by giving her the sample medication he brought into the room to dispense (Treatment A). This would have saved her the expense and inconvenience of buying another prescription or over-the-counter medication.

The moral value of the fetus is a controversial issue. It is also one about which this physician had very strong convictions. It may be that he simply could not countenance any involvement with threatening fetal well-being. As a moral agent, not simply a technician (cf.,

Veatch, 1972, 1978), his conviction should not be disregarded, requiring the physician to act against his moral conscience. Treatments C and D provide alternatives that would not involve the physician with an action that would pose a threat to fetal health.

Treatment C provides an alternative that resulted in no threat to the fetus but provides stronger pain medication for Maria. It had the disadvantage over treatment A of costing more than a free sample and of requiring that Maria go to a pharmacy to purchase the medication. It would, however, avoid involving the physician in what he might consider an immoral act and provides Maria with stronger pain medication which may allow her to continue at work and not suffer a loss of income.

Treatment D is a referral to a physician who does not share this resident's moral conviction. It is possible that the resident will still consider this to be personal involvement, albeit indirect, with an immoral action. This alone may make treatment C more desirable to the resident. Assuming that the referral could have been to another physician in the clinic at the moment, this treatment would have had the same advantages as A. These are clearly the ones which are most to Maria's advantage, saving her the cost and trip to the pharmacy and giving her the stronger pain medication.

Maria's preferences regarding the factors which

were material to the treatment decision were not sought. The physician double-checked to make sure she is considering an abortion, and that she would not be paid for any time she needed to take off. These facts notwithstanding, ne chose the least effective treatment which might well have had the greatest disadvantages. Maria accepted the treatment decision wintout any requests for clarification or options.

In Vicki's case, the physician agreed to remove Vicki's moles. Considering the options listed in Table III the decision to fulfill Vicki's request seemed to be the least advantageous and the one with the highest degree of risk and fewest potential benefits (Treatment A). Vicki seemed to be most concerned with expense and least concerned with the medical risks of disfigurement. The physicians seemed to accept Vicki's assessment of the financial concern as accurate and as outweighing the medical risks over which they had expressed concern. Two of the treatment alternatives seemed implied in the concerns expressed by the physicians. Treatment B, removal of a less conspicuous mole first was actually suggested by the resident, never to enter into the discussion again. Treatment D, referral to a dermatologist (or a plastic surgeon), was expressed as the usual practice. It may be that treatment C, which implied that Vicki might go to the more specialized physician for the facial mole, is implicitly acknowledged as an option in

the physicians' expressions of concern over the facial mole in particular.

The treatment chosen was not medically disastrous, though it did present the poorest sum of medical and practical advantages and disadvantages. Vicki had chosen this treatment, if her request is taken at face value. It was, however, based on information about costs that did not seem accurate. The physicians did not seem to share Vicki's lack of concern over scarring, but certainly they were aware of her attitude. The only discussion of the inconvenience of return visits closed with the physician estimating that he could do about half a dozen at one time. There was no discussion of the fact that the physician was a resident, therefore, less experienced than would have been a more experienced physician. With the reference to "older" rather than "staff" doctor, Vicki certainly was not offered any clarification on this issue. The "less than desirable" quality of available equipment only arose in the process of the actual facial surgery, so it was not a part of either the physicians' agreement to do the surgery, nor part of Vicki's request. It is reasonable to suggest that the treatment actually given (A), when compared to the alternatives, was not the one most serving of the relevant medical and practical issues even though Vicki requested it. She was consulted about the option of referral, but her possibly inaccurate cost evaluation and rejection was not

challenged. Many of the factors which made this a treatment less serving of the patient's concerns were not part of the explicit discussion nor among the ascribable presuppositions. The treatment chosen did eventually fulfill Vicki's request, though the physicians did not check to ascertain her agreement to accept the particular risks and disadvantages which were immediately apparent or arose as the surgery was proceeding.

All three women received treatment that met their medical needs. They also received treatments whose alternatives either possibly or actually were better serving of their and their caregivers' concerns. Sheila was asked if she was allergic to medication. Beyond that question, she was not informed of the reasons for the treatment decision, nor asked for her preference regarding a controversial medical choice or non-medical convenience and cost factors. Maria was asked whether she would get paid time off work and had indicated that she intended to get an abortion. The treatment decision was one which conflicted with serving her concern about work and respecting her intent to abort. She was told that the sample of medication that the physician contemplated giving her was contraindicated for pregnant and nursing mothers. She was not told that it was fetal health that was protected. Any of the alternatives mentioned would have been better choices if fetal health was discounted, but Maria was not asked for

her preference nor given reasons for the treatment decision. Vicki's treatment fulfilled her request though it is at least questionable whether to do so was in her interest, or whether her request was based on accurate information. She was given reasons why the usual practice was not to treat as she was requesting; malpractice insurance, risk of disfiguring and the availability of specialists who are better equipped and more experienced. She was not told why her case was treated differently, though she might reasonably have concluded that it was due to her request. As the treatment developed, it became more inconvenient for both Vicki and the physician. The physicians clearly knew that Vicki wanted treatment by them for financial reasons. They did not question the accuracy of her judgment, though they explained their hesitancy in terms of professional liability. They treated her in a manner which she might not have chosen if she were better informed. Vicki did not complain or ask for clarification when the mole removals were clearly going to be more inconvenient than she had thought and the resident had initially indicated.

In all three treatments, the women were treated without reasons given as to why the treatments were preferred by the physicians. The treatments were productive of inconvenience and costs for the women. The women did not take initiative to request such information or to suggest alternatives. The fact that the women came with complaints

which were treated in a medically adequate manner, together with the interactional observation that they did not express hesitancy to follow the treatment, may be taken to imply consent. The absence of information about the treatment decision and alternatives is a good reason to question whether the consent was informed. Another approach would be to argue that the consent to this sort of routine treatment is consent to medical paternalism for routine treatments of minor ailments. Rather than moving into this normative analysis at this point, I will ask two different questions in continuation of the social analysis:

1. Why did the women passively accept the treatment decisions?

2. How did the physicians make the treatment decisions without inquiring into the patients' preferences?

The Doctor-Patient Relationship

Note that as this social analysis progresses, the questions and issues under consideration are more abstract or general. The issues of what patients were told and how they were treated are answered with direct reference to the content of the interactions. Though this part of the analysis takes a particular perspective on the interaction in the sense of being directed by the type of questions asked and the analytic goals, the questions are raised by an attempt to understand the communication and action in the

interaction. Consideration of the consequences of the treatments and their alternatives is a little further removed from the interaction. Though these discussions are directed by the information gleaned from the interaction, the consequences and alternatives are drawn from a broader understanding of the patients' and physicians' social world which we may reasonably ascribe to the interactional context as presupposed.

Our ability to understand the interactions and the consequences and alternatives to the treatments is an implicit understanding of the "grounding" of these isolated interactions in the larger social world of the participants, which we share. The analysis is an explicit discussion of this implicit understanding. But it is also an explicit discussion of elements of our lived-in social world. These elements are, as was discussed in Chapter II, part of our methodology. Explicit discussion and conceptualization of these elements gives them a sense of concreteness that they do not have in our communicational activities. The description of how the presuppositions play a role in the interactions make them sound like necessary and sufficient conditions or causal explanations. But there is not any necessity intended in this analysis. Rather, this analysis is a depiction of a shared social world; more a literary-sociological than a scientific-normological account. As such, it can of course be questioned, but the challenger

must provide an alternative account of the interaction which situates the behavior in the larger social world which we share with the patients and physicians.

This is not a different sense from Glaser's (Glaser and Strauss, 1967) use of "grounded" in "grounded theory." Glaser uses the term to refer to the use of background readings in the relevant sociological literature as preparation for observation. As was briefly mentioned in Chapter II (page 76), the issues and conceptualizations gained from this familiarity with the literature serve as "sensitizing concepts" which can be checked and confirmed or reflected as the observer gathers data and engages in analysis of the information. This literature provides characterizations of social patterns and more abstract theories of social structures and behaviors. As such they are more or less accurate (or inaccurate) depictions of what is observed in the interactions. They are open to rejection or modification to increase their ability to show how the concrete interactional behavior reflects and validates the social norms, institutions and social structure of society. These latter entities are not "found" in the social world, but are descriptions of how layers of habits, practices and communication shape the concrete interactions under consideration. The only "reality" which these descriptions have is that of being represented in the concrete interactions between members of the social world. They do

not "exist" independent of these manifestations. As characterizations they are expressions of how people have come to interact. As generalizations or theories, they typify rather than present deterministic causal pictures.

All three interactions are communications between patients and physicians in a particular setting. They have been chosen as typifications of a pattern of behaviour observed in the interactions recorded. The first focus of the analysis was to describe the patients' lack of input into the decision-making process. Discussion of the alternative treatments and the consequences of each were to establish that the context is one within which it is advisable for the patients to be involved in the decisions and to ask questions in order to decide on the most effective and practical treatment. The following discussion attempts to account for the lack of participation of the patients. These are of interest because the interactions are being examined for the normative purpose of evaluating the quality of the consent in such routine care.

The interactions have been typified as doctor-patient communication. This is recognition of the physical location of the interaction in a medical setting and of the "goal" of the exchange as the dispensing of medical care. The analysis now focuses on describing the social context in a manner that makes understandable the women's passive

acceptance of the treatment decisions and the particular treatments which the physicians chose.

The women asked no questions and the physicians did not seem to think this strange. This is a typical pattern in recordings of physician-patient interactions. Fisher (1979, 1982, 1983, 1986) has characterized the social presupposition behind this pattern as a reciprocal belief that "doctor knows best and is acting in the patient's best interest." Others have suggested that the passive acceptance of this authority of the medical role is descriptive of most physician-patient encounters (Scully, 1980; Fisher, 1979, 1982, 1983, 1986; Todd, 1982, 1983; Fisher and Todd, 1983; Shuy, 1983; Ehrenreich and English, 1978; Rothman, 1982; Starr, 1982; Waitzkin, 1983). These various accounts are based on empirical, historical and theoretical evidence.

It is fruitful to unpack what is implicit in Fisher's characterization. "Doctor knows best" implies an asymmetry of knowledge, with the physician knowing much more about health care, treatments and consequences. Physicians are trained for years and patients are quite aware of that fact. There has also been a significant increase in the effectiveness of medical treatment over the last century, which has added to the cultural authority of the medical profession (Starr, 1982: 3-21). The trust implied in the second part of the characterization " . . . and is acting in

the patient's best interest" shows the widespread acceptance of this knowledge and the trust that patients have come to have in the medical care dispensed by physicians in medical institutions (cf., Friedson, 1970b). It may also be that the assumption includes the expectation that the physician will also take care of the patient's general health by providing medically adequate care (Fisher and Groce, forthcoming). This is why it makes sense to speak of "agendas" which depict why the patient really came to the clinic. If, for example, we heard Maria complaining that the physician did not give her information on the abortion or birth control, her disappointment would be understandable. Physicians are expected to address all health issues that are mentioned in the interview.

The patients in the three interactions are not told the reasons for the physicians' choice of treatment. They do not seem to take exception to this lack of explanation. If they are seen to operate from within a context which presupposes the view that doctor knows best and is acting in their interest, this becomes quite reasonable. The physicians do not expect otherwise, and this is also reasonable from the perspective of the reciprocal assumption (Fisher), or presupposition-ascription (Coulter, 1979). If the patients recognize personal inconvenience, they may assume that the treatment suggested simply inevitably entails such inconvenience for medical reasons or be

unwilling to break with the practice of minimizing demands on physicians' time. Not knowing the reasons for, or alternatives to, the treatment chosen, they may assume that there must be good medical reasons. It is the presupposition of physicians' expertise and authority which makes such an assumption reasonable. If patients assume that the particular treatment plan is unambiguously in their medical interest, then there is little reason for them to consider whether there are less inconvenient or more effective treatments. Nor is there any reason to assume that other factors besides their interests might influence the physician's choice of treatment. The patient simply does not have the knowledge necessary to ask questions about alternatives and consequences of treatments (Friedson, 1970a).

Starr (1982) has discussed in great detail the development of the cultural authority of the medical profession in America (cf., Stevens, 1971). Starr describes how this authority is social in that physicians regulate behavior through medical definitions which only they have the "expertise" to make, classifying the problem as one which is appropriately treated under the medical model.

But prior to making any recommendations, physicians have to define and evaluate their patients' condition. Patients consult physicians not just for advice, but first of all to find out whether they are "really" sick and what their symptoms mean. "What have I got, doc?" they ask. "Is it serious?" Cultural authority, in this context, is

antecedent to action. The authority to interpret signs and symptoms, to diagnose health or illness, to name diseases, and to offer prognoses is the foundation of any social authority the physician can assume. By shaping the patients' understanding of their own experience, physicians create the conditions under which their advice seems appropriate. (Starr, 1982: 14)

The patients sought medical advice in a culture where the cultural authority of the medical profession is strong. They passively accepted the treatments prescribed within the traditional medical setting where the physicians' cultural authority is strongest. The treatments were for problems which the physicians labelled for the patients, or confirmed that they were appropriate problems for medical care.

Sheila is told "you may have a little strept throat" and that the physician is going to start her on antibiotics before reading the strept screen. If the screen is negative, she "won't have to take a full course of antibiotics but . . . [if] it's strept well we'll have you go ahead and take a course." Sheila has come to the physician with a sore throat and he has defined it as potential strept infection. The discussion is ambiguous enough that Sheila may not realize from it that the antibiotic's effectiveness is expected to be conditional upon her having this infection, which can only be determined through the culture. Nevertheless, there does seem to be enough evidence present to make it reasonable to wonder why she did not ask if the purchase of pencillin could wait

until the screen was read. Moments later, when the physician writes two prescriptions to be filled at different times if necessary, Sheila still does not ask why this is necessary or if there is another more convenient procedure. To most of us, this may not seem exceptional. Both Sheila's lack of concern and our acceptance of it as "normal" is reasonable in light of the cultural authority of the physician and the reciprocal assumption that physicians are best placed to decide our medical interests. Or, alternatively, we may consider such concerns too trivial to raise, based on the conception of the physician as being "too busy."

Maria's physician enters the examination room with pain medication in hand, asks if she will get paid for time off, and expresses doubt over her abortion; "Well, I'm real hesitant about medication. . . . You're not sure, even though, you know, you think you may want to have an abortion." Maria confirms that she will definitely pursue an abortion, but does not ask why her abortion is relevant to the contraindication of the pain medication, or if there are any other medications that would not be contraindicated. The assumption that the physician is looking after her medical concerns makes this a reasonable omission. Were her employer laying her off after expressing doubt about her abortion, she might be more argumentative. The cultural authority of the physician together with the assumption of

taking care of her medical interests describes a social context in which this feature of the interaction is not exceptional.

Vicki is told that the physician can remove half a dozen moles at one time. She is also told that he might do a less conspicuous one first to make sure they are both comfortable with his performance. But she does not ask any questions when he prepares to remove the mole on her face, nor when he sends the nurse to look for better equipment. When he completes the removal of the facial mole and expresses a preference to do the rest later, Vicki asks "Why is that?" He says that they have already gone over time and she simply accepts that as a reason. We might ask what time limits he was referring to or why he does not honor his claim earlier that he could do six at a time. Vicki, however, does not ask. She continues in the apparent trust that she had on entering the clinic and maintained even with the resident's and staff physician's expressions of hesitancy to remove her facial mole. While it may appear that Vicki negotiated for her treatment, the very willingness to trust a family practice resident, or physician, to do the removal reflects once again the cultural authority and patient's faith in the good will and expertise of the physician.

All three patients have not sought clarification of reasons or alternatives to treatment decisions which

presented them with some degree of inconvenience and expense. This common interactional pattern was seen throughout many of the recorded interactions. It is a reasonable omission within a social context of the cultural authority of the physician and the shared assumption that the physician is well qualified to take care of the patient's medical interests. Earlier consideration of the alternative treatments cast some doubt on whether the physicians in fact selected the treatment which most conveniently or practically served patients' interests. It may even be true that the best medical care, as opposed to adequate medical care, may not have been provided. Having briefly characterized the social context which makes reasonable the patients' behavior, we now turn to consider the social context within which the physicians made their treatment decisions. Once again, there is not any causal analysis intended. Rather the description of social factors present in medical practice and the larger social context will be explored to see if they make more reasonable the treatment decisions.

The Social Context of Medical Practice

Starting at the interactional level of analysis, there are several factors which make reasonable the physicians' treatment decisions. Most obviously, the patient's presenting complaints and relevant medical factors

influence physicians' treatment decisions. All three patients received medical care that probably fit well within community standards and which they would stand a good chance of receiving if they went to another medical office, or to a different physician. Sheila presented with a sore throat and apparently had clinical signs of strept infection. Antibiotics would be effective for treating strept, so the physician set out to verify whether or not it was a strept infection and treated Sheila in manner that would most likely be effective if it was. He also asked Sheila if she was allergic to penicillin. Presumably he would have dispensed a different antibiotic if she had turned out to be allergic to the penicillin.

Maria's leg pain and pregnancy were among the formative interactional factors which shaped the treatment decision. The physician first had the leg x-rayed to check for a fracture. He then deliberated over dispensing a sample pain medication, deciding against it because Maria was pregnant. He checked to see if she would be paid sick leave, likely either to see if he should write a letter to her employer and/or as part of his deliberations over the medication.

Vicki requested that the physician remove her moles, including the facial mole. The physician's treatment was removal of the facial mole. Clearly he was guided by Vicki's request. He checked to see if she would rather go

to a specialist, accepting her economic reason for settling for his treatment. After explaining that he could do a mole removal from "another location" besides Vicki's face, Vicki says, "But it's like (unintelligible) I would not be ashamed to have a scar." The resident removes Vicki's facial mole. It seem reasonable to assume that Vicke's assurance had some affect on this decision.

So there are interactional factors which help to produce the treatment outcomes. Predominant are the presenting complaints, allergies and conditions which are contraindications for particular treatments. Of course, the patients have already conceptualized their problems as medical problems and present themselves to the physicians to be treated. Their complaints are ones which are seen as routine medical problems within the larger social context. It would be unusual for any of them to go to a non-medical person for treatment of these problems. Thus the interactional influence of the presenting complaints and contraindicating conditions are defined as legitimate medical complaints prior to the patients' presenting to the clinic. Even this interactional factor reflects a broader cultural acceptance of the authority of the medical profession over these aspects of peoples' lives.

These interactional factors do not explain, or even make reasonable the particular choice that the physicians made. Since they did not consult with the patients about

their preferences, and the alternatives are reasonable, there may be other factors which make the behavior more understandable. This particular family practice unit contains social or medical factors which influence the treatment decisions. For example, the particular drug that the physician considered dispensing to Maria may have been influenced by the availability of samples in the clinic. Perhaps this was the only available pain medication. That might make it more reasonable that he would consider giving a drug which he shortly thereafter decides is contraindicated.

Vicki's medical risks are increased by the shortage of medical tools for the mole removal. This is a factor which does not become apparent until the resident has already started the removal. It might typically dictate against the removal until the proper equipment is available. In this case, however, the late discovery of the fact does not seem to influence the decision to treat, though it affects the risks entailed.

Sheila's case does not seem to have any influences unique to this particular setting. Her treatment does not involve any free samples nor any unique equipment. She does have a throat culture done, but there is good reason to think that this would have been the case regardless of the medical setting; even if she needed to go to an independent laboratory. As a matter of fact, suspected strept infected

throats are fairly routinely treated with a screen and immediate initiation of antibiotics (Lasagna, 1980: 233). This pattern of medical practice may well have influenced the treatment decision in Sheila's case. But why would this routine practice form when there is controversy over the use of antibiotics before they are known to be needed? This question shifts the focus of our discussion to the formation of professional practices and the influences other social contextual factors might have on them.

Are there any advantages to the chosen treatment options for the physicians? Therapeutic medical interactions are typically presented as free from conflict with patients' interests: What is in patients' interest is in the physician's, since the physician's reputation and the patient's continued trust in the physician are both said to depend on the effectiveness of the treatment. The physician's good will is also sometimes used to buttress this position. The physician has trained long years to be able to treat the patient and spends most of his waking hours doing just this. There seems to be little reason for the patients to suspect that the physician has anything but patients' interests at heart.

Somewhere between benevolence and maliciousness there exists a more realistic state of disinterested concern. The delivery of medical care is, among other things, a job for physicians with the mundane aspects and

recurring tasks of most jobs. It is reasonable to assume that routine treatments and procedures become automatic responses to certain presenting complaints and clinical signs. Routinization carries with it the advantages for the physician of minimizing the deliberation required for the most frequently occurring routine complaints. This economy of attention may result in the physician not noticing some medically relevant fact unique to the patient. The routinization of behavior always occurs in a complex social context with a constellation of influences, only one of which is concern for patients' medical interests. In order to understand the treatment decisions made by the physicians, the content of the treatment decisions require careful attention.

Sheila

Since a sicker patient is more difficult to treat, it seems that the therapeutic goal of preventing complications and treating as soon as possible could not provide a conflict of interests. In this manner, it may be argued that the immediate treatment of Sheila with antibiotics served both her physician's and her interests. She will likely recover earlier and he will not have a more difficult medical problem to deal with, such as a spread of the infection, fever, or a more distressed patient. But Sheila's immediate treatment may also be seen

as an instance of a wider professional tendency to initiate antibiotic treatment prior to testing for specific appropriateness of the drug. The ordering of the screen even though treatment has begun may also be an instance of the profession's heavy emphasis on diagnostic testing. The information about the prescription of antibiotics dispensed by pharmaceutical companies and duplicated in the Physician's Desk Reference is heavily regulated by the Food and Drug Administration. This literature recommends that antibiotics only be given after the presence of the particular bacteria and its sensitivity to the drug has been verified (Physician's Desk Reference, 1979: 1874). This precaution is designed to avoid the sort of side effects that have been noted.

Though far from universal, there does exist a pattern of practice within the profession which does not follow this recommendation (Lasagna, 1980). The possibility that Sheila might have particular objections to this practice, perhaps due to a predisposition to yeast infections, has already been discussed. The issue here is not the formation of the particular treatment decision, but of a professional practice which is reflected by Sheila's treatment. There are less obvious advantages to this pattern of prescription practice whose pursuit may not be the goals of any particular interaction. This routine

practice is formed within a larger social context whose elements aid in understanding the formation of the practice.

One of the concerns regarding treatment with antibiotics is patient compliance. Patients may not fill a prescription immediately, resulting in a delay in initiating the treatment. Further, they may cease the regimen prematurely because they are feeling better. Dispensing the antibiotic prescription to be filled immediately stands a better chance of getting the patient onto medication earlier. If the patient waits for two days, calls to see if the prescription is needed, and then fills the prescription, there is a better chance of further delay before the regimen is begun. The medical authority of the physician is most obvious and influential in the context of a medical encounter, so the immediate prescription may be more likely to be filled without delay than would be the case if it was contingent on hearing over the phone from the doctor or a nurse that the screen was positive. This recommends the immediate prescription of antibiotics, whether due to explicit professional observation or a habit formed-in-practice. Note too that if the physician had given Sheila two- and eight-day prescriptions, that there could have been a delay in filling the second prescription. As it happened, the regimen prescribed gives Sheila three days to fill the second prescription if the screen is positive.

The medical profession has also come under public

criticism for not treating patients' presenting complaints. In reaction to this criticism, it is at least possible that there is a predisposition to treat when in doubt and the side effects of treatment are unlikely or minor. In this manner, the public have pressured the medical profession to treat them with drugs where such treatment may not be needed, with serious risks (cf., Silverman and Lee, 1974: xiv).

Silverman and Lee (1974) have written a critical assessment of the current situation of drug use, describing the role of pharmaceutical companies in promoting the use of drugs. Notwithstanding the tremendous benefits that have come about through pharmaceutical research and marketing, typically at the initial expense of the pharmaceutical companies, the advertising campaigns and inter-relations among medical professional organizations and pharmaceutical companies reasonably cast suspicion on the effects such practices have on patient care. Much of the drug trials on efficacy, proper prescribing practices and dosages are formed as a result of pharmaceutical industry sponsored research and promotion. As the struggle for patents and control of market is fought by the companies, the proliferation of brand names and modifications make it quite difficult for the practicing physician to keep up with new innovations. This combines with other factors of medical practice, such as severe restriction of time for reading, to

create a situation where the physician is dependent on the pharmaceutical companies' literature and representatives for information. Combined with the industry's considerable support of the profession's journals, conferences and clinical research, such factors foster a (perhaps inappropriate) degree of trust and dependence of the profession on the industry. The current situation is one of widespread overuse of medication, notably antimicrobials (Silverman and Lee, 1974: 282-292). The ability of individual practitioners to make appropriate therapeutic recommendations in such a confusing social context has not gone unchallenged (U.S. DHEW Task Force on Prescription Drugs, Final Report, 1969: 22). As early as 1968, AMA president Dwight Wilbur thought this situation serious enough to comment that medical students should be educated to consult pharmacologic experts rather than the advertising of pharmaceutical manufacturers (Wilbur, 1968).

Note that such an analysis is a direct criticism of the defense that a medical treatment is acceptable if it is in keeping with the community standard of practice. Since professional prescribing practices are formed in a context which casts doubt on whether the routines are in patients' medical interests, this appeal carries no weight. It is in fact an appeal to misplaced authority. The research and actual authority behind some prescribing practices is that of the pharmaceutical companies. But it is clearly in their

interest to form practices which sell their products and establish promise of future profits. So the routine prescription of antibiotics prior to reading the screen is not justified by an appeal to profession-wide practice, since the context within which such practices are formed contain significant conflicts of interest with that of patients. The treatment that Sheila received, immediate prescription of antibiotics, may have been influenced by the physician's concerns about medical factors. But the particular responses in the form of routine practices may also have indirectly been shaped by research and marketing practices of those with major concern for such market values as sales and capturing a market. This is a fact that patients could reasonably want to know about, or perhaps should know about. Yet it is not obvious what a patient could do with such information.

This latter fact is further elaborated by considering what Eliot Freidson has described as professional dominance (Freidson, 1970a). Freidson has described the profession's ability to regulate the practice of its members as uniquely well established by the medical profession. Once a practice is well established in the profession, the profession's authority within a culture is strong enough to prevent any other group from having sufficient authority to challenge the practice. This cultural authority has historically been fought for by the

profession (Starr, 1982; Stevens, 1971). It also has ideological force, as Howard Waitzkin (1983) has discussed at length, which is derived in part from scientific ideology (Waitzkin, 1983: 140-143; Habermas, 1971). The cultural authority of the profession is based on its ability to claim that its expertise uniquely qualifies its members to judge patients' medical interests and how they are best served. This is also extended to include the claim that they ought to be able to control the form that their practice will take; whether fee-for-service, socialized, group practice, etc., (Freidson, 1970a: 91-100). This claim is buttressed by the appeal to a scientific basis for medical treatment. Such a claim is based on the idea that scientific issues and methods are objective and value-free, consequently above any political or personal bias. As Habermas has argued of scientific ideology that it is expansionistic in its definition of problems which are amenable to scientific solutions (Habermas, 1971: 83-84), so Waitzkin argues that scientific medicine, using scientific ideology as its legitimating device, "medicalizes" social and other non-medical problems (Waitzkin, 1983: 142). This is a manifestation of the cultural authority of the medical profession which makes it quite effective as an enforcer of social norms since the profession is not as accountable to the public as are other institutions (Freidson, 1970a: 205-301). The cultural authority is also the basis for the

interactional asymmetry that has been discussed earlier. In the interaction, the cultural authority tends to prevent patients from questioning physicians' judgments and recommendations. Even those factors which are not obviously medical are considered to be within the purveyance of physicians' authority. But this medicalization of non-medical needs is a reflection of the larger cultural pattern of defining more problems as solvable through technology, a process which serves to legitimate and reinforce current patterns of technological rather than personal or political change. In turn, this furthers the interests of the "advantaged" in society who own and profit from technology as well as from maintenance of the current socio-economic systems. Technological responses also depoliticize the social difficulties of the disadvantaged. This social-control function of the medicalization of social distress and removal from patients' control of controversial medical judgments is neither the design nor intent of the medical professionals. As Waitzkin comments:

Social control in medicine is often an unintended process, dimly perceived by the participants in doctor-patient encounters. With the holistic purpose of caring for the totality of a client's needs, health professionals assume control over wide facets of social and personal life. (Waitzkin, 1983: 142)

So the choice to treat before reading the screen is typical of a professional practice, but this alone does not

justify, though it does help to explain, the physician's presuming to make the decision for Sheila. The two-part prescription is not in anyway medically necessary. It is accepted by Sheila as part of the medical treatment of her illness without challenging the inconvenience. This is a concrete instance of the extension of medical authority to factors of treatment which are not medical, and a consequent extension of medical authority into the patient's life activities.

It is reasonable to assume that the resident's choice of treatment for Sheila was motivated by a concern to meet her needs. Considering what those medical needs were-- a sore throat with the possibility that it is due to a strept infection--there are several treatment regimens that are reasonable alternatives. The resident's choice among the alternatives is not strictly determined by Sheila's presenting complaints nor by universal medical practice. The choice to treat Sheila with antibiotics prior to reading the screen is a common but controversial practice within the medical profession. It may well be a means of reducing the risks that Sheila will bear due to the immediate initiation of the treatment. But since Sheila is not aware of the controversy surrounding antibiotic treatment prior to reading the screen, this concern over the unintended and undesirable effects of the drug does not raise any questions. Both of these common practices in medicine are

formed as routines within a context which presents factors that are either potential or actual conflicts with patients' medical and practical concerns. As a reflection of routine practices, Sheila's treatment has indirectly been influenced by these factors.

The decision was not simply a reflection of these routine practices. It was a decision to combine two alternatives; immediate treatment and avoidance of unnecessary treatment. In case the strept screen is negative, the resident has divided Sheila's prescription into two five day prescriptions, saving her the expense of the second one if the screen is negative. This may also have the medical benefit of assuring that Sheila calls to check the screen before taking the full ten days' worth. As such, this represents a direct decision to regulate a non-medical aspect of Sheila's life; time and money. But this is an expected consequence of medical treatment, as is illustrated by the fact that Sheila does not ask for explanation of the odd prescription's rationale, or for alternatives. The choices involved in the treatment decision include the exposure of Sheila to the side effects of antibiotic treatment whose need is yet to be established, the running of the strept screen to verify need, the possible saving of money for the second half of the prescription and the inconvenience of an extra trip if the second half is needed. Sheila accepts the treatment which

includes these risks, benefits and inconveniences without comment (other than seeking clarification of the confusing directions). At no point is consent explicitly sought, nor are these consequences of treatment, or their alternatives, ever discussed, although Sheila may refuse treatment by not filling the prescription or taking the pills.

Maria

It also appears that there is no apparent conflict of interests for Maria and her physician. The physician's continued reputation and accumulation of patients depends on his treating his patients to their satisfaction. If Maria is dissatisfied with her treatment by him, she could go to another physician for this or future problems. Of course, it would only make sense for Maria to go to the extra inconvenience and possible expense of getting another opinion on her leg pain if she thinks that she is likely to get more satisfactory treatment.

As has been discussed, it may well be the case that Maria would have received pain relief medication from another physician. And she may not be pleased that she can only get whatever relief from her pain that acetaminophen offers. The resident's religious convictions seem to be a key factor in the treatment decision. The lack of expression of these convictions which direct Maria's treatment, Maria's unquestioning acceptance of his

withholding of the medication, and the failure of the medical context to guarantee Maria the care she desires and avoid conflicts of value are all factors which deserve attention.

There are interactional cues as to why the interaction does not serve Maria's interests nor that of her physician (i.e., assuring the physician of her future return and promoting his reputation as a competent physician). These cues will lead to a consideration of the particular institutional context. Note the close of the interview:

- P. Same to you. I'll come back whenever I need to see a doctor cause I'll never have a doctor here.
- D. Hopefully 24-year-old ladies don't need many doctors.
- P. Yeah, okay. Thanks a lot, bye bye.

What is not apparent from the interactional script as presented earlier is the tone of the interaction. The resident, and a medical student accompanying him, were clearly quite entertained by this woman who was so different from most they encountered in this setting. The detail with which they pursued how she injured her leg was not required for medical diagnosis or treatment. When Maria comments that if she does not have a period she should "start praying hard and heavy" this conservative protestant physician responds by suggesting that she could also go to Mass "two or three times a day." This is a clear recognition of the cultural difference between himself and the patient. The

above quoted close of the interview suggests that he is not anxious to deal with Maria again. All of this suggests that the physician is not influenced by the consideration that for further income and reputation he needs to culture a certain relationship with the patient.

This "attitude of withdrawal," if it can be so characterized, is subtly expressed throughout the interview. The only time that the resident suggests that Maria ought to get back in touch with him is if the pain in the leg persists. When talking about the pregnancy test, he suggests that she should "come back in" with no personal reference (i.e., rather than "come back to see me"). When Maria had asked about abortions, he simply denied knowledge of the available places, and did not offer to look further into this aspect of her medical concern. Despite his easy and casual style, it seems that the physician is uncomfortable with Maria.

Eliot Freidson has discussed how the medical profession has gained control over the conditions of their practice, as well as over the content. He has indicated that the organization of a medical practice influences the type of medical care that the patients receive. Fee-for-service organizations tend to be more patient oriented, while group practices tend to be more colleague oriented (Freidson, 1970b). The university family practice unit is organized to simulate the group practice form of

organization (cf., ethnographic description in Chapter III). Maria's physician is salaried and his income would not be affected by her failure to return to him for future medical care. Combined with Maria's request for abortion information and cultural differences which may set the physician ill at ease, it is not hard to understand why he might feel this way.

So the interactional cues give reason to construe the resident as taking full responsibility for treating Maria's leg, but less or no responsibility for her pregnancy and desire for an abortion. His knowledge of Maria's possible pregnancy influences his treatment decision for her pain relief. Though it is belied by the subtle interactional cues, an apparent concern for Maria's general health ("the medication I want to use, it's not recommended during pregnancy") combines with the physician's cultural authority to give a superficial rationale for his rejection of the pain medication for medical reasons. Without explicit expression of his religious convictions, or an awareness of the discomfort he has with Maria's previous abortions and general lifestyle, Maria has no reason to question his treatment decision. The organization of the setting has failed to establish an order within which patient and physician concerns are communicated to result in mutually accepted treatment.

The cultural authority of the medical profession

has already been discussed in connection with Sheila's case. In Maria's case this cultural authority helps to explain why the physician's convictions are able to influence the treatment decision without ever becoming an explicit part of the interaction. The cultural authority and the scientific ideology upon which medicine has established its authority make reasonable the presupposition that the physician is withholding the pain medication for medical reasons--scientifically based concerns for Maria's health. Maria does not expect an education in scientific medicine from her physician, just appropriate care. This presupposition of scientific appropriateness enables the physician to decide how to treat Maria, complete with moral judgment, affecting her everyday life in a manner that is not necessary and protecting the fetus which Maria intends to abort. This authority extends to controlling access to the pain medication, the x-ray and abortion. As a member of the medical profession, and particularly as a family practitioner, these medical concerns are controlled by the physician. His ordering the x-ray was a necessary condition of Maria receiving the x-ray and the subsequent assurance that her leg was not fractured. His denial of the pain medication leaves her with only the weaker over-the-counter medication. His denial of knowledge as to where or how to procure an abortion leaves Maria with the need to search for further medical advice.

The physician's unintended but effective role as an agent of social control is now obvious. The physician is able to prevent Maria's threatening the fetus' health by denying her access to the medication, and less effectively by denying knowledge of how to get an abortion. Thus the influence of this medical encounter extends to some degree of control over Maria's sexuality, work and leisure. The only concern that the physician explicitly raises over not treating Maria's pain is over her ability to continue to work. This may be intended by him to be a concern over her loss of income, but it is also a manifestation of the tendency to define health in terms of ability to be productively employed (Waitzkin, 1983: 141-142, 149). That this concern is the only one which appears to qualify the physician's protection of the fetus seems to be an indication of either the importance he attaches to it or his acceptance of a work-performance oriented definition of health and illness (cf., Waitzkin, 1983: 141-145, 147-161; E. Brown, 1979: 112-134).

The physician did not offer a prescription drug which would not threaten the health of the fetus. Given his concern over the fetus and Maria's ability to continue to work, it seems reasonable that he would consider this alternative. There are at least a couple of factors which might have influenced this omission, since they are common to the organization of medical practice within capitalist

societies. The first is that there may not have been any other appropriate pain medications available in the unit as free samples. The family practice unit, as in most clinics and medical offices, are stocked with samples that pharmaceutical representatives leave in an effort to get the practitioners to try new drugs or to establish a habit of using their drug over their competitors. The drug choice then is not simply a choice of effective treatment, but also a reflection of what is available due to the generosity and profit motives of pharmaceutical companies and their agents (cf., Silverman and Lee, 1974: 48-84). So the choice of drug for Maria may have been influenced by the choices of the pharmaceutical companies and what happened to be left in the unit's pharmacy.

As was the case for Sheila, there is also indirect influence. The physician could have prescribed a drug for pain relief that would not have presented a threat to the fetus. Maria may well have been willing to spend money for relief of her leg pain. In fact there might be a net gain if she spends money on a prescription that allows her to work, rather than having to take time off work until the pain eases. If the resident simply did not think of this alternative, then it seems that Maria received less than optimum care. That she did not ask for it may be evidence that she assumed that if there was an option, he would have

thought of it. But there may be further contextual evidence which helps explain this event.

First, Maria has asked for an abortion where she will not have to pay prior to receiving the service. She works as a cook at a truck stop where she will not be paid sick time. The resident may perceive Maria's economic status as one which is quite precarious. Perhaps he initially brought the medication in as an effort to save Maria the expense of a prescription. It may even be that he considered setting aside his concern for the fetus, though he did not in fact do so. Yet the economic factor is not explicitly discussed in the interaction. Consequently, Maria's financial status, if it influences his decision, serves to limit her treatment options without ever being communicated to her or allowing her to express her opinion. That this is unchallenged by Maria is partially explained by cultural authority, including control of access to prescription drugs. If Maria had been a wealthier client, it may be that she would have received a prescription for pain relief.

This practice may be an instance of the pattern noted by many critical medical sociologists. Conrad and Kern (1981) argue that the poor need more medical attention and have less access to it than do higher socio-economic classes whose need is less. In the analysis of a doctor-patient interview, Waitzkin has discussed how physicians

may use their discretion regarding whether and how financial concerns may affect treatment, and this in turn may affect patients' leisure and work activities (Waitzkin, 1983: 163). These interactional patterns reflect what has been characterized as a "two-class system" of health care--one for the poor and one for the wealthier (Waitzkin and Waterman, 1974: 66-67); Ehrenreich and Ehrenreich, 1970; Fisher, 1979, Navarro, 1973). While some analysts are critical primarily of the organization of the health care delivery system (Waitzkin and Waterman, 1974; Ehrenreich and Ehrenreich, 1970; Navarro, 1973), others include the interactional element in their critique. So the institutional context (Fisher, 1979, 1983; Cicourel, 1983; Robillard, White and Maretzki, 1983) combines with the cultural authority of the physician to make more understandable the resident's behaviour and Maria's acceptance. Through the probably well-meaning actions of a resident trying to be sensitive to a patient's financial status, the two-class system of health care is reflected. Rather than asking if Maria would prefer a sample, a prescription, or to take less expensive analgesic, the physician simply acts in a manner that decides the issue in Maria's behalf without her even being aware that there was any option.

Second, Maria is a woman whose pain may be interpreted as being less serious than it is. There is some

controversy over the actual extent of sexist practices in the delivery of medical care (Verbrugge and Steiner, 1981; McCranie, Horowitz and Martin, 1978; Verbrugge, 1980; Cooperstock, 1978). Some hold that physicians do have presumptions about women patients which affects their health care (Armitage, Schneiderman and Bass, 1979; Wallen, Waitzkin and Stoekle, 1979; Milliren, 1977). Others maintain that the sex roles and attitudes are either irrelevant (Verbrugge, 1980; McCranie, Horowitz and Martin, 1978) or insufficient factors to explain differences in diagnosis and treatment of illness (Bernstein and Kane, 1981; Cooperstock, 1978; Verbrugge and Steiner, 1981). Nevertheless, there is some indication of a pattern of differential treatment of women due to conceptions of their "proper" role and of their responses to pain and emotional problems (cf., Waitzkin, 1983: 161; Fisher, 1979, 1983; Fee, 1973). Such accounts are supported by discussions of the literature used to train physicians (Paulshock, 1976; Scully, 1980; Scully and Bart, 1973). Feminist accounts on a more theoretical and historical level also make such claims (Chesler, 1972; Daly, 1978; Gordon, 1974: 1-91; Fisher, 1979; Fisher and Todd, 1983: 9-11; Barker-Benfield, 1976; Henley and Thorn, 1975; Ehrenreich and English, 1978). Since it seems from the interaction that the one thing that almost overruled the physician's concern for fetal health was Maria's ability to work, which apparently was not

sufficient reason, it is at least plausible to think that she might have been treated with the sample drug if she were a man. Of course, if she were a man, she would not be pregnant and so that could not be considered a contraindication for the medication. But she is neither given the choice of protecting the fetus or receiving the pain medication nor is it an explicit element of the interaction that she might be over-reacting to the pain. That this may be an influence though not expressed in the interview is feasible if we consider the education of physicians as described by those who critically analyze the overt and covert messages about women (Scully and Bart, 1973; Scully, 1980). As discussed in Chapter II, many of the ascribable-presuppositions of our actions are learned not as explicit beliefs or propositions, but rather as methodological assumptions. As any of the factors which form the larger context within which these interactions occur, these posited assumptions only arise as part of an analysis of routine behavior.

A third factor may help explain the withholding of pain medication, whether in the form of a sample or a prescription. To a conservatively religious physician in the culture within which the family practice unit is found, Maria presents as a very liberal and perhaps promiscuous woman. The history of three abortions and a miscarriage, apparent non- or misuse of contraception resulting in yet

another pregnancy, living with her boyfriend, coming from California and driving a motorcycle (as opposed to being a passenger) combine to make Maria an oddity in this physician's experience. It is possible that the physician is concerned to keep from putting Maria into the position of being able to abuse the pain medication. This might serve to reinforce his conviction about protecting the fetus, or may simply affect his judgement as to whether to prescribe medication. All of the literature cited to this point supports the contention that social criteria are used in the dispensing of medical care (cf., Fisher, 1979, 1983; Todd, 1983; Fisher and Todd, 1983: 9-11; Ehrenreich and English, 1978). Once again, the implicit nature of the medical decision and the cultural authority of the physician prevent any explicit mention of these factors which Maria might then question, or seek alternative help.

Vicki

Vicki's physician, despite expressed hesitancy, the usual referral practices, a suggestion to remove a bodily mole first, insufficient time to complete the job and a lack of "desirable" tools, follows her request and removes her facial mole. There are a variety of contextual factors which make this action more reasonable. The hesitancy and the practice of referral are similar in that they are concretely expressed in the interaction and always occur

accompanied by reassurance of the resident's ability to perform. Whereas routine practices which form part of Sheila's treatment were unexpressed and yet influential, they are expressed and non-directive in Vicki's. Interactionally, both of these patterns may be manifestations of communication patterns which sociolinguistic studies have noted in medical interviews (Shuy, 1983; Fisher and Groce, forthcoming; Fisher, 1983). But such interviews are structured in a manner which serves particular functions (Fisher, 1979, 1983; Fisher and Todd, 1983, 1986). Careful examination of the organization of the setting and the profession, as well as the history of its development, reveals some of the social factors which help to direct the structuring of the interaction and the function which this structuring serves.

The first expression of hesitancy and referral practice is intertwined with reassurance of the resident's ability to perform:

- D. . . . Well, the problem is that, ah, on ah, young attractive females I don't usually take them off the face. But I can do it and probably every thing will go well, but those are best done by either a dermatologist or a plastic surgeon. But I'll be glad to do it. We can do one in another location and see how it goes, and if you feel comfortable with it and I feel comfortable with it we'll do the one on your forehead.

Note the pattern of "No, yes, no, yes, maybe." Vicki has not interrupted this piece of discourse. It is as if the

resident is struggling with his lack of confidence and desire to remove the mole for Vicki. Then he struggles with the practice of referral and his desire to do the surgery. Finally, he comes up with a compromise. The reasons for referral and the resident's hesitancy is technical expertise; but, at no point does this enter explicitly into the discussion. As noted by Waitzkin (1983: 138-159, this avoidance of providing technical information affirms medical authority and control of technical ability. This prevents the patient from actively participating in the deliberation over who is in fact best or adequately prepared to do the procedure, increasing the asymmetry of the interaction and asserting medical authority, which is based on what has been called medical ideology (Waitzkin, 1983, 157-159). As Freidson (1970b) has noted, the organization of the practice of medicine has a considerable effect on patient care. In his case, the profession's concern with issues of how to divide professional care, thus income and experience, affects the physician's deliberations on Vicki's appropriate treatment.

In the second piece of the interview, the resident raises the question of referral and expresses his hesitancy, still intertwined with assurance of his ability to perform, a pattern of "Maybe, no, maybe, yes" is manifested:

D. Okay. Uh, if it's all right with you I want to have one of our old doctors come look at this mole on your forehead and get his opinion on it. I

was telling him about it, you know, describing it and, uh, you know, as I was saying family practioners normally don't take moles off faces, faces just because of, uh, mal, you know they have to go up on your malpractice insurance and things like that, that we normally handle by people who do it all the time, however, I have removed them off peoples' faces without any problems before. It's just that we are being conservative and protecting ourselves when we do so. But I wouldn't hesitate at all to take that one off.

The physician is a third year resident who is not required to consult with staff unless he feels he needs to do so. So his talking to the staff physician is a further expression of his anxiety. It sounds as if he needs approval to do the surgery, but then he qualifies that it is not for Vicki's sake that he is hesitant, but for his own, since the primary concern discussed is malpractice insurance premiums. Of course the reason that malpractice might be increased is due to increased risk of successful suits. Minor facial surgery, such as mole removal, is actually covered by the unit's malpractice insurance. It is, of course, possible that the resident was not aware of the coverage. But the discussion of this practical concern of the physician's masks the technical point that he may not be well qualified to perform the surgery.

Historically, there has been a struggle between family practioners and surgeons over who is qualified to perform surgical procedures. As early as the turn of the century, there was an obvious need to consider how the medical profession ought to regulate specialization of

medical practice, with a significant concern being the future of general practice (Stevens, 1971: 78-97). The early 1900's saw an increase in the number of general practitioner referrals to surgeons (Stevens, 1971: 82). In 1912, Franklin Martin began campaigning for the founding of an American College of Surgeons whose primary purposes included the standardization of surgical procedures and a medical degree supplement to qualify a physician to do surgery. Despite the then influential American Medical Association's (AMA's) current policy against distinguishing marks for specialists, they were silent when the American College of Surgeons was formed in 1913 (Stevens, 1971: 87-89). As specialization developed, the general practitioner was seen as one who had stopped short of specialization; as less educated than the specialist. Physicians were first to be generalists, and then specialists. Practicing general practitioners simply had not specialized. In 1940, the general practitioners were notable in their unique position of not having any certifying machinery or even a section within the AMA. By 1947, they had an active section within the AMA and had begun working toward a mechanism for formal specialization through board examinations (Stevens, 1971: 297-305). The rise of the role of the hospital in medical practice raised further problems for the general practitioner which were partially alleviated in 1947 by the establishment of general practice residencies (Stevens,

1971: 305-310). In 1959 a final report of a widely representative committee to study general practice preparation did not include surgery, a point which raised considerable discussion (Stevens, 1971: 311). Following this report, twenty graduate training programs were set up, but because they included some surgical training, they were called general practice instead of family practice (Stevens, 1971: 312). In 1965, the American Academy of General Practice decided to promote the motion of a certifying board examination for family medicine, which was approved in 1969 (Stevens, 1971: 313). Stevens points out that the thirty years struggle to gain specialty recognition and status, based on educational equality, was a hard won battle perhaps resulting in family practitioners who were overeducated for their responsibilities;

But such a comment ignores the compelling pressures of professionalization, toward higher educational standards and peer recognition. (Stevens, 1971: 314).

The relevance of this historical development to Vicki's case is that her consulting the family practitioner for facial surgery is a borderline issue for professional boundaries. Family practitioners as professional group have fought hard to maintain the right to perform some types of surgery. They have also struggled hard to win the reputation of educational and technical equals of specialists in other areas. It is reasonable to assume that

some of these values and their strategic value have been passed onto Vicki's physician. Furthermore, the residents are evaluated on their performance in their residencies, and attention is paid to the variety and type of procedures in which they show proficiency and gain experience. All of these professional concerns are served by the choice to proceed with the removal of Vicki's facial mole. It is unlikely that the resident would proceed if he was convinced that he could not perform the procedure, but in the face of hesitancy and a borderline case which might normally be referred, it is understandable that he would choose to operate, to work through noon, to use tools which he considers less than desirable, and to come in on his day off to check on Vicki. The context of the delivery of health care within which Vicki receives her care is a complex one which provides some reason to think that there are conflicts with simply serving her interest.

There may be another factor which makes more reasonable the resident's decision to do the surgery. After his first expression of hesitancy, the patient expresses her comfort with his performing the surgery:

- P. I would not be afraid to have you do it all.
First of all I can't afford anybody else.
- D. Okay.
- P. But it's like (unintelligible) I would not be
ashamed to have a scar.
- D. Okay. Well it shouldn't leave a scar. . . .

Perhaps all that the resident heard was that Vicki

was not afraid to have him do the facial surgery. It is also possible that he accepted her financial reason. But since the financial reason is responsible for directing Vicki to the unit for the mole removal, it is influential in shaping the treatment she receives regardless of whether or not the resident was influenced by it. This is another manifestation of what was earlier discussed as a two-class system of health care which yields lower quality health care for the poorer members of the society (cf., page 212). As hospitals developed and medical care increasingly depended on hospitals, poorer communities attracted fewer physicians and investment in hospitals due to the inability to generate funds. In 1946, the Hill-Burton program attempted to redistribute the construction of hospitals and to bring the number of available hospital beds in lower-income neighborhoods up to that of middle-class neighborhoods (Starr, 1982: 347-351). Though the program seems to have been responsible for this redistribution, it failed to attract doctors to low-income states, or to lower-income regions within states (Clarke, 1980: 532-550; Rushing, 1975: 200-203). It has become a common feature of hospital care in low-income and public hospitals that much of the care, especially that of clinics such as this family practice unit, is preferred by physicians-in-training. The two-class system of health care is thus reinforced by an organizational tendency to use those who cannot afford

private care as a means of educating the physicians. Ehrenreich and Ehrenreich (1970: 22, 23, and Chapter One) have argued that the poor have been our society's research and educational material since the profession began apprenticing, internships and research. Vicki's explanation that she cannot afford to go to a specialist, or perhaps even to a private family practitioner's office, fits into this pattern. Her presence in the unit for a facial mole removal is a direct result of her financial status, whether or not the resident takes it as sufficient reason to operate on her rather than refer her, which, as he describes, is the usual practice.

Another interesting feature of the interaction is the number of times that Vicki asserts that she is not concerned about facial appearance or scarring. As quoted above, she initially expresses it as part of the reason that she is not concerned to have the family physician do the removal. Later she laughs when the staff physician explains that the scar should match a line on her forehead. When he expressed hesitancy to do the surgery, she again asserts that she does not care about her facial appearance:

SD. We're reluctant to cut on women's faces.

P. Well I'm not very vain on my face.

SD. Well, we are (laughs).

When the resident explains that the incision may be longer than Vicki might expect, Vicki again affirms that she is no

concerned about her face and that she had planned to take out the stitches herself:

- D. And don't be grossed out by the fact that the incision is a little longer than you might have expected, but I opened it a bit like that so that it would be, leave less of a scar.
- P. I won't be.
- D. You're not too particular are you?
- P. No I'm not. I was planning on taking the stitches out myself. I//
- D. // Well, on this one I'd like to see it, on the others I might go along with the idea, okay?
- P. Uh huh.
- D. This one is on your face. I can't have that, you know. Turn around. . . .

It seems a little odd that if Vicki is so unconcerned about her facial appearance and cannot afford a dermatologist to have it removed that she is concerned to have it removed at all. Once this feature is noted, what becomes striking is the lack of reason for the removal, unless it is for cosmetic reasons, which seems belied by Vicki's claims that she is not concerned with her facial appearance. If she is acting out of fear of malignancy or other medically relevant detail, she never mentions it and the resident never asks for her reasons. Rather, both the staff physician and the resident reinforce that Vicki ought to be concerned with her facial appearance more than she appears to be. Yet if they think that her lack of concern is strange, especially in light of the fact that she is willing to undergo facial surgery to remove the mole, they never raise the issue.

As Waitzkin (1983: 151-163) has pointed out in analyzing doctor-patient interviews, the technical orientation of the procedure is what gives the physicians the "right" to discuss Vicki's facial appearance, and their response to her desire to have her mole removed is not to explore whether there is some fear or social situation to which this is a response, but rather to use their technical ability and medical ideology to direct attention to the medical response and away from the inconsistent attitudes of their patient. They are able to make this response, which Vicki has solicited by coming to the unit for mole removals, due to their cultural authority and the widespread acceptance of medical ideology. Thus both Vicki's presence in the unit for facial mole removals and their acting in support of her request, rather than referring or raising the issue of why she wants this medicalized cosmetic surgery, are manifestations of the control that the profession has over non-medical aspects of patients' lives. Rather than suggest that Vicki resist the notion that her mole is dangerous or unbecoming and therefore worthy of the risk, discomfort, inconvenience and expense of removal, the physicians act in a manner that reflects their attitude that the technical-medical response is appropriate. This of course also feeds into the notion that a woman in our society is required to be attractive.

One further aspect of the interaction seems a

little odd. When the resident admits to Vicki that he did not have the proper tools, or at least the ones he thought would be best, she is not at all expressive of disappointment or fear which might be appropriate. Combined with his earlier hesitancy to remove the mole at all and the expressed intent to do a bodily one first to make sure they are both comfortable with his proficiency, this seems to be a strange lack of response. Perhaps this is so because it is too late now. On the other hand it may be that Vicki is operating on the assumption that the physician is the technical expert, and as her physician, has no reason to have operated on her if he thought there was any unnecessary risk or pain involved. The same cultural authority and medical ideology which helped to direct Vicki to the unit for the facial mole removal and gave authority to expressions of ability in the face of hesitancy and common practice may have justified even this expression of increased risk.

Though Vicki has requested the removal that she receives, it is not clear why she wants her mole removed. Nor do the physicians pursue this issue. There are good reasons why the physicians might want to have the opportunity to do the surgery. Though they indirectly refer to reasons why they perhaps should not do the removal, their willingness to do so prevails and carries the decision, without any overt expression of their reasons for doing so.

Vicki has come for the removal because she does not believe that she can afford a higher level specialist while it is possible that a specialist in the immediate community could have cost the same or less. But there is neither incentive nor encouragement for patients to verify such information. She has come for reasons that are either not expressed (fear of malignancy, cosmetic concern), contradictory to her expressed attitude about her face (unconcern), or erroneous (cost). The removal is done without any explanation as to why her case is different from usual practice.

In all three interactions there are elements of the interview which on close examination are puzzling. Consideration of the social context within which the patients and physicians live and the more specialized setting of the delivery of health care results in a more reasonable explanation of these otherwise puzzling interactional elements. The descriptions of the historical and social patterns of medical practice have been observed by others and are not explanations unique to the particular analyses. What emerges from this analysis is support for the claim that there is a basic asymmetry in the doctor-patient relationship which both supports and reflects the social norms of the society and sub-culture within which health care is delivered. As Waitzkin has commented:

medicine ultimately is inseparable from the wider society. Problems in medical care derive from and reinforce social contradictions. Distorted

communication in medical encounters both reflects and supports the institutional context in which doctors and patients participate. The study of ideologic reproduction and social control in medicine must link concrete medical encounters with this wider context. (Waitzkin, 1983: 144)

Fisher, among others, has argued that this "top-down" approach must be accompanied by a "bottom-up" whalysis which links the analysis of medical ianteractions with the wider social context (Fisher, 1979, 1983, 1986; Fisher and Todd, 1983; Habermas, 1970; Knorr-Centina and Cicourel, 1981). Theoretical accounts such as Habermas' are notoriously weak in their lack of presentation of concrete instances of the phenomena claimed to be so influential (Watizkin, 1983: 141). Such accounts gain plausibility as the asymmetry is placed in its historical and larger social context. Behavior which is difficult to understand within a trusting therapeutic relationship becomes comprehensible if we recognize the complex social context of such relationships. The failure of institutions and social arrangements to provide as they were expected or designed to must be examined within the social climate and political limitations which constrain the form and content of the relationships formed therein (Waitzkin and Stoekle, 1976; Stevens, 1971; Starr, 1982; Waitzkin, 1983; Navarro, 1973; Fisher, 1979, 1983, 1986; Fisher and Todd, 1983; Waitzkin and Waterman, 1974).

The need for such accounts is well documented and this

type of social analysis has much to recommend it. My thesis is that such a social analysis is a profitable addition to deliberation over ethical issues in medicine. The next chapter is an application of the previous social analysis to the ethical issue of informed consent as well established doctrine in support of patient autonomy. The line of argumentation, as established in Chapter I, is that informed consent, as protection of patient autonomy, must consider the asymmetry of the doctor-patient relationship. As we have seen, this leads us far beyond the usual boundaries of discussions of informed consent.

Chapter V

Normative Analysis

I have argued that in the interviews with Sheila, Maria and Vicki there has been a lack of information shared with the patients, that they have not been involved in the deliberations over the treatment decisions and that the context of the delivery of their health care is responsive to social factors which conflict with their interests. I do not think that any of these claims are obvious on a superficial examination of the interactions but are only arguable upon close scrutiny of both the interactions and the social context of the delivery of health care. No explicit normative claims have been made in Chapter IV. The task of this final chapter is to consider the social analysis and apply the normative considerations which are based on the analysis of the doctrine of informed consent (cf., Chapter I, pages 48-73). This discussion will lead to considerations of the necessity of a social component for all applied ethical analyses.

Three Goals of the Doctrine of Informed Consent

As was concluded in Chapter I, a helpful technique for applying a socially-sensitive normative critique is to specify the social picture which is desired in fulfillment

of the ethical concerns. I have specified three such practical social goals (agreement with physician, shared responsibility, reduction of asymmetry). The interactions which have been subjected to a social analysis may be readily compared to these normative models in an effort to analyze their normative adequacy. The comparisons, in turn, show both 1) the empirical fact that these interactions fail to fulfill the ethical requirements and, 2) the normative inadequacy of the first two models.

The most conservative of these goals for ethically valid consent is assuring that the patient understands the physician's reasons for the treatment chosen, and agrees to the treatment on that basis.¹ This is the most conservative goal because it preserves the medical paternalism

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It may be that the legal doctrine of informed consent is even more conservative, requiring only disclosure of risks. This may be due to the influence of litigation on legal doctrines, since such suits typically involve injury which the patient may have been able to avoid if he or she had been warned of the risk (U.S. President's Commission Report, 1982: 23-26). As the President's Commission Report (1982: 16) queries "To what degree does this legal requirement of informed consent advance the ability of patients to maintain control of and be responsible for decisions regarding their lives and their health?" I assume that simple disclosure of risks of the prescribed treatment is so obviously insufficient that the ethical discussion may reasonably commence with a standard which provides reasons for, as well as risks of, the prescribed treatment. (The President's Commission Report recognized this as well; cf., U.S. President's Commission Report, 1982: 29-31).

of the traditional physician-patient relationship. The only difference between this model and the authoritarian prescribing of treatment by the physician is that patients are to be told the reasons which presumably may have the prudential effect of increasing the chance of accurate compliance. If we assume the consent is optional, this goal may also be giving the patient a choice between being treated or not being treated. This model is not concerned with presenting to patients a choice between alternative treatments, since it is not required that patients be told these. This model may be ethically sufficient in a consent to research with no therapeutic effects, since the choice for non-therapeutic research is whether or not to undergo the procedure and refusal has no therapeutic implications. Perhaps the history of this model is tied to responses to research-related abuses revealed in the Nuremburg trials (U.S. Defense Department, 1948, 1974). Therapeutically, this model can be interpreted as an effort to serve patients' best interests, since the medical experts are undoubtedly better prepared than the average patient to deliberate between treatments. This model of informed consent has the advantage over the simple consent-to-treatment in that patients may not be treated simply as a means to their own health, as those in the Kantian tradition are likely to emphasize. It may also represent an attempt to balance promoting patients' welfare (beneficence) while preserving

their autonomy. A final ethical justification for this model might be a utilitarian argument that this form of informed consent is likely to maximize good consequences in that patients are likely to accept what is probably the best treatment, while preserving a degree of control over their treatment and establishing a less authoritarian physician-patient relationship. It might be more practical in its implicit recognition that physicians are better acquainted with medical knowledge than are patients.

Before critiquing this model and discussing the others, note that even this minimal model of informed consent is not met in any of the cases discussed. According to this model, the physicians must share the reasons for their treatment. In both Sheila's and Maria's cases there are few, if any, reasons given for the treatments. In Vicki's case, it seems that the reasons for the physician treatment may have been identical with Vicki's for coming to the unit. She came because she could not afford a higher level specialist and did not mind risking facial scarring. When the physicians expressed their hesitancy, she responded with these reasons, and they seemed to accept them. However, on closer scrutiny, it is not interactionally obvious why the physician proceeded, despite expressions of concern over malpractice and the intent to do a less conspicuous mole first, as well as problems of time and equipment.

It is also clear that the three patients either did not receive the best medical treatment option, or that the best treatment was not medically obvious. Sheila commenced treatment with a wide-range antibiotic prior to the screen being read. Starting the treatment after verifying the infection (or omitting the screen if treatment is initiated) is arguably a better option and a narrow range antibiotic would then be possible, since sensitivity could be checked. Maria was simply not treated for her medical problem. Any of the alternative treatment options would have been better. She was given reasons for non-treatment, but since she neither knew her options nor understood the reasons, this information did not help. Vicki was treated as requested, but not in the most medical risk-minimizing manner.

Since there are different modes of treatment, different prescribing practices and practical and financial consequences of these, simply informing patient of the reasons for the chosen treatment fails to guarantee the "best treatment". If physicians are taken to be the authorities of what treatment is the best for a certain ailment in the case of each particular patient, then the "best" must be interpreted as "best medical" interest. As has been argued, it does not appear that the physicians, unencumbered by even the minimal requirement of informing their patients, chose the "best medical treatment for this

patient". Neither does it seem likely that the medical judgment will be greatly improved upon by patient involvement. Good, experienced physicians probably are the most likely sources of good medical judgment, though there may be some limited exceptions (e.g., midwives, herbalists, chiropractors, nutritionists, physical therapists, health psychologists).

Rather than simply trying to maximize the medical quality of care, the second goal or model of informed consent focuses on increasing patient control. Since some medical judgments are controversial, carrying different medical consequences (e.g., side effects of drugs, impact on society, etc.) as well as practical and financial consequences, patients who will bear these consequences ought to be involved in the deliberations over which option to choose. As discussed in the U.S. President's Commission Report (1982: 85-89) medical diagnosis and treatment is fraught with uncertainty in terms of incompleteness of medical knowledge, its application to particular cases, practitioners' personal knowledge limits and practitioners' lack of familiarity with the very broad range of patients' life circumstances. Placing a heavier emphasis on autonomy, recognizing the controversy and uncertainty in medical treatment and the effect of medical definitions of illness and treatments on non-medical components of patients' lives, the second goal for informed consent emphasizes that

patients ought to choose from a knowledge of the alternatives and their consequences (cf., Burgess, 1985). This is in fact the type of informed consent insisted upon by consumer- or patient-rights oriented groups (e.g., women's health groups who emphasize the choice of birth control rather than agreement to a physician's recommendation).

That this goal is unfulfilled in the interactions is obvious. But there is evidence in the interactions that the goal of promoting patient control would not be fulfilled by further disclosure. First, there is the widely recognized problem of patient comprehension of disclosed information (see discussion in Chapter I). This is demonstrated in the cases. Sheila did not ask why she should start a drug which she might need to discontinue in a few days. Maria probably did not understand why the physician considered her pain medication to be contraindicated. Vicki apparently failed to understand the physicians' hesitancy and their concern about malpractice. Second, it is not unreasonable to suggest that, even if they were informed regarding the alternatives and effects of their treatments, Sheila and Vicki, and perhaps Maria, would choose the options favored by their physicians. They are consulting these physicians by choice and thus have some degree of trust in the physicians' medical judgments. Third, the patients are also consulting the physicians

because they believe themselves to be in need of medical care. The practical and financial differences for the patients are reasonably small, so the deciding factor may well be medical efficacy. Any expression of preference on the part of the physicians in such a context of ambiguity is at least possibly, if not likely, to be grasped as a medical reason to prefer that option. Finally, for such minor treatments, with these sorts of differences in effects of treatment, it is likely that most patients will generally be hesitant to request lengthy clarification.

If the second goal of informed consent does not frequently result in a practical difference, it may be a wasted effort. Perhaps only patients who are assertive enough to request the more detailed disclosure ought to be given it. For those who will predictably choose as the physician would suggest, perhaps the action is not unjustifiably paternalistic (cf., Ackerman, 1982). If physicians are willing to take the responsibility for such decisions, and patients are willing to accept this arrangement, this could be construed as an implied "contract" whereby the patient consents to any treatment the physician believes is appropriate (cf., Veatch, 1972: 7; U.S. President's Commission Report, 1982: 50-51). Such an arrangement would allow for the expedient delivery of medical care in such routine and minor cases as the three here considered. Certainly in these cases the physicians

intended only to dispense good medical care and the patients received medical care.

It is not the purpose of this analysis to claim that the patients should have received different medical treatments. Nor are the consequences of the treatments enough to merit much ethical concern. Whether the reason patients agreed to treatment was based on trust of their physician and knowledge of the reasons for the recommended treatment (the first social-normative goal), or knowledge of the alternatives and their consequences (the second social-normative goal) is not the crucial normative feature. Rather, the important feature is that perhaps surprisingly, even informed patients are likely to accept uncritically physicians' medical recommendations as authoritative and as completely constituted by medical considerations. In as much as this is an accurate depiction of physician-patient encounters, the basis of information which the patients possess is practically and ethically irrelevant. This is because the goal of informed consent, whether it is personal evaluation of physician's reasons for treatment or to promote patient choice is, generally speaking, undercut by patients' continued trust and respect of physicians. This dependence on physicians as authorities about what is in patients' interests is ill-founded because, as the social analysis of the three interactions demonstrated, the trusted medical practices are shaped by

social factors which may conflict with patients' interests, resulting in treatments which are probably not even the best medical treatment, let alone most serving of patients' general interests. Thus there is little reason, in defense of patient choice, to prefer full disclosure over simple disclosure of reasons for treatment or, for that matter, non-disclosure.

There is, however, good reason to prefer full disclosure over partial or none, though it is not because it is likely to immediately increase patients' autonomy or control over their health. Rather, the third social-normative goal proposes that full disclosure of treatment options and consequences is important as part of an overall project to reduce the asymmetry of control in physician-patient encounters and to establish a more equal distribution of the responsibility for health. As the social analysis has shown, the professional practices of physicians are developed in a manner that is responsive to, and consequently supports, social factors which conflict with patients' medical or non-medical interests. What is learned are methods, "how to" diagnose and treat, or to seek medical care as an appropriate response to certain problems. The context of both the learning and the practice affects what methods are learned and used. The practices are not ethically problematic because of their intended purpose (i.e., medical treatment). Nor is the issue that

medical practices uniquely reflect and reinforce social factors which do not explicitly enter into the encounters. The ethical objection is that due to medical authority, patients accept and participate in such practices and reinforce social factors both of which they might reasonably find objectionable.

More specifically, the three women patients do not simply accept uncritically personal inconvenience, expense and the risks implied by the treatments. They also accept treatments which promote the pharmaceutical industry's manipulation of medical treatment (Sheila, Maria), the overuse of wide-range antibiotics (Sheila), the protection of fetal over maternal health (Maria), the use of financially disadvantaged patients for educational purposes (Vicki), the definition of illness in terms of work-performance (Maria), the control of access to specialists by medical professionals, and personal or professional values (Maria and Vicki). The last three of these factors in turn contribute to a double-standard in health care. This unintentional and uncritical participation in these social values is ethically problematic for two reasons. First, it is not explicitly consented to chosen. Patients accept medical care. They rarely consider the sorts of social practices and patterns they support by doing so. Physicians also are usually unwitting supporters of this social order. That they

benefit considerably by doing so does not establish moral blame. But their ability to more directly influence the practices which support these social values and effects does imply a degree of responsibility to work for change, once they are aware of the problem.

Secondly, the formation of medical practice in response to these social factors constitutes a conflict of interest with that of patients. This conflict of interest is one to which patients have not consented, since they are unaware of it. The reason patients accept practices so influenced is that they have come to trust the authority of the medical profession. Members of the medical profession, of course, believe that they deserve this trust, though they do occasionally recognize that some of their professional interest and social connections conflict with that of patients or society (e.g., opposition to socialized health care, policy proposals regarding malpractice suits, increases in charges). But medical treatments are typically recommended by physicians because they believe them to be required, and accepted by patients because they trust physicians' judgments. The influence of the non-medical social factors on these practices is neither intended nor consented to. As such, these factors are not likely to become a part of the medical interaction even in the form of a disclosure in an informed consent procedure.

It would be ludicrous to claim that prior to

medical treatment every patient must be given a Wittgensteinian analysis of the practices they are likely to participate in and then to ask if they still consent to the treatment. Not only would such an explanation be quite meaningless, it does not increase the patients' (or practitioners') alternatives within the interaction. There typically does not exist an interactional course of action the physician or patient can engage in to avoid the influence and reinforcement of most of these social factors. Furthermore, they might not want a different treatment, and/or they may even support some of the social factors (e.g., the influence of profit through pharmaceutical companies' efforts, justified on an "invisible hand" theory of economics). Informed consent is helpful in promoting personal responsibility, self-control of one's health and autonomy only when there are options. The most serious ethical problem is the unwitting, and "unconsented-to" participation in social forms which may be objectionable and/or conflict with patients' needs or interests. This problem exists due to the organization of medical practice within the structural constraints of society, and participation in it is accepted by patients (and propagated by physicians) due to the asymmetrical relations between physicians and patients, as well as between public and professional groups. This asymmetry, as has been discussed, is one of possession, by the

professional, of knowledge, access to diagnostic and treatment facilities or substances and the subsequent control of definition of illness, conditions of medical practice and even the structure of physician-patient encounter.

Organizational/Structural Normative Analysis

It might, of course, be objected that this analysis is drawing some very broad conclusions based on three isolated cases. It is certainly accurate to claim that the analysis is most obviously applicable to the three cases, and perhaps to the typical practices of the three residents at that point in their careers, or perhaps to the particular unit during the few months the interactions were recorded. But there are good reasons to extend the analysis.

First of all, the interactions are selected as paradigm cases of varying consequences. There are examples of this sort of paternalism in most, if not all, of the interactions in the study from which these examples were taken (cf., Fisher, 1983, 1986; Fisher and Groce, forthcoming). These cases are not unique, they are exemplary. But their relevance does not stop at being depictions of patterns expressed in the recorded interviews, nor only of the clinic at that time.

The interactional patterns are similar to those found in other analyses of medical interviews (Fisher, 1979, 1983, 1986; Fisher and Groce, forthcoming; Todd, 1983; Robillard, White and Maretzki, 1983; Frankel, 1983; Paget, 1983; Waitzkin, 1983) as well as of other institutionally situated, non-medical, communicational events (Mehan, 1979; Mehan, Fisher, Maroules, in press; cf., Fisher and Todd, 1986). The intelligibility and explanatory power of the presupposition-ascriptions which form the basis of the analysis depends in part on readers' familiarity with the practice of "making sense" of utterances and with the practices described. So the familiarity of the analysis of the social organization of medical practice throughout at least North American society lends credence to its accuracy as an account of routine medical practice in general. Finally, in as much as the analysis is "grounded" (cf., "grounded theory," Glaser and Strauss, 1967) in other social analyses of medical (Freidson, 1970a, 1970b, 1973; Mechanic, 1974; Parsons, 1951; Navarro, 1973; Conrad and Kern, 1978; Waitzkin, 1983; Waitzkin and Waterman, 1974; Ehrenreich and Ehrenreich, 1970; Ehrenreich and English, 1978), institutional (Mehan, 1979; Labov, 1972), and societal (Habermas, 1970; Parsons, 1951; Marx, 1964) accounts and theories, further credence is lent the analysis.

Of course there are variations in organization of medical practice which may alter how or to what degree

specific social factors influence medical practices. For example, it is unlikely that reimbursement by an insurance company that is higher for one procedure than for another equally effective one would influence a salaried physician (cf., Freidson's discussion of fee-for-service and group-practice settings, 1970a: 91-100). Health Maintenance Organization (HMO's) are responses to the rising cost of health-care for consumers and employers. A standard fee is paid in exchange for whatever medical attention an enrollee might require. Rather than any professional or group profiting from a more expensive procedure or group of tests, the HMO's profits are diminished by such practices. Although this is not always a social arrangement which serves patients' interests (cf., Waitzkin and Waterman, 1974: 92), it does affect the social analysis, requiring context-specific accounts of communication events and practices. Even patient assertiveness is an interaction-specific factor which qualifies the specific manifestations of particular practices (such as psychosomatic labelling of women's complaints, cf., Bernstein and Kane, 1981; cf., Verbrugge and Steiner, 1981).

The ethical claim is that the concern with the doctrine of informed consent as a means to promote and protect patient autonomy or participation and shared responsibility for health leads to a critique of routine medical practice. The pattern of routine medical practice

that is of concern is the complacency of physicians and patients in allowing social factors which conflict with patient interests to shape medical treatment, without patients' (or physicians') knowledge due to the asymmetry in physician-patient relations and communication. The ethically germane social factors in this pattern are:

1. lack of informed consent to treatment, analyzed as due to--

2. the asymmetry of the physician-patient relationship, in which physicians may prescribe without patients' objecting or knowing that the medical practices are shaped by--

3. social factors which conflict with patients' medical need or practical and financial preferences.

An ethical "program" to respond to these issues must do much more than promote a standard of disclosure and patients' rights to choose their own treatment. The goal is to develop a context of health-care delivery in which professionals and patients come to a mutually acceptable treatment decision based on an understanding of medical, practical and financial alternatives and consequences. But such a goal is impeded by the organization of the physician-patient relationship as asymmetrical and the influence and reinforcement of irrelevant or patient-interest-conflicting social factors. The asymmetry must be balanced and the influence of those social factors,

or at least those which conflict with patient interests, must be eliminated or controlled.

Just as the social analysis showed that the influence of the organizational or structural social factors on medical practice is manifested in concrete interaction, any effective response to those factors will need to address both levels. The influence of certain factors on medical settings may be dealt with in part by policy responses, and in part by interactional innovation. Consider the influence of pharmaceutical companies on physicians' prescribing practices, specifically through stocking clinics with samples. I argued in Chapter IV that Maria's non-treatment may have been influenced in this manner. The physician arrived with a drug sample which was contraindicated for pregnant or nursing mothers and, because Maria was pregnant, he did not dispense the drug, recommending over-the-counter medicine instead. A policy response could take a variety of forms. One form would be to forbid pharmaceutical companies from dispensing free samples. This would also decrease the cost of marketing such drugs. Another policy response would be to require that the physician prescribe before checking the availability of a sample, so that the decision would not be influenced by availability or supply by the pharmaceutical company. Either of these policies would probably have resulted in Maria receiving a prescription for a non-contraindicated drug, which she would need to fill at

her expense. The policies prevent the physician's possible concern over Maria's financial status, combined with sample availability, influencing his prescribing practice as it seems to have done in Maria's case.

There are clearly controversial aspects of either policy response. While they are discussed, and other policy responses are considered, there are interactional responses which might equalize this social factor for Maria. If the physician were more expressive of his reasons for not prescribing the drug sample (protection of fetus) as well as his concern for Maria's expenses, and Maria were more assertive in negotiating her pain relief, a different outcome is predictable. One possibility is the treatment of Maria's pain by prescribing a pain-relief medication which is not threatening to fetal health, avoiding the violation of the physician's conscience. Another would be that Maria insist on seeing a colleague of the physician who is not concerned with protecting the fetus but has a moral attitude more like Maria's. This physician could then dispense the sample medication. This latter response may also have the benefit of Maria's receiving the abortion information she requested. In this manner, as an interactional practice, informed consent has a role to play within the larger program.

The "New" Doctrine and Practice of Informed Consent

The part that informed consent can play in a program to reduce the asymmetry of the physician-patient encounter (and its profession-public counter-part in the area of policy matters) and to promote shared profession-patient responsibility for health care (and health-related social issues), is two-fold. First, the practice of informed consent is to encourage those patients and/or physicians who already desire this "balancing" and to enable them to fulfill such goals as much as is now possible within the current social context of medical care. Second, the practice of informed consent may bring to patients' and physicians' attention the reasons for treating "routinely," opening these to examination and thereby increasing both professionals' and clients' discomfort with medical paternalism.

It is important to realize that fulfillment of the first task may undercut the goal expressed in the second. If all and only those patients who desired a detailed disclosure, and negotiation of their treatment with their physician received such care, there might be a considerable drop in the general sense and expression of frustration over such issues. Those who are not troubled by medical paternalism could go on allowing medical professionals to make decisions in their behalf. "Advocates," "ethicists,"

and others who are working for a change in the practice of paternalism in medicine might then find that their audience is less receptive because they are more comfortable. If the only ethical concern were unconsented-to cases of medical paternalism, this might also fully respond to the ethical issue.

As the preceding four chapters have endeavoured to establish, allowing (competent, mature, etc.; autonomous) patients as much control over their medical care as they wish is not the only ethical concern. Patients who do not desire such autonomy are responding to, and reinforcing, medical paternalism and authority, both of which are generally overextended in unjustified ways. Those patients who do desire such control have their ethical claims strengthened and extended by the social analysis which identifies specifically that over which they have not previously had such control and why. That the asymmetry in knowledge, control of diagnostic and treatment modes and interactional ability to initiate and control topics is the method whereby undisclosed, and frequently unconsented to, treatment has been prescribed and accepted shows the need to share information in order to alter this lack of patient participation and control. But it also shows that information alone is not enough. Interactional asymmetry can insert itself into the very process of informed consent which may then function as persuasion (Robillard, White, and

Maretzki, 1983). The organization and setting of the medical interview serve to reinforce this asymmetry, as do societal attitudes about illness, treatment and work (see Chapter IV). None of these are consented to by patients, nor can they be constructively responded to by the doctrine of informed consent, as it is generally understood.

Medical professional control of treatment and diagnostic options is not only interactionally expressed through non-disclosure, but it is also more effectively controlled through professional dominance and cultural authority (Freidson, 1970a, 1970b; Mechanic, 1974; Conrad and Kern, 1981; Waitzkin, 1983; Waitzkin and Stoekle, 1976; Waitzkin and Waterman, 1974; Ehrenreich and Ehrenreich, 1970; Ehrenreich and English, 1978; Starr, 1982; Stevens, 1971; Navarro, 1976; Fisher, 1979, 1982, 1983, 1986) It is far beyond any reasonable expectation of informed consent that individual patients will be capable of challenging this control, much less the social factors which affect the formation of treatment practices and are in conflict with the interests of patients. Nevertheless, awareness of such formative factors gives further ethical grounds to question the reason for specific medical treatment recommendations and to insist on active participation in their choice and construction.

Not only do such considerations strengthen claims to informed consent in the sense described above, but they

extend the ethical claim beyond that of a right to informed consent. What is mandated by this analysis is patient and public participation in the (re-)organization of medical interviews and practice. Non-medical factors which affect patients' medical options, participation in medical decisions and eventually the non-medical aspects of their lives ought to be scrutinized by "patients" in the form of public or political criticism of the organization and institutional goals of medicine. Of course, such directive action by professional and non-professional groups also implies shared ethical responsibility for the consequences of the choices.

The second purpose of informed consent (cf., page 69) is to increase patients' and the "public's" understanding of the ambiguities of medical practices, as well as the influence of non-medical social factors on treatment decisions and general medical practice. Such an increased awareness will result in an increase in the discomfort with medical paternalism and with the asymmetry of both medical interviews and professional-public discussions of health-care or medical-institution related issues. This discomfort may also increase among medical practitioners, so that they will seek more and better-informed patient input in medical interviews and public input into broader issues. Of course, such threats to professional autonomy (the freedom of the profession to

define both the context and conditions of its practice) have historically been heavily resisted (Freidson, 1970a, 1970b, Starr, 1982; Stevens, 1971). This resistance has no effect on the normative force of the current argument that patients ought to be more aware of these conflicts of interest and share in policy, institutional and treatment decisions. The profession's past political resistance may forecast that some of these issues will become political-economic battles. Since these discussions will make normative and empirical claims regarding professional and patient rights and obligations, they too are extensions of the present discussion of normative goals and social critique.

More specifically, the normative concerns supporting the doctrine and practice of informed consent also support other recommendations for social change in the organization of medical practice. Among these social concerns are the demedicalization of social problems, the reduction of profit-motivated influences, the reduction of professional control over medical treatment, a more "rational" division of labor and an increase in public participation in the structuring of the "conditions" of medical practice (including considerations of allocation of research and development funds, development of health-care delivery systems, access to technology, geographical distribution of medical professionals, etc.) Each of these have been discussed at length in medical sociological and

political literature, but the normative basis for their necessity is rarely discussed.

The U.S. President's Commission report (1982) recognizes that the normative concern for joint decision-making in medical treatment leads to considerations of legal, educational and economic dimensions of health care. The Commission suggests that hospitals, professional schools, courts and legislatures must reflect this concern for ethically valid consent (U.S. President's Commission Report, 1982: 1-5, 102-111, Part 3). Correctly perceiving that the education and socialization of health care professionals, legal standards and method of payment influences physician-patient encounters, the Commission's suggestions are primarily organizational. While the concentration on the context of medical care is a considerable improvement, there may be other organizational factors, as well as structural, which reinforce the Commission's targeted-for-change organizational factors and their effects on medical encounters.

The social analysis in Chapter IV established that structural factors influence the organization and practice of medicine, and makes patients' compliance more intelligible to the analyst. There are many medical sociologists and social critics who focus on structural criticism and change. I will now examine some of their

claims, illustrating their relevance to the ethical concerns underlying my normative social goal of informed consent.

Demedicalization is a term used by several social theorists in calling for different sorts of change. Ivan Illich (1975: 37) criticizes the medical care industry as therapeutically ineffective as well as stimulating the overuse of the medical system resulting in patients who search out a technological response to their social problems. As he is so well known for doing, Illich argues for personal and public scrutiny, legal licensing of professionals as a means of assuring adequate health care (Illich, 1975: 121). Health, for Illich, is a thing for which each individual has personal responsibility (cf., Illich, 1975: 167-169).

Vincente Navarro argues that Illich is wrong, that it is not industrialization which is responsible for manipulating people's increasing consumption of medical care. Rather, the "capitalist mode of production and consumption" stimulates "commodity fetishism" which is a necessary condition of the capitalist production system (Navarro, 1976: 112). Navarro summarizes that "addiction and dependency on consumption," or medicalization in the health-industry sector is the result of the capitalist socio-economic system which:

requires for its survival (a) the creation of wants, however artificial or absurd they may be,

(b) the existence of a passive and "massified" population of consumers, and (c) the replication of consumer ideology whereby the consumer is judged not by what he does (his work) but by what he has (his consumption). Within that system, the citizen, the consumer, is made to believe that his fulfillment depends in large degree on his consumption, be it of drugs, pills, prescriptions, cosmetics and whatever else may be required for his fitness, well being, and pursuit of happiness. (Navarro, 1976: 113).

Ehrenreich and Ehrenreich note how medical practice has shifted from professionals practicing medicine to medical institutions educating, "researching", profiting and providing medical services. They argue that the increased dependence on technology of post-war medical practice resulted in greater dependence on hospital facilities, increasing physicians' dependency on hospitals for expensive technology and support personnel and increasing the need for third-party financial support of medical care and equipment. Most of the public funding plans (e.g., Blue Cross, commercial health insurance, Medicare, the federal Hill-Burton program) financed hospitals exclusively, or in addition to physicians (Ehrenreich and Ehrenreich, 1970: 29-39; cf., Stevens, 1971: 274-275, 509-513; Starr, 1982: 347-351, 374-378). This independence and institutionalization of the health care system has resulted in concerns other than health care (i.e., technology, training, and profit) shaping medical practice. Ehrenreich and Ehrenreich, stating the thesis of their book, claim that "the American health system is not in business

for people's health" (Ehrenreich and Ehrenreich 1970; vi). If their analysis is at all accurate, much medical care is influenced or directed by these concerns which conflict with patients' medical needs. As Illich and Navarro have also claimed, "medicalizing" need, or defining certain health or social problems as in need of medical care or technology, results in inappropriate responses to patients' needs from which institutions and sometimes medical professionals benefit in terms of payment, public demand for funding, and increased role in directing public and private policy.

Howard Waitzkin (1983) is also critical of the medicalization of social problems and the influence of non-health concerns of a capitalist economic arrangement. He suggests that the rapidly growing concern with the financial burden of health care can be adequately analyzed only when "the connections between the health sector and the structure of the capitalist system" are recognized (Waitzkin, 1983: 89). The power of technological medicine, combined with the pseudo-objectivity of medical science, inspire hope among professionals, politicians and the public for a value-free, effective and individualized response. Responding to such issues as sexual dysfunction, family discord, depression in the work place, adjustment problems relative to stages of life (i.e., child-rearing, adolescence, aging, etc.), educational problems, and the like, medicalization removes the desire or need for

individuals and groups to take responsibility for social change (Waitzkin, 1983: 41).

All of these authors agree that current Western medical practice fails to meet certain medical needs (especially Illich and Ehrenreich and Ehrenreich), mitigates personal responsibility for health (especially Illich and Waitzkin), and prevents recognition and organization to confront social issues (especially Navarro, Ehrenreich and Ehrenreich, Waitzkin). They also agree that the mechanism through which these social facts are accomplished, and conceded, is through medicalization of people's problems and desires. Medicalization defines problems or desires as an event happening to a person, to be treated by medical professionals and institutions in a manner as minimally disrupting of the social order as possible, usually through prescribing some technological treatment to which patients only have access through the medical profession. They further agree that this medicalization serves the interests of the larger social order, often not that of patients. Professionals, institutions, industry and corporations all gain profit from such a process. Medicalization of patients' problems and desires, as well as their creation by definition and marketing, occurs and is sustained because it serves these purposes, not because it serves patients well, or even in some cases, adequately.

Note that the analyses are of the social context,

albeit a large and diverse one. The breadth of the context makes generalization or description more defeasible. But the argument that no one in the "system" acts with corporate profit or market control as an intention, if accurate, does not defeat the description. It is, as was discussed in Chapter II, a "scenic" description of the context within which practices are formed, institutionalized and sustained. The description is of methodological assumptions which shape the practices. Their description is akin to Coulter's presupposition-ascription in that they make more intelligible the particular organization and practice of medical care.

Though different in their specific recommendations, these authors are members of a group of sociologists and political theorists who agree that a complete analysis of problems in the delivery of health care must include an examination of the effects of structural level factors of cultural-economic-political arrangements. Since these structural factors describe part of the context within which medical institutions and practices are formed, they may reasonably be expected to shape the medical institutions and practices. Having become practices in a social setting which emphasizes or limits concerns such as profit, responsible employee behavior, prestigious conditions of work, technological innovation, etc., medical diagnosis and treatment reflect the influence of structural

factors and reinforce their assumption as acceptable normative principles.

Medical practice is not unique in this, but neither is it exempt. Patients' acceptance and physicians' prescriptions of medical definitions and treatments are each based on the acceptance and legitimacy of medical authority. But this authority is not legitimately extended to cover non-medical aspects of patients' lives, nor to choosing to support social factors which are irrelevant to or conflict with patients' health. Informed consent, if it is a doctrine whose practice is to result in patients' effective responsibility for their whole lives, and shared responsibility with medical professionals for health-issues, requires that we further analyze the definitions and control of these aspects of people's lives through medical practice.

A carefully implemented practice of informed consent is not likely to result in more than a very limited extension of patients' actual exercise of autonomy. Recognizing that this is due to the social context of implementation leads to consideration of medical paternalism and cultural authority as expressed in interactional asymmetry. Examining the social and historical basis for these interactionally manifested factors brings into focus the fact that medical authority, practice and institutions are, to a great extent, constituted by social factors which

are either not germane to, or actually conflict with health care. Informing patients of this social analysis is both impractical and ethically irrelevant. Patients who were made aware of this analysis could not do much differently individually, in terms of their own treatment, than could those who are simply fully informed of the medical options and consequences.

There is, however, much that can be done publicly outside of the medical interviews. For example, recognition that certain issues, such as stress and depression in the work place, are not individual-medical problems but social problems may encourage organization of workers for social change rather than their division into private patients. Perhaps pressure from organized patient groups, or from malpractice suits, will result in future Sheilas contemplating non-treatment, requesting a cheaper, generic drug, or negotiating access to an antibiotic to be taken only if the screen is positive and her symptoms worsen. Future Marias might have easier access to abortion information and pain medication, as well as be able to get paid time off of work so that her leg can heal less painfully. Perhaps Vicki, at a "better" time, might choose not to have her moles removed, or not have to be concerned with whether she can afford the least hazardous location and practitioner. At least her choice of specialist should not be made out of a sense of financial handicap.

Physicians also stand to benefit by such changes. Sheila's physician could share the responsibility of unnecessary treatment versus adequate care, rather than devising elaborate schemes to cover all the concerns. Maria's physician could simply consider Maria's leg pain, or could freely express his concern over fetal health, negotiating with Maria or referring her to a colleague. Perhaps he would never encounter her, if the time off work was permitted without endorsement of Maria's need by a physician, and abortion information were more accessible. Vicki's physician could not be caught in the middle of concern over adequate patient care and the need for surgical experience, if he were more adequately prepared or Vicki did not need to be concerned about money.

The doctrine of informed consent is a practical attempt to extend patients' autonomy in medical encounters in a manner that gives them control over the non-medical aspects of their lives and results in their sharing responsibility for medical issues with the medical professionals. But the asymmetry of medical interviews prevents the goal from being achieved, since it results in patients' and physicians' uncritical acceptance of routine medical treatment, and conceals the non-medical factors which exercise considerable influence on what practices become routine in medical settings, as well as in the home, work place, etc. The normative goals of informed consent,

requiring the expressions of autonomy mentioned above, cannot be fulfilled simply by instituting the practice. Explicit disclosure of the reasons for treatment decisions or diagnostic procedures increases the visibility of non-medical considerations, and raises the possibility of questioning the more basic assumptions which reflect the presuppositions of the practices' formation and use. The more abstract social analysis of the organization of medical practice and its institutionalization within the structure of society are now more obviously relevant. Now it is more feasible for patients to recognize the concrete effects and manifestations of medicalization, pursuit of profit, technology, etc. Furthermore, though the analysts are not in agreement on appropriate political recommendations, the relevance of social organization and political-economic factors would more adequately be dealt with by an educated public.

Implications of Combined Social/Normative Analysis

Informed consent and medical paternalism are only two of the complex issues which arise in discussions of medical ethics. Other issues could also be treated in a similar fashion. The issues of abortion, genetic manipulation and reproductive technologies should be examined in the context of medicalization of sexuality and reproduction. Much of these technologies and treatments

reflect non-medical issues, the promotion of technology and profit, and the concealing of personal and social problems (cf., Daly, 1978; Fisher, 1979; Gordon, 1974; Ehrenreich and English, 1978; Scully, 1980; Scully and Bart, 1973; Todd, 1982). Issues in definitions of mental health and illness, involuntary commitment and modes of treatment quite obviously connect with social control (cf., Chesler, 1972; Szasz, 1961). The effect of financial status on place and mode of treatment or the emphasis on suicide prevention rather than examination of high risk groups' socially caused distress reflect individualistic-interventionistic approaches rather than entertaining the need for socio-economic change. Euthanasia, non-treatment, refusal of life-saving treatment, definitions of death, artificial organs, and organ transplants should be discussed in a context of the marketability, and thus profit-creation and medicalization, of death-avoidance.

Of course, patients and practitioners must respond to these issues today, in the current context of medical care. Policy decisions, such as allocation of research and development funds, affect the options which will be available to future physicians and patients. The social analysis may, in the short term, suggest non-medical, or less technological medical responses to problems which patients bring to physicians. But the initiative to make personal changes in promotion of health, and to organize for

social change, might not be completely undermined by a medical-technological response if analysts, professionals and patients are more cognizant of the influence of the social context.

Some of the most resourceful organizing and fund-raising groups today are those organized around the cause of disease research and treatment. It is the medicalization of the social processes which results in these groups' being mouthpieces and fund-raisers for medical research and treatment. They are also support groups for victims of disease and their loved ones. Perhaps a more comprehensive social analysis could guide these groups into constructive organization around social issues such as reducing costs of treatment, channelling research money and alternative ways of accepting and accommodating handicap and death.

I have argued that a social analysis increases the normative force of ethical claims and recommendations, broadens their scope and effectiveness, and unites as well as increases the effectiveness of case and policy approaches. Concrete exploration of how ethical problems arise in medical interactions leads to reflection on the legitimacy of the social processes which contribute to the constitution of the ethical problem. Recognizing the complexity of the social setting within which these processes are formed and practiced, it is reasonable to

consider what social factors have affected the formation of the social processes and practices. These social factors may, in turn, be subjected to normative analysis. There is, as has been shown, good reason to be suspicious of medical practice for reasons of efficacy as well as propagation of undesirable, unhealthy or unethical social effects.

Recommendations in medical ethics, or any other area of applied ethics, need to be integrated and graduated. Particular and immediate ethical problems, while clarified by the social analysis, may or may not greatly benefit in terms of increased options or normative clarity. In Maria's case it is evident that she had options of which she was not aware (insist on a prescription, ask for a referral) and which social analysis might raise. Vicki or her physician might have chosen an experienced dermatologist if either had known that it would not cost more than the family practice resident, and if they had known of time and equipment factors. It is not obvious that Sheila or her physician would have been aided by the social analysis. Note, however, that a more complete disclosure of the options and reasons for choosing them would accomplish these immediate goals.

Considering the medicalization of needs raises a different set of ethical recommendations, although not ones which help these patients now. Recognizing that personal or social needs are often medicalized, we can see the need for

those in Maria's situation to receive paid sick leave which would reduce or avoid her need for medication. Vicki's cosmetic concerns may reasonably be responded to by her talking about it to someone in her life who is making her self-conscious. She may, of course, decide to have the moles removed anyway. This raises the perhaps ethical question of whether such a medical response to cosmetic dissatisfaction ought to be covered by a privately or publicly funded insurer. The ethical analysis of these issues leads to recommendations for change in minimum conditions of employment and in appropriate responses, whether they are personally or publicly financed, to cosmetic desires.

Sheila receives antibiotics for a sore throat, possibly due to strept infection. If this is so easily diagnosed and routinely treated, why do Sheila and her physician need to engage in this interview? Control of diagnosis and access to treatment by the medical profession may be an inefficient arrangement. Such medical care can and has been delivered by nurse practitioners. Once in a medical interview with a physician, patients are most directly affected by the asymmetry and there is almost no limit to the time, information and tests which physicians may demand. A visit to a "technician," who has limited tasks of diagnosis and treatment may not only be more efficient in terms of patients' and physicians' time, but it

avoids unnecessarily subjecting patients to the inconvenience and personal invasiveness that medical interviews may promote. Physicians, especially those in family practice, would benefit in conservation of time and effort for more complicated tasks. The recommendation at this level is for a rearrangement of the organization of primary care within the hierarchy of medical professionals.

Some would object that patients need practitioners who will be concerned with their general health. For Vicki, this does not seem assured by her going to a physician. For Maria, this is quite obviously not achieved. Perhaps recommendations of a team approach would have been more helpful for Maria. A social or psychological professional might pursue the fact that Maria has a history of abortions which is not a healthy practice for her. But this medicalizes what is probably a social problem for Maria. The presence of a health-psychologist in the setting did not help Maria, since the physician also controls access to this resource. Two ethical recommendations arise from these social facts. One is the increased use of support professionals in the medical setting. However, since this does contribute to the medicalization of sexuality and reproduction (which is taken here, for the sake of argument, to be "unhealthy" and perhaps unethical) a second recommendation is the provision and promotion of non-medical sources of such information and service.

As the recommendations broaden in scope, two further social factors affect their effective implementation. First as the scope of social organization increases, the group(s) to which it must be addressed becomes broader and more diverse. With this increase in scope comes an increase in reasons for opposition. Some employers do not want to pay workers for sick-time, family physicians do not want to give up the routine treatment of simple maladies, the medical profession does not want to publish charges and information of experience, and patients tend to want to consult physicians for even their simple or questionably medical needs. This set of social circumstances provides opposition to the broader ethical recommendations. Social analysis of why this opposition exists leads to the influence of profit, prestige and professional autonomy on medical practice. This level of social analysis generates yet another set of ethical recommendations.

The broader ethical recommendations are necessarily harder to implement and more likely to meet opposition. they are also more dependent on the accuracy of the social analysis. As discussed in Chapter II, less context-specific descriptions are less dependable because they cannot account for context-specific elements. It is for this reason that such recommendations run the risk of being too general and ineffective, or wrong, and thus having

undesirable or even unethical effects on the interaction. This problem can be (fallibly) responded to by breadth of discussion of the analyses and by constant reference to the interactional level. Reductions in controversy over points of a social analysis through discussion with other analysts capitalizes on inter-subjectivity and breadth of experience. Medicalization of social and personal needs is perceived as problematic by analysts who disagree on the social analysis of why it exists. Reflecting on interactional manifestations of medicalization gives further empirical support to this factor's influence on medical practice and patients' attitudes.

Ethical and social analysts must also guard against paternalism. Recommendations for re-organization of medical practice or of other institutions embody compromises of interests which cannot always be decided through ethical deliberation. Decisions of allocation of funds toward reproductive technologies have implications for the quality of life of individuals. The provision of more basic health needs (nutrition, shelter, etc.) take ethical priority over such medicalized responses to infertility, due to their being basic to pursuit of any quality of life. But if such needs are adequately provided for, then decisions of what quality-of-life enhancing options to pursue, questions of equal access aside, are less ethical than a matter of personal or social preference. Compared to other items in a

national budget, these may collectively be of greater or lesser importance. Such decisions on behalf of individuals ought to be made by them in as democratic a manner as is possible. But this too implies a critique of the current irrational "system" of allocation of health resources and priorities (Waitzkin, 1983: Chapter Four; Ehrenreich and Ehrenreich, 1970: especially 19-20, 191-198).

A combined social-normative analysis clarifies the ethical problems at various levels of complication of social organization, starting with the physician-patient interaction and concluding with criticism of political and economic structures. The normative analysis of the more concrete ethical problems actually gains force from the social analysis. Recognition of the concrete manifestations of ethical problems based on broader social analyses increases their support as accurate normative and social analyses. An integrated social-normative analysis is necessary to verify accuracy and to construct effective recommendations. Failure to integrate interactional recommendations with the broader recommendations will result in only short-term change which will accommodate rather than challenge the social production of the ethical problems. Failure to integrate the broader recommendations will result in ineffective, undesirable or unethical effects on the interactions among people.

The necessity of a social-normative analysis in

medical ethics has several implications for the role of the applied philosopher in medical ethics (hereafter referred to as "medical ethicist"). First, and most obvious, this type of analysis reaffirms the already widely acknowledged claim that medical ethics is an interdisciplinary effort. More specifically, health-care professionals, philosophers, sociologists, political theorists, economists, administrators, politicians and representatives of public opinion all have a contribution to make. Obviously, different levels of analysis and recommendations will require the relevant contribution from different people. But as a philosopher, the medical ethicist ought to be able to engage in such interdisciplinary endeavors, at least as a member of the community of applied philosophers who may draw on colleagues' expertise.

The second implication is due to the need for medical ethicists, or at least some members of that academic community, to have access to medical professional-patient interaction. For reasons discussed in Chapter II, recording these interviews greatly enhances the analysis. Clearly, this requires some relation with a medical practitioner or institution. Within this setting, the ethicist will need to be concerned with the most concrete of recommendations and policy. Whenever the context of the delivery, or its practitioners, are criticized, it is important that the social production of the problem (how it came about or why

it arose) be emphasized so that whatever practitioners, patients or administrators are able to do to avoid the problem's recurrence is clear. Malicious actions ought not simply be condemned but features of the setting which permitted or encouraged the action should be critiqued.

Third, recommendations for change in the organization of medicine require that the ethicist convince medical professionals, administrators, patients and others affected or in a position of power that there exists an ethical need and of the social advantage of the change. Careful social analysis ought to aid this effort, though social change is often not responsive to careful analysis as much as to emotional appeal. Encouraging such practices as informed consent, however, may stimulate enough suspicion and frustration among health professionals and patients that these groups might be more interested in education and social change. Once again, a familiarity with, and illustration of, the analysis through medical interviews is a better and more convincing analytic basis. Case studies, policy discussions, issue-oriented seminars ought to provide both immediate responses to the ethical issues, while emphasizing that the response is limited in effectiveness and ought not be treated as a final answer or panacea (cf., Burgess, 1985; Burgess and Wylie, 1985).

Fourth, in recognition of the homogeneity of the medical professions, the class structure of society and

their own academic membership, medical ethicists ought to call for and facilitate the public's involvement in ethical and policy discussions and decisions. Emphasizing the ethical reasons for countering medical paternalism with patient/public participation and shared responsibility, ethicists should provide medical professionals and institutions with the social analysis which shows their prudential advantage in this approach over full responsibility, litigation, legislation, and complete control (cf., Starr, 1982; Waitzkin, 1983).

Fifth, where social or political action (organizing, campaigning, lobbying, etc.) is required, those medical ethicists who are involved with medical institutions ought to call medical professionals to fulfill their social-ethical obligations in promoting public health. In recommending or directing such action, medical ethicists ought to create a social description of the desired changes in both the social organization and of the medical interview. If the connections between the recommended social change and the ethically mandated change in the medical encounter cannot be explained in detail, the analysis is weak, and the recommendations not well supported.

Sixth, a single medical ethicist clearly cannot fulfill all of the above duties with equal facility. Rather, cooperation with academic, professional, political

and public communities is required. It is the analysis as an integrated social-normative assessment of what social changes are required, and its interdisciplinary essence, which the medical ethics community can most adequately fulfill. It is at such an end that this dissertation is aimed.

Finally, as philosophers, medical ethicists ought to engage their philosophical colleagues in criticizing and improving on the ethical and epistemological foundations of this endeavor. Further discussion into the analysis of human action along the lines suggested by Jeff Coulter (1979) and outlined in Chapter II may aid efforts in applied ethics and, combined with social analysis, may complicate and challenge notions in traditional ethics and meta-ethics. The emphasis on social contexts as constraining but not determining people's behavior raises the issue of freedom and moral responsibility. The application of the normative sub-discipline of ethics in social contexts suggests that there ought to be a theoretical bridge between ethical and social-political philosophy. This theoretical development might assist the understanding of the normative connections here posited on the basis of a model social analysis.

In affirming these philosophical roots, it is also interesting to note how different areas of application of ethics have resulted in different types of approaches. For

example, medical ethics is frequently treated as if quite different from business ethics, partly on the notion that medicine is a "profession" and that business is a pursuit of profit in exchange for goods or services. As this analysis has shown, this distinction does not run very deep.

Philosophers in different areas of application should be cautious not to assume that the considerations in one area are inapplicable to another. This is quite obvious as the analysis broadens.

Conclusion

Assuming that one of the objectives of medical ethics is effective recommendations, I have argued that a social analysis is required to understand the occurrence of ethical problems. Arguing for the superiority of an ethnomethodological over a cognitive or intentional model of analysis, I have shown that the normative analysis and recommendations are best directed at elements of the social context over which actors have the most control. By extending the social analysis to better understand the social constitution of the ethically problematic actions I argued for further ethical recommendations and additional support for the normative analysis. But the social analysis also shows the limitations or inadequacies of the interactional-level recommendations. Consequently, it is

important that more normatively adequate goals be set as part of an overall program. Immediate-interactional recommendations must be carefully devised so as to stimulate, rather than conceal, the need for further change in the organization of the practice of medicine, as well as in the structural elements of society which promote unethical practices.

BIBLIOGRAPHY

BIBLIOGRAPHY

- Ackerman, Terry. Why Doctors Should Intervene. The Hastings Center Report, 12, 1982, 14-17.
- Alfidi, R. J. Informed Consent: A Study of Patient Reaction. Journal of the American Medical Association, 216, 1971, 1325-1329.
- Alfidi, R. J. Controversy, Alternatives and Decisions in Complying With the Legal Doctrine of Informed Consent. Radiology, 114, 1975, 231-234.
- Annas, George J.; Glantz, Leonard H.; Katz, Barbara F. Informed Consent to Human Experimentation: The Subject's Dilemma. Cambridge, Mass.: Ballinger Publishing Co., 1977.
- Armitage, K. J.; Schneiderman, L. F.; Bass, R. A. Response of Physicians to Medical Complaints in Men and Women. Journal of the American Medical Association, 241, 1979, 2186.
- Barber, Bernard. Informed Consent in Medical Therapy and Research. New Brunswick, New Jersey: Rutgers University Press, 1980.
- Barker-Benfield, G. J. The Horrors of the Half-Known Life. New York: Harper Colophon, 1976.
- Beauchamp, Tom L. & Childress, James F. Principles of Biomedical Ethics. New York: Oxford University Press, 1979 (Second Edition, 1983).
- Beauchamp, Tom L. & McCullough, Laurence. Medical Ethics: The Moral Responsibilities of Physicians. Englewood Cliffs, New Jersey: Prentice Hall, 1984.
- Bellah, Robert. Beyond Belief. New York: Harper and Rowe, 1970.
- Berstein, B. & Kane, R. Physicians' Attitudes Toward Female Patients. Medical Care, 18, 1981, 600.
- Blumer, Herbert. Symbolic Interactionism: Perspective and Method. Englewood Cliffs, New Jersey: Prentice-Hall, 1969.
- Bosk, Charles L. Forgive and Remember: Managing Medical Failure. Chicago: University of Chicago Press, 1981.
- Bransford, J. D. & McCarrell, N. S. A Sketch of a Cognitive

- Approach to Comprehension. In Weimer, W.B. & Palermo, D.S. (eds.), Cognition and the Symbolic Processes. Hillsdale, New Jersey: Lawrence Erlbaum Associates, 1974.
- Brock, Dan & Buchanan, Allan. Ethical Issues in For-Profit Health Care. Unpublished manuscript.
- Brown, E. Richard. Rockefeller Medicine Men. Berkeley: University of California Press, 1979.
- Brown, R. Words and Things. New York: The Free Press, 1968.
- Burgess, Michael M. Informed Consent in Routine Contexts. Unpublished master's thesis. University of Tennessee, Knoxville, Tennessee, 1983.
- Burgess, Michael M. Informed Consent: A Medical Ethicist's Perspective. Annals of the Royal College of Physicians and Surgeons, 18(6), 1985, 491-493.
- Burgess, Michael M. & Wylie, Alison. Anthropology and Ethics. Praxis, University of Calgary. In press.
- Burgess, Michael M. An Empirically Grounded Approach to Ethical Analysis and Social Change. In Fisher, S. and Todd, A. (eds.), Discourse and Institutional Authority: Medicine, Education, Law. Norwood, New Jersey: Ablex Publishing Corporation, 1986.
- Capron, Alexander M. Informed Consent in Catastrophic Disease: Research and Treatment. University of Pennsylvania Law Review, 123, 1974, 340-438. As reprinted in Biomedical Ethics, 1st. Edition. Mappes, Thomas and Zembaty, Jane (eds.). New York: McGraw-Hill, 1981, 74-78.
- Chesler, Phyllis. Women and Madness. Garden City, New York: Doubleday, 1972.
- Childress, James. Who Should Decide? Paternalism in Health Care. New York: Oxford University Press, 1982.
- Chomsky, Noam. Cartesian Linguistics: A Chapter in the History of Rationalist Thought. New York: Harper and Rowe, 1966.
- Cicourel, Aaron V. Cognitive Sociology: Language and Meaning in Social Interaction. London: Macmillan, 1973.
- Cicourel, Aaron V. Discourse and Text: Cognitive and Linguistic Processes in Studies of Social Structure. Versus. Quaderni di Studi Semetici, 12, 1975, 33-84.

- Cicourel, Aaron V. Hearing is Not Believing: Language and the Structure of Belief in Medical Communication. In Fisher, S. and Todd, A. (eds.), The Social Organization of Doctor-Patient Communication. Washington, D.C.: Center for Applied Linguistics, 1983, 221-239.
- Clarke, Lawrence J., et al. The Impact of Hill-Burton: An Analysis of Hospital Bed and Physician Distribution in the United States, 1950-1970. Medical Care, 18, 1980, 532-550.
- Conrad, Peter & Kern, Rochelle (eds.), The Sociology of Health and Illness: Critical Perspectives. New York: St. Martin's Press, 1981.
- Cooperstock, R. Sex Differences in Psychotropic Drug Use. Social Science and Medicine, 128, 1978, 179.
- Coulter, Jeff. The Social Construction of Mind. Totowa, New Jersey: Rowman and Littlefield, 1979.
- Culver, Charles M. & Gert, Bernard. Philosophy in Medicine: Conceptual and Ethical Issues in Medicine and Psychiatry. New York: Oxford University Press, 1982.
- Daly, Mary. Gyn/Ecology: The Metaethics of Radical Feminism. Boston: Beacon Press, 1978.
- Davis, Fred. Passage Through Crisis. Indianapolis: Bobbs-Merrill, 1963.
- Dworkin, Gerald. Paternalism. The Monist, 56, 1972, 64-84.
- Dworkin, Gerald. Autonomy and Behaviour Control. The Hastings Center Report, 6, 1976, 23-28.
- Edwards, Rem. Pleasures and Pains: A Theory of Qualitative Hedonism. Ithaca, New York: Cornell University Press, 1979.
- Ehrenreich, Barbara. Gender and Objectivity in Medicine. International Journal of Health Services, 4, 1974, 617.
- Ehrenreich, Barbara, & Ehrenreich, John. The American Health Empire. New York: Vintage Books, 1970.
- Ehrenreich, Barbara, & English, Deirdre. For Her Own Good. Garden City, New York: Anchor Press/Doubleday, 1978.
- Encyclopedia of Bioethics. Reich, Warren T. (Editor-in-chief). New York: The Free Press, 1978. (4 vols.)

Erikson v. Dilgard. 224 Misc. 2d 27, 252 N.Y.S. 2d. 705 (Supt. Ct, 1962).

Faden, Ruth R. Disclosure and Informed Consent: Does It Matter How We Tell It? Health Education Monographs, 5, 198-215.

Faden, Ruth R. & Beauchamp, Tom. L. Informed Consent and Decision: The Impact of Disclosed Information. Social Indicators Research, 7, 313-336.

Federal Register. Vol 46 #16, January 1981. Rules and Regulations, Section 46.117 Documentation of Informed Consent. running title: Record Retention Guide.

Federal Regulation of Human Experimentation, Prepared by Freeman H. Quimby, Susan R. Mollenbie and Cynthia B. Chapman. Subcommittee on Labor and Public Welfare, United States Senate, 94th Congress, 1st Session. Washington: Superintendent of Documents, Government Printing Office, 1975.

Fee, Elizabeth. Women and Health Care: A Comparison of Theories. 115-132, in V. Navarro (ed.), Health and Medical Care in the U.S.: A Critical Analysis. Farmingdale, New York: Baywood Publishing Company, 1973.

Fidell, L. S. Sex Role Stereotypes and the American Physician. Psychology of Women Quarterly 4, 1980, 313.

Feinberg, Joel. Social Philosophy. Englewood Cliffs, New Jersey: Prentice Hall, 1973.

Fisher, Sue C. The Negotiation of Treatment Decisions in Doctor- Patient Communications and Their Impact on Identity of Women Patients. Unpublished doctoral dissertation. University of California, San Diego, California, 1979.

Fisher, Sue C. The Decision-Making Context: How Doctor and Patient Communicate. In Di Pietro, R.J. (ed.), Linguistics and the Professions. Norwood, New Jersey: Ablex Publishing Corporation, 1982.

Fisher, Sue C. Doctor Talk\Patient Talk: How Treatment Decisions are Negotiated in Doctor\Patient Communication. In Fisher, S.C. and Todd, A. (eds.), The Social Organization in Doctor-Patient Communication. Washington, D.C.: Center for Applied Linguistics, 1983.

Fisher, Sue C. 134-157, in Fisher, S.C. and Todd, Alexandra (eds.), The Structure of Discourse and Institutional

- Authority: Law, Medicine, Education. Norwood, New Jersey: Ablex Publishing Corporations, 1986.
- Fisher, Sue C. & Todd, Alexandra (eds.), The Social Organization of Doctor-Patient Communication. Washington, D.C.: The Center for Applied Linguistics, 1983.
- Fisher, Sue C. & Todd, Alexandra (eds.), Discourse and Institutional Authority: Law, Medicine, Education. Norwood, New Jersey: Ablex Publishing Corporation, 1986.
- Fisher, Sue C. & Groce, Stephen. Forthcoming.
- Fodor, Jerry & Katz, J. J. What's Wrong with the Philosophy of Language? In Lyas, C. (ed.), Philosophy and Linguistics. London: Macmillan; New York: St. Martin's Press, 1971.
- Frankel, Richard M. The Laying on of Hands: Aspects of the Organization of Gaze, Touch and Talk in a Medical Encounter. 19-54, in Fisher, S. and Todd, A. (eds.), The Social Organization of Doctor-Patient Communication. Washington, D.C.: The Center for Applied Linguistics, 1983.
- Frankel, Richard M. Talking in Interviews: A Dispreference for Patient Initiated Encounters. To appear in Psathas, G.; Coulter, G. and Frankel, R. (eds.), Interactional Competence. Norwood, New Jersey: Ablex Publishing Corporation, forthcoming.
- Freedman, Benjamin. A Moral Theory of Consent. Hastings Center Report, 5, 1975.
- Freidson, Eliot. The Profession of Medicine: A Study of the Sociology of Applied Knowledge. New York: Dodd, Mead & Company, 1970(a).
- Freidson, Eliot. Professional Dominance: The Social Structure of Medical Care. New York: Atherton Press, 1970(b).
- Freidson, Eliot, (ed.), The Professions and Their Prospects. Beverly Hills, California: Sage Publication, 1973.
- Fried, Charles. Medical Experimentation: Personal Integrity and Social Policy. Amsterdam: North Holland Publishing Company; New York: Americal Elsevier, 1974.
- Fried, Charles. Right and Wrong. Cambridge, Massachusetts: Harvard University Press, 1978.

- Gay-Williams, J. The Wrongfulness of Euthanasia. 156-162, in Munson, R. (ed.), Intervention and Reflection. Belmont, California: Wadsworth Publishing Company, 1983.
- Garfinkel, Harold. Studies in Ethnomethodology. Englewood Cliffs; New Jersey: Prentice-Hall, 1967.
- Glaser, Barney, G. & Strauss, Anselm, L. The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Aldine Publishing Company, 1967.
- Goffman, Erving. Asylums: Essays on the Social Situations of Mental Patients and Other Inmates. Garden City, New York: Anchor Books, 1961.
- Goffman, Erving. Behavior in Public Places. New York: Free Press, 1963.
- Gordon, Linda. Woman's Body, Woman's Right. Middlesex, England: Penguin Books, 1974.
- Graber, Glenn C. On Paternalism and Health Care. 233-244, in Davis, John W.; Hoffmaster, Barry and Shorten, Sarah (eds.), Contemporary Issues in Biomedical Ethics. Clifton, New Jersey: Humana Press, 1978.
- Graber, Glenn C. & Eaddy, John. Medical Ethics: Zebras vs. Horses. Journal of the Tennessee Medical Association 75\1, 1982, 22-23.
- Graber, Glenn C.; Beasley, Alfred D. & Eaddy, John, A. Ethical Analysis of Clinical Medicine: A Guide to Self-Evaluation. Baltimore, Maryland: Urban & Schwarzenberg, 1985.
- Griffin, Peg & Humphrey, Frank. Task and Talk. In Shuy, R. and Griffin, P. (eds.), The Study of Children's Functional Language Education in the Early Years. Final Report to the Carnegie Corporation of New York. Arlington, Virginia: Center for Applied Linguistics, 1978.
- Habermas, Jurgen. Toward a Theory of Communication Competence. In Dreitzel, P. (ed.), Recent Sociology No. 2: Patterns of Communication. New York: Macmillan Company, 1970.
- Habermas, Jurgen. Science and Technology as "Ideology." 81-122, in Toward a Rational Society. Boston: Beacon Press, 1971.

Henley, Nancy. Body Politics: Sex and Non-Verbal Communication. Englewood Cliffs, New Jersey: Prentice-Hall, 1977.

Henley, Nancy & Thorn, Barry. Language and Sex: Difference and Dominance. Rowley, Massachusetts: Newbury House Publishers, 1975.

Howell, M. C. What Medical Schools Teach About Women. New England Journal of Medicine, 1974, 291-304.

Hunter, J. F. M. "Forms of Life" in Wittgenstein's Philosophical Investigations. In Klemke, E.D. (ed.), Essays on Wittgenstein. Urbana: University of Illinois Press, 1971.

Hunter, J. F. M. Essays After Wittgenstein. Toronto, Canada: University of Toronto Press, 1973.

Hunter v. Brown. 4 Wash. APP. 899, 484 P. 2D 1162 (1971).

Hymes, Dell. The Ethnography of Speaking. In Anthropology and Human Behavior. Washington, D.C.: Anthropological Society of Washington, 1962.

Illich, Ivan. Medical Nemesis: The Expropriation of Health. London: Calder and Boyars, 1975.

Ingelfinger, Franz J. Informed (but Uneducated) Consent. New England Journal of Medicine, 287, 1972, 465-466.

Jagger, Allison. Feminist Politics and Human Nature. Totowa, New Jersey: Rowman and Allanheld, 1983.

Jonas, Hans. Ethical Aspects of Experimentation with Human Subjects. In Munson, R. (ed.), Intervention and Reflection. Belmont, California: Wadsworth, 1983. As originally published in Daedalus, the Journal of the Americal Academy of Arts and Sciences, Boston, Massachusetts, 1969.

Kamisar, Yale. Euthanasia Legislation: Some Non-Religious Objections. Minnesota Law Review, 42, 1958, 969-1042. Reprinted, 415-422, in Biomedical Ethics, (Second edition), Mappes, Thomas and Zembaty, Jane (eds.), New York: McGraw-Hill, 1986.

Kant, Immanuel. Groundwork of the Metaphysics of Morals, 1785. Translated and analyzed by Paton, H.J. New York: Harper and Rowe, 1964.

- Katz, J.; Capron, Alexander M. & Glass, E.S. Experimentation with Human Beings. New York: Russell Sage Foundation, 1972.
- Knorr-Cetina, K. & Cicourel Aaron V. (eds.). Advances in Social Theory and Methodology: Toward an Integration of Micro- and Macro-Sociologies. Boston: Routledge & Kegan Paul, 1981.
- Konald, Donald. Codes of Medical Ethics - History, Vol 1, 162-171, in the Encyclopedia of Biomedical Ethics. Reich, Warren T. (editor-in-chief). New York: The Free Press, 1978.
- Krause, E.A. Power and Illness: The Political Sociology of Health and Medical Care. New York: Elsevier, 1977.
- Labov, William. Sociolinguistic Patterns. Philadelphia: University of Pennsylvania Press, 1972.
- Labov, William & Fanshel, David. Therapeutic Discourse: Psychotherapy as Conversation. New York: Academic Press, 1977.
- Lasagna, Louis. Some Ethical Problems in Clinical Investigation. In Mendelsohn, E.; Swazey, J. P. and Taviss, I. (eds.), Human Aspects of Biomedical Innovation. Cambridge, Massachusetts: Harvard University Press, 1971.
- Lasagna, Louis (ed.), Controversies in Therapeutics. Philadelphia: W.B. Saunders Company, 1980.
- Lyons, John. Noam Chomsky. New York: Viking Press, 1970.
- Macklin, Ruth. On the Ethics of Not Doing Scientific Research, (originally published in the Hastings Center Report, 7, 1977, 11-13. As reprinted in Biomedical Ethics, 1st. Edition. Mappes, Thomas and Zembaty, Jane (eds), New York: McGraw-Hill, 1981, 510-514.
- Mappes, Thomas & Zembaty, Jane. Biomedical Ethics and Ethical Theory. 1-19, in Biomedical Ethics, (First Edition), Mappes, Thomas and Zembaty, Jane. New York: McGraw-Hill, 1981.
- Mappes, Thomas & Zembaty, Jane (eds.), Biomedical Ethics. New York: McGraw-Hill, 1981 (Second Edition, 1986).
- Marx, Karl. The Economic and Philosophic Manuscripts of 1844. Translated by Milligan, Martin. Edited with an introduction by Streuk, D. New York: International Publishers, 1964.

- McCranie, E. W.; Horowitz, A. J. & Martin, R. M. Alleged Sex-Role Stereotyping in the Assessment of Women's Physical Complaints: A Study of General Practitioners. Social Science and Medicine 12, 1978, 111.
- McIntyre, Alasdair. A Short History of Ethics. New York: Macmillan Publishing Company, 1966.
- Mechanic, D. Medical Sociology: A Selective View. New York: The Free Press, 1968.
- Mechanic, D. Politics, Medicine, and Social Science. New York: John Wiley, 1974.
- Medical Research Council of Canada. Report Number Six: Ethics in Human Experimentation, Ottawa, Canada: Minister of Supplies and Services, 1978.
- Mehan, Hugh. Learning Lessons: Social Organization in the Classroom. Cambridge, Massachusetts: Harvard University Press, 1979.
- Mehan, Hugh & Wood, Huston. The Reality of Ethnomethodology. New York: John Wiley Publishing, 1975.
- Mehan, Hugh; Fisher, Sue & Maroules, Nick. Students' Formulating Practices and Instructional Strategies. In the Annals of the New York Academy of Science, in press.
- Mill, John Stuart. Utilitarianism. Edited by Priest, Oscar. New York: Bobbs Merrill, 1957.
- Mill, John Stuart. Essays on Politics and Culture/John Stuart Mill. Edited with an introduction by Himmelfarb, Gertrude. Garden City, New York: Doubleday, 1962.
- Mill, John Stuart. On Liberty. New York: The Liberal Arts Press, 1974.
- Millman, Marcia. The Unkindest Cut: Life in the Backrooms of Medicine. New York: Morrow, 1977.
- Milliren, J. W. Some Contingencies Affecting the Utilization of Tranquilizers in Long-Term Care of the Elderly. Journal of Health and Social Behavior 18, 1977, 206.
- Mulford, R. D. Experimentation on Human Beings. In the Stanford Law Review 70, 1967, 106.
- Munson, Ronald (ed.), Intervention and Reflection. Belmont, California: Wadsworth, 1979 (Second Edition, 1983).

Narveson, Jan. Morality and Utility. Demand UMI, 1967.

Natanson v. Kline. 186 Kan. 393, P. 2d 1093 (1960)
rehearing denied, 198 Kan. 196, 354 P. 2d 670 (1960).

National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects for Research. Washington, D.C.: U.S. Government Printing Office, 1978.

Navarro, Vincente. Health and Medical Care in the U.S.: A Critical Analysis. Farmingdale, New York: Baywood, 1973.

Navarro, Vincente. Medicine Under Capitalism. New York: Prodist, 1976.

Nielsen, Kai. Medical Cases of Justified Paternalism.
Forthcoming.

New York Regents. Journal of a Meeting of the Board of Regents of the University of State of New York, 1965, 787.

Paget, Marianne A. On the Work of Talk: Studies in Misunderstandings. 55-74, in Fisher, S. and Todd, A. (eds.), The Social Organization of Doctor-Patient Communication. Washington, D.C.: The Center for Applied Linguistics, 1983.

Parsons, Talcott. The Social System. New York: The Free Press, 1951.

Pellegrino, Edmund & Thomasma, David C. A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions. New York: Oxford University Press, 1981.

Paulshock, B. Z. What Every Woman Should Know About Hysterectomy. Today's Health 54(2) (February), 1976, 23-26.

Physicians' Desk Reference (33rd ed.). New Jersey: Litton Industries, 1979.

Pitkin, Hanna F. Wittgenstein and Social Justice: On the Significance of Ludwig Wittgenstein for Social and Political Thought. Berkeley: University of California Press, 1972.

Polyanyi, Michael. Personal Knowledge. Chicago: University of Chicago Press, 1958.

- Ramsey, Paul. The Patient as Person. New Haven: Yale University Press, 1970.
- Ramsey, Paul. Ethics at the Edges of Life: Medical and Legal Intersections. New Haven: Yale University Press, 1978.
- Robillard, Albert B.; White, Geoffrey M. & Maretzki, Thomas W. Between Doctor and Patient: Informed Consent in Conversational Interaction. 107-133, in Fisher, S. and Todd, A. (eds.), The Social Organization of Doctor-Patient Communication. Washington, D.C.: The Center for Applied Linguistics, 1983.
- Robinson III, Spotswood W. Opinion in Canterbury vs. Spence. 464 F.2d 772 (D.C.C.A. 1972).
- Roth, J. A. Timetables: Structuring the Passage of Time in Hospital Treatment and Other Careers. Indianapolis: Bobbs-Merrill, 1963.
- Rothman, B. K. In Labor. New York: Norton, 1982.
- Rushing, W. A. Community Physicians and Inequality. Lexington, Massachusetts: Lexington Books, 1975.
- Ryle, Gilbert. The Concept of Mind. London: Penguin University Books, 1973.
- Sacks, Harvey; Schegloff, Emanuel & Jefferson, Gail. A Simplistic Systematics for the Organization of Turn-taking in Conversation. Language 50, 1974, 696-735.
- Schegloff, Emanuel. Sequencing in Conversational Openings. American Anthropologist, 70, 1968, 1075-1095.
- Schegloff, E. & Sacks, Harvey. Openings and Closings. Semiotica 8, 1973, 289-327. Reprinted in Ethnomethodology, Turner, Roy (ed.) Middlesex, England: Penguin Books, 1974.
- Schloendorff v. N.Y. Hospital. 105 N. E. 92 (N.Y. 1914).
- Schutz, Alfred. The Structure of the Life-World. Translated by Zaner, Richard and Englehart, H. Tristram, 1973.
- Schwartz, Harvey & Jacobs, Jerry. Qualitative Sociology: A Method to the Madness. New York: The Free Press, 1979.
- Scully, Diane. Men Who Control Women's Lives. Boston: Houghton Mifflin, 1980.
- Scully, Diane & Bart, P. A Funny Thing Happened on the Way

- to the Orifice: Women in Gynecological Textbooks. American Journal of Sociology, 78(4), 1973, 1045-1050.
- Shuy, Roger W. Three Types of Interference to an Effective Exchange of Information in the Medical Interview. In Fisher, S. and Todd, A. (eds.), The Social Organization of Doctor-Patient Communication. Washington, D.C.: The Center for Applied Linguistics, 1983.
- Siegler, Mark. Searching for Moral Certainty in Medicine: A Proposal for a New Model of the Doctor-Patient Encounter. Bulletin of the New York Academy of Medicine, 57(1), 1981, 56-69.
- Silverman, Milton & Lee, Philip. Pills, Profits and Politics. Berkeley: California Press, 1974.
- Starr, Paul. The Social Transformation of American Medicine. New York: Basic Books, 1982.
- Stevens, Ruth. American Medicine and the Public Interest. New Haven: Yale University Press, 1971.
- Strong, P. M. The Ceremonial Order of the Clinic. Boston: Routledge and Kegan-Paul, 1979.
- Szasz, T. The Myth of Mental Illness. New York: Hoeber-Harper, 1961.
- Todd, Alexandra. The Medicalization of Reproduction: Scientific Medicine and the Diseasing of Healthy Women. Unpublished doctoral dissertation. University of California, San Diego, California, 1982.
- Todd, Alexandra. A Diagnosis of Doctor-Patient Discourse in the Prescription of Contraception. 158-187, in Fisher, Sue and Todd, Alexandra (eds.), The Social Organization of Doctor-Patient Communication. Washington, D.C.: The Center for Applied Linguistics, 1983.
- Turner, Roy (ed.), Ethnomethodology. Middlesex, England: Penguin Books, 1974.
- United States Defense Department. Trials of War Criminals Before the Nuremberg Military Tribunals, Volumes I and II, The Medical Case. Washington, D.C.: U.S. Government Printing Office, 1948.
- United States Defense Department. Nuremberg Code. U.S. v. Karl Brandt. Volume II, 181-183, Trials of War Criminals before Nuremberg Military Tribunals under Control Law No. 10. Washington: Government Printing Office, 1974.

- U.S. Department of Health, Education and Welfare, Office of the Secretary. Task Force on Prescription Drugs, Final Report. Washington, D.C.: U.S. Government Printing Office, 1969.
- U.S. Department of Health, Education & Welfare: The Institutional Guide to DHEW Policy Protection of Human Subjects. (1971) as ammended by 39 Fed. Reg. 18914 (1974).
- U.S. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Making Health Care Decisions, Volume One: Report, Washington, D.C.: U.S. Government Printing Office, 1982.
- Veatch, Robert M. Models for Ethical Medicine in a Revolutionary Age. Hastings Center Report, 2, 5-7, (June), 1972. (Reprinted 51-55, in Mappes, T. and Zembaty, J. (eds.), Biomedical Ethics, First Edition. New York: McGraw Hill, 1981.)
- Veatch, Robert M. Case Studies in Medical Ethics. Cambridge, Massachusetts: Harvard University Press, 1977.
- Veatch, Robert M. Three Theories of Informed Consent: Philosophical Foundations and Policy Implications. Publication No. (OS) 78-0014. The Belmont Report. Washington, D.C.: DHEW, 1978.
- Veatch, Robert M. A Theory of Medical Ethics. New York: Basic Books, 1981.
- Veatch, Robert M. & Branson, Roy (eds.), Ethics and Health Care Policy. Cambridge, Massachuesetts: Ballinger Publishing Company, 1976.
- Verbrugge, L. M. Sex Differences in Complaints and Diagnoses. Journal of Behavioral Medicine, 3, 1980, 327.
- Verbrugge, L. M. & Steiner, R. P. Physician Treatment of Men and Women Patients: Sex Bias or Appropriate Care? Medical Care, 19(6), (June) 1981.
- Waitzkin, Howard B. The Second Sickness: Contradictions of Capitalist Health Care. New York: The Free Press, 1983.
- Waitzkin, Howard B. & Stoekle, John D. Information Control and the Micropolitics of Health Care: Summary of an Ongoing Research Project. Social Sciences and Medicine, 10, 1976, 263-276.

- Waitzkin, Howard B. & Waterman, Barbara. The Exploitation of Illness in Capitalist Society. Indianapolis: Bobbs-Merrill, 1974.
- Wallen, J.; Waitzkin, Howard B., & Stoekle, John D. Physician Stereotypes About Female Health and Illness: A Study of Patient's Sex and the Informative Process During Medical Interviews. Women and Health, 4, 1979, 135.
- West, Candace. What is a Medical Interview? A Preliminary Investigation of Physician-Patient Interaction. Unpublished paper presented at the American Sociological Association Meetings. New York, 1980.
- West, Candace. When the Doctor is a Lady: Power, Status and Gender in Physician-Patient Conversations. In Stromberg, A. (ed.), Women, Health and Medicine. Palo Alto: Mayfield, 1982.
- West, Candace. Ask Me No Questions. . . . An Analysis of Queries and Replies in Physician-Patient Dialogues. 75-106, in Fisher, S. & Todd, A. (eds.), The Social Organization of Doctor-Patient Communication. Washington, D.C.: The Center for Applied Linguistics, 1983.
- Wilbur, Dwight L. Pharmacology and the Practising Physician. 5-11 in Proceedings of the Western Pharmacological Society, 11, 1968.
- Wilkinson v. Vesey. 295 A 2d 676 (R.I. 1972).
- Williams, Glanville. Euthanasia Legislation: A Rejoinder to the Non-Religiousness Objections. Minnesota Law Review, 43(1), 1958, 1-12.
- Winch, Peter. The Idea of a Social Science and Its Relation to Philosophy. London: Routledge & Kegan-Paul, 1958.
- Wittgenstein, Ludwig. Philosophical Investigations. Anscombe, G.E.M. and Rhees, R. (eds.). Oxford: Basil Blackwell, Second copyright, 1958.
- Wittgenstein, Ludwig. On Certainty. Anscombe, G.E.M. and von Wright, G.H. (eds.). Oxford: Basil Blackwell, 1961.
- World Medical Association. Declaration of Helsinki, Revised Version. From the Twenty-Ninth World Medical Assembly Tokyo, Japan, 1975.
- World Health Organization. The First Ten Years of the World Health Organization. Geneva: World Health Organization, 1958.

Zembaty, J. A Limited Defense of Paternalism in Medicine.
Proceedings of the 13th Conference on Value Inquiry: The
Life Sciences and Human Values. State University of New
York College at Genesco, 145-158, 1979. Reprinted 60-66, in
Biomedical Ethics, (Second Edition). Mappes, Thomas and
Zembaty, Jane (eds). New York: McGraw-Hill, 1986

APPENDIX

University of Tennessee

Consent to Act As Human Subject

Consent to Act As Human Subject

Subject's Name: _____

Date: _____

This study examines, for research and educational purposes, how doctors and patients communicate.

- I. I hereby authorize Sue Fisher and the assistant selected by her to gather information in the following ways:
 - a) to audio-tape, video-tape and observe interactions between my physician and I;
 - b) to review my medical records;
 - c) to conduct interviews with my attending physician.
- II. I hereby authorize Sue Fisher and the assistant selected by her to use these tapes and this information to teach residents about communicational skills.
- III. I understand that the information-gathering techniques described in Paragraphs I and II hold the potential to enhance doctors' and patients' abilities to communicate with each other.
- IV. I understand that my confidentiality will be protected by removing my name and all other personally identifying information from all teaching and reserching materials obtained by audio-taping, video-taping and observing the the interactions between my physician and I.
- V. I understand that Sue Fisher and the assistant selected by her will answer any inquiries I may have at any time concerning the information-gathering techniques.
- VI. I understand that my participation in the study is voluntary and that I may terminate it at any time with no risk to my doctor/patient relationship or to the quality of care I am receiving.

Subject's Signature _____

Witness _____

VITA

Michael MacDonald Burgess was born in Calgary, Alberta, Canada. He graduated from Ernest Manning Senior High School in 1974. Beginning his college career in 1975, in 1979 he received the Bachelor of Arts degree with a Philosophy-Religion major from Spring Arbor College. Michael graduated Cum Laude with divisional honors in philosophy.

Accepting an assistantship from the University of Tennessee, Knoxville, Michael began his graduate career in Philosophy, specializing in medical ethics, in September of 1979. He received his Master of Arts degree from the University of Tennessee, Knoxville, in March, 1983. For the period of September, 1981 to June, 1983, Michael accepted a position teaching in the University of Calgary's philosophy department and serving on the Faculty of Medicine's Conjoint Medical Ethics Committee. In 1985, Michael's contract was renewed at the University of Calgary.