Models for Ethical Medicine in a Revolutionary Age

What physician-patient roles foster the most ethical relationship?

by ROBERT M. VEATCH

Most of the ethical problems in the practice of medicine come up in cases where the medical condition or desired procedure itself presents no moral problem. Most day-to-day patient contacts are just not cases which are ethically exotic. For the woman who spends five hours in the clinic waiting room with two screaming children waiting to be seen for the flu, the flu is not a special moral problem; her wait is. When medical students practice drawing bloods from clinic patients in the cardiac care unit—when teaching material is treated as material—the moral problem is not really related to the patient's heart in the way it might be in a more exotic heart transplant. Many more blood samples are drawn, however, than hearts transplanted. It is only by moving beyond the specific issues to more basic underlying ethical themes that the real ethical problems in medicine can be dealt with.

Most fundamental of the underlying themes of the new medical ethics is that health care must be a human right, no longer a privilege limited to those who can afford it. It has not always been that way, and, of course, is not anything near that in practice today. But the norm, the moral claim, is becoming increasingly recognized. Both of the twin revolutions have made their contribution to this change. Until this century health care could be treated as a luxury, no matter how offensive this might be now. The amount of real healing that went on was minimal anyway. But now, with the biological revolution, health care really is essential to "life, liberty, and the pursuit of happiness." And health care is a right for everyone because of the social revolution which is really a revolution in our conception of justice. If the obscure phrase "all men are created equal" means anything in the medical context where biologically it is clear that they are not equal, it means that they are equal in the legitimacy of their moral claim. They must be treated equally in what is essential to their humanity: dignity, freedom, individuality. The sign in front of the prestigious, modern hospital, "Methadone patients use side door" is morally offensive even if it means nothing more than that the Methadone Unit is located near that door. It is strikingly similar to "Coloreds to the back of the bus." With this affirmation of the right to health care, what are the models of professional-lay relationships which permit this and other basic ethical themes to be conveyed?

1. **The Engineering Model.** One of the impacts of the biological revolution is to make the physician scientific. All too often he behaves like an applied scientist. The rhetoric of the scientific tradition in the modern world is that the scientist must be "pure." He must be factual, divorcing himself from all considerations of value. It has taken atomic bombs and Nazi medical research to let us see the foolishness and danger of such a stance. In the first place the scientist, and certainly the applied scientist, just cannot logically be value-free. Choices must be made daily—in research design, in significance levels of statistical tests, and in perception of the "significant" observations from an infinite perceptual field, and each of these choices requires a frame of values on which it is based. Even more so in an applied science like medicine choices based upon what is "significant," what is "valuable," must be made constantly. The physician who thinks he can just present all the facts and let the patient make the choices is fooling himself even if it is morally sound and responsible to do this at all the critical points where decisive choices are to be made. Furthermore, even if the physician logically could eliminate all ethical and other value considerations from his decision-making and even if he could in practice conform to the impossible value-free ideal, it would be morally outrageous for him to do so. It would make him an engineer, a plumber making repairs, connecting tubes and flushing out clogged systems, with no questions asked. Even though I strongly favor abortion reform, I am deeply troubled by a physician who really believes abortion is murder *in the full sense* if he agrees to either perform one or refer to another physician. Hopefully no physician would do so when confronted with a request for technical advice about murdering a postnatal human.

2. **The Priestly Model.** In proper moral revulsion to the model which makes the physician into a plumber for whom his own ethical judgments are completely excluded, some move to the opposite extreme, making the physician a new priest. Establishment sociologist of medicine Robert N. Wilson describes the physician-patient relationship as religious. "The doctor's office or the hospital room, for example," he says, "have somewhat the aura of a sanctuary;" "...the patient must view his doctor in a manner far

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removed from the prosaic and the mundane."

The priestly model leads to what I call the "As-a syndrome." The symptoms are verbal, but the disease is moral. The chief diagnostic sign is the phrase "speaking-as a...." In counseling a pregnant woman who has taken Thalidomide, a physician says, "The odds are against a normal baby and "speaking-as-a-physician that is a risk you shouldn't take." One must ask what it is about medical training that lets this be said "as-a-physician" rather than as a friend or as a moral man or as a priest. The problem is one of generalization of expertise: transferring of expertise in the technical aspects of a subject to expertise in moral advice.

The main ethical principle which summarizes this priestly tradition is "Benefit and do no harm to the patient." Now attacking the principle of doing no harm to the patient is a bit like attacking fatherhood. (Motherhood has not dominated the profession in the Western tradition.) But Fatherhood has long been an alternative symbol for the priestly model; "Father" has traditionally been a personalistic metaphor for God and for the priest. Likewise, the classical medical sociology literature (the same literature using the religious images) always uses the parent-child image as an analogy for the physician-patient relationship. It is this paternalism in the realm of values which is represented in the moral slogan "benefit and do no harm to the patient." It takes the locus of decision-making away from the patient and places it in the hands of the professional. In doing so it destroys or at least minimizes the other moral themes essential to a more balanced ethical system. While a professional group may affirm this principle as adequate for a professional ethic, it is clear that society, more generally, has a much broader set of ethical norms. If the professional group is affirming one norm while society affirms another for the same circumstances, then the physician is placed in the uncomfortable position of having to decide whether his loyalty is to the norms of his professional group or to those of the broader society. What would this larger set of norms include?

a. Producing Good and Not Harm. Outside of the narrowest Kantian tradition, no one excludes the moral duty of producing good and avoiding harm entirely. Let this be said from the start. Some separate producing good and avoiding evil into two different principles placing greater moral weight on the latter, but this is also true within the tradition of professional medical ethics. The real difference is that in a set of ethical norms used more universally in the broader society producing good and avoiding harm is set in a much broader context and becomes just one of a much larger set of moral obligations.

b. Protecting Individual Freedom. Personal freedom is a fundamental value in society. It is essential to being truly human. Individual freedom for both physician and patient must be protected even if it looks like some harm is going to be done in the process. This is why legally competent patients are permitted by society to refuse blood transfusions or other types of medical care even when to the vast majority of us the price seems to be one of great harm. Authority about what constitutes harm and what constitutes good (as opposed to procedures required to obtain a particular predetermined good or harm) cannot be vested in any one particular group of individuals. To do so would be to make the error of generalizing expertise.

c. Preserving Individual Dignity. Equality of moral significance of all persons means that each is given fundamental dignity. Individual freedom of choice and control over one's own life and body contributes to that dignity. We might say that this more universal, societal ethic of freedom and dignity is one which moves beyond B.F. Skinner.

Many of the steps in the hospitalization, care, and maintenance of the patient, particularly seriously ill patients are currently an assault on that dignity. The emaciated, senile man connected to life by IV tubes, tracheotomy, and colostomy has difficulty retaining his sense of dignity. Small wonder that many prefer to return to their own homes to die. It is there on their own turf that they have a sense of power and dignity.

d. Truth-telling and Promise-keeping. As traditional as they sound, the ethical obligations of truth-telling and promise-keeping have retained their place in ethics because they are seen as essential to the quality of human relationships. It is disturbing to see these fundamental elements of human interaction compromised, minimized, and even eliminated supposedly in order to keep from harming the patient. This is a much broader problem than the issue of what to tell the terminal carcinoma patient or the patient for whom there has been an unanticipated discovery of an XYY chromosome pattern when doing an amniocentesis for mongolism. It arises when the young boy getting his measles shot is told "Now this won't hurt a bit" and when a medical student is introduced on the hospital floor as "Doctor." And these all may be defended as ways of keeping from harming the patient. It is clear that in each case, also, especially if one takes into account the long range threat to trust and confidence, that in the long run these violations of truth-telling and promise-keeping may do more harm than good. Both the young boy getting the shot and the medical student are being taught what to expect from the medical profession in the future. But even if that were not the case, each is an assault on patient dignity and freedom and humanity. Such actions may be justifiable sometimes, but the case must be awfully strong.

e. Maintaining and Restoring Justice. Another way in which the ethical norms of the broader society move beyond concern for helping and not harming the patient is by insisting on a fair distribution of health services. What we have been calling the social revolution, as prefigurative as it may be, has heightened our concern for equality in the distribution of basic health services. If health care is a right

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The priestly model leads to the "as-a" syndrome

then it is a right for all. It is not enough to produce individual cases of good health or even the best aggregate health statistics. Even if the United States had the best health statistics in the world (which it does not have), if this were attained at the expense of inferior health care for certain groups within the society it would be ethically unaccepable.

At this point in history with our current record of discriminatory delivery of health services there is a special concern for restoring justice. Justice must also be compensatory. The health of those who have been discriminated against must be maintained and restored as a special priority.

3. **The Collegial Model.** With the engineering model the physican becomes a plumber without any moral integrity. With the priestly model his moral authority so dominates the patient that the patient's freedom and dignity are extinguished. In the effort to develop a more proper balance which would permit the other fundamental values and obligations to be preserved, some have suggested that the physician and the patient should see themselves as colleagues pursuing the common goal of eliminating the illness and preserving the health of the patient. The physician is the patient's "pal." It is in the collegial model that the themes of trust and confidence play the most crucial role. When two individuals or groups are truly committed to common goals then trust and confidence are justified and the collegial model is appropriate. It is a very pleasant, harmonious way to interact with one's fellow human beings. There is an equality of dignity and respect, an equality of value contributions, lacking in the earlier models.

But social realism makes us ask the embarrassing question. Is there, in fact, any real basis for the assumption of mutual loyalty and goals, of common interest which would permit the unregulated community of colleagues model to apply to the physician-patient relationship?

There is some proleptic sign of a community of real common interests in some elements of the radical health movement and free clinics, but 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 are a mere pipedream. 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.

4. **The Contractual Model.** The model of social relationship which fits these conditions is that of the contract or covenant. The notion of contract should not be loaded with legalistic implications, but taken in its more symbolic form as in the traditional religious or marriage "contract" or "covenant." Here two individuals or groups are interacting in a way where there are obligations and expected benefits for both parties. The obligations and benefits are limited in scope, though, even if they are expressed in somewhat vague terms. The basic norms of freedom, dignity, truth-telling, promise-keeping, and justice are essential to a contractual relationship. The premise is trust and confidence even though it is recognized that there is not a full mutuality of interests. Social sanctions institutionalize and stand behind the relationship, in case there is a violation of the contract, but for the most part the assumption is that there will be a faithful fulfillment of the obligations.

Only in the contractual model can there be a true sharing of ethical authority and responsibility. This avoids the moral abdication on the part of the physician in the engineering model and the moral abdication on the part of the patient in the priestly model. It also avoids the uncontrolled and false sense of equality in the collegial model. With the contractual relationship there is a sharing in which the physician recognizes that the patient must maintain freedom of control over his own life and destiny when significant choices are to be made. Should the physician not be able to live with his conscience under those terms the contract is not made or is broken. This means that there will have to be relatively greater open discussion of the moral premises hiding in medical decisions before and as they are made.

The real, day-to-day ethical crises are not so exotic

With the contractual model there is a sharing in which the patient has legitimate grounds for trusting that once the basic value framework for medical decision-making is established on the basis of the patient's own values, the myriads of minute medical decisions which must be made day in and day out in the care of the patient will be made by the physician within that frame of reference.

In the contractual model, then, there is a real sharing of decision-making in a way that there is realistic assurance that both patient and physician will retain their moral integrity. In this contractual context patient control of decision-making in the individual level is assured without the necessity of insisting that the patient participate in every trivial decision. On the social level community control of health care is made possible in the same way. The lay community is given and should be given the status of contractor. The locus of decision-making is thus in the lay community, but the day-to-day medical decisions can, with trust and confidence, rest with the medical community. If trust and confidence are broken the contract is broken.

Medical ethics in the midst of the biological and social revolutions is dealing with a great number of new and difficult ethical cases: in vitro fertilization, psychosurgery, happiness pills, brain death, and the military use of medical technology. But the real day-to-day ethical crises may not be nearly so exotic. Whether the issue is in an exotic context or one which is nothing more complicated medically than a routine physical exam, the ethos of ethical responsibility established by the appropriate selection of a model for the moral relationship between the professional and the lay communities will be decisive. This is the real framework for medical ethics in a revolutionary age.