The Linacre Quarterly

Volume 44 | Number 4 Article 11

November 1977

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In this paper I propose to examine three models of the doctor-patient relationship. After a descriptive characterization of the alternative models, I will offer a series of arguments to support the claim that there is a moral priority of one model over the others, viz. the model of mutual participation.

I. Szasz and Hollender and Veatch

Thomas Szasz and Marc Hollender have argued that there are three basic models of the doctor-patient relationship.[1] The model of *Activity-Passivity* is a minimal relationship in the sense that the doctor acts and the patient is acted upon. The patient contributes little or nothing to the success or failure of therapy. The model is especially appropriate for care of the comatose and the mentally incompetent, including children. The model of *Guidance-Cooperation* is a more genuine relationship. It is one in which the doctor commands and the patient obeys. The patient's cooperation is crucial to therapeutic success (perhaps the taking of prescribed medicines at the prescribed intervals) but he does not enter into the decision-making process. The doctor is deferrred to completely in this respect. This model, therefore, is highly paternalistic. The third and last model is that of *Mutual Participation*. In this relationship doctor and patient are assumed to be relatively equal in power, aware of their mutual interdependence and conscious of engaging together in a venture that is satisfying to both. This model is most appropriate for the management of chronic and degenerative diseases.

Although Szasz and Hollender claim that model three, Mutual Participation, is more highly developed in an evolutionary sense they refuse to admit that any of the models is fundamentally better or more ethical than the others. Each has, they claim, its appropriate use.

Robert Veatch in a more recent article offers a similar typology.[2] The *Engineering Model* is a relationship in which the doctor views

himself as an applied scientist. It makes him "an engineer, a plumber making repairs, connecting tubes and flushing out clogged systems, with no questions asked." He refrains from considering the moral upshot of his activities with the patient. The *Priestly Model* describes just the opposite. Far from refraining from value decision-making, the doctor in this model is frankly paternalistic. As a "father" he makes the patient's choices for him. Veatch's third model is the *Collegial Model*. In this model the doctor and patient pursue together, as colleagues, the common goals of eliminating the patient's disease and preserving his health. Trust, confidence and mutuality in decision-making are the hallmarks of this model. Although obviously attracted to this model, Veatch argues that it is overly Utopian and he offers a fourth model, the *Contractual Model* as a suitable compromise with social realities. Within this model, mutuality of interest is put aside but the norms of freedom, dignity, truth-telling, promise-keeping, justice and real sharing in decision-making remain central.

If we assume that Szasz and Hollender did not intend the model of Mutual Participation to include equality of doctor and patient to the point of becoming "pals," I think it is fair to say that we have essentially the same three models here: Activity-Passivity or the Engineering Model, Guidance-Cooperation or the Priestly Model and Mutual Participation or the Contractual Model. For the sake of simplicity I will refer to these as model one, model two and model three, respectively. With reasons not developed by Veatch, I will attempt to do what Szasz and Hollender eschewed. I will argue that model three has a moral priority over the other two models. This does not mean, of course, that there are not circumstances in which models one and two might be more appropriate relationships. It does mean that the doctor in models one and two has a moral obligation to move the relationship, so far as this is feasible, toward model three. It means, if I am correct, that there is a moral directionality, a moral *telos*, in the doctor-patient relationship.

Broadly speaking, ethicians demonstrate moral obligations in two ways: by utilitarian arguments and by deontological arguments. I plan to explore both.

II. Utilitarian Considerations

My first utilitarian argument will be one to which Veatch did allude. The biological revolution which we are witnessing is raising moral questions of massive significance. Behavior control techniques, genetic engineering, and life support technologies have or will have a great impact on the role of the doctor. With respect to these areas, it is not possible to speak of what is medically "indicated" without reference to a background of individual moral choices, social and political considerations, and religious and ethnic dispositions. Since the doctor

can hardly be considered an expert in all of these fields, maximization of good consequences suggests the increasing priority of model three.

Another aspect of the biological revolution has been medicine's control, at least in the economically developed nations, of the infectious diseases. As a result of these successes, chronic and degenerative diseases have come to make a much higher percentage of these same nations' mortality and morbidity rates. Since chronic and degenerative diseases are intimately related to life-styles, model three again suggests itself. One is hardly likely to respond favorably to life-style admonitions from a physician without the supportive background of a relationship of mutuality. Since the doctor can hardly be an expert in all the aspects of living these diseases affect (e.g., smoking, drinking, eating, exercise), coping with these diseases demands the mutuality of decision-making which model three offers. Of the three models, it is most likely to produce good consequences in these circumstances.

A second utilitarian consideration here is the professional fulfillment of the doctor. If his or her primary occupational commitment is to help persons recover and maintain their health, the doctor will be professionally fulfilled so far as he is accomplishing this goal. Given the inevitabilities of disease and death, no doctor can reach complete satisfaction on this score. All of his patients will get sick; they will all die. Nevertheless, it seems that the doctor's professional satisfaction can be maximized by maximizing in turn the number of healthy days his patients experience. There is evidence to suggest that patients follow doctors' medical advice better, understand their conditions and how better to improve them and are more highly motivated to do so when conditions similar to those described upon model three prevail.[3]

A third argument of this sort relies on an interesting observation made by Hegel in his *Phenomenology of Spirit*. In a master-slave relationship, Hegel noticed, the master is as enslaved to the relationship as the slave. In one crucial respect he fares worse. The slave has the master as his representation of what it is to be a human person. He relates to a superior person. The master, by contrast, has a slave representing humankind. In spite of his practical dominance, the master relates to an inferior. The slave will be more psychologically satisfied since the role model he perceives is of a higher kind than that the master perceives. Extrapolating this insight to the doctor-patient relationship, the doctor who commits himself to anything less than model three condemns himself to a lifetime of relating to inferiors. Only model three offers the personal fulfillment of associating with patients perceived to be equally worthy persons and, therefore, acceptable role models.

A fourth consequential consideration relates to the patient's perception of the doctor. For a number of reasons patients are not usually able to evaluate the medical abilities of the doctor. Their judgment of

the doctor and their subsequent satisfaction with him will often be based upon other factors. Important among these factors is the doctor's affective behavior, especially his ability to feel and demonstrate empathy with his patients.[4] The chances for empathetic relationships and positive affective behavior in general would seem to be increased in model three. Therefore, if a doctor is concerned to maximize client satisfaction and his good reputation, he will commit himself to model three.

Fifth and finally, we should consider the impact of these various models on medical care as a system. Because of the increased use of medical machinery, the over-specialization of health care professionals and the bureaucratic elements of hospital care, contemporary medicine is frequently charged with dehumanizing and alienating its customers. A wholesale institutional commitment to model three might go a long way to responding to these charges. It might increase the presently diminishing prestige of medical practice. It might even help to reduce the number of medical malpractice suits.

All of these considerations provide utilitarian support for the claim that there is a moral directionality in the doctor-patient relationship. Good consequences will be maximized when the doctor, wherever possible, moves his relationship with his patients toward model three, toward mutual participation.

III. Deontological Support

Utilitarian arguments rely on consequences. The central problem with this reliance, from an ethical point of view, is that consequences are empirical sorts of things. It is often difficult to tell with any degree of certitude whether some event is an empirical consequence of another event. Additionally, there are always empirical facts on the other side of the ledger, those alleging that one's choice, in fact, will lead to more evil than good, more pain than pleasure. These claims are notoriously difficult to measure and evaluate. Perhaps most doctors will actually prefer the dominance of model two to the equal role presentations of model three. Perhaps most patients prefer to be told in a blatantly paternalistic manner what to do and what not to do. And even if only a few of each prefer these options, perhaps their displeasure at losing a model one or two relationship "outweighs" the good consequences gained by others adopting model three. Faced with these and similar problems, ethicians are likely to seek support for their views with deontological arguments.

The most straightforward deontological approach here would be to insist that as persons, doctors have an obligation to treat other persons as equals. They must treat their patients as infinitely valuable ends-in-themselves. They must be prepared to universalize their choices, to only choose as every person would choose, as one would have the patient choose for the doctors were the roles reversed. Models one and

two may at times be necessary compromises with circumstances but model three because of its very character is obligatory for the doctor because of his nature as a person.

As simple as this sounds it relies on a powerful assumption of the metaphysics of personhood. One must have already demonstrated value of the person before any such argument as the one above can get started. Unfortunately this is just what the biological revolution is undermining. New behavior control techniques push us toward viewing the person merely as a seat of highly manipulable behaviors. Discussions of genetic engineering often lead one to suspect that persons are being made equivalent to organic transmitters of DNA. The recent sophistications of medical technologies, especially life support machinery, often place individuals in situations that threaten to make persons a category of experimental and research materials. The deontological argument sketched above would appear to be a begging of the question, an assuming of a metaphysics which is itself at stake.

These problems are overwhelming philosophically. Faced with ambiguities and doubts in utilitarian arguments and the difficulties in providing philosophical ground for deontological approaches one might be inclined to foresake a theoretical solution altogether. Philosophically, that may be the appropriate response. However, these are not simply philosophical problems. The question of the moral dimensions of the doctor-patient relationship is equally a social problem for medicine as a whole and an existential problem for the doctor. In this light, a solution suggests itself. When we are speaking of medical practice in general and doctors in particular we are not speaking of neutral participants. If the assumption referred to above, viz., that medical institutions and doctors are committed to helping persons recover and maintain their health, is accurate, then medicine and doctors have overcome this philosophical difficulty by what amounts to a leap of faith. Theirs is not a descriptive commitment based on anticipated consequences or metaphysical considerations; it is, instead, prescriptive. Medicine as an institution and doctors as individuals have already bound themselves to the value of persons. They have already assumed moral obligations. The deontological task, then, is a far less onerous one. The commitment having been made, the ethician need only spell out the implications.

Presumably the doctor chose his profession because he had some intimate acquaintance with the need for doctoring, perhaps his own suffering or that of someone close. Building on this as an existential point of departure, the ethician can point out that the obligation which follows upon this is one which mirrors the original commitment: to treat others as you would have yourself or loved one treated. Once this is accepted, all the Kantian apparatus of personhood will follow. There is no need for metaphysics. Model three, mutual partici-

pation in the doctor-patient relationship, will be grounded in the nature of the doctor's personal commitment and medicine's institutional commitment to helping other persons recover and maintain their health.

IV. Some Results

Suppose that the conjunction of utilitarian and deontological arguments offered here is compelling; what follows? What would be some results of the general adoption of model three? Let me suggest just two of them: the effect on patients and the impact on medical education.

My suspicion is that most patients would welcome a more open mutual relationship with their doctors. However, model three entails a greater responsibility on the patient's part and this may result in a good deal of resistance. There is comfort in having others make our choices for us. Like the adolescent who wants freedom from parental control but not responsibility for his decisions, and the student who wants flexibility in educational requirements but not responsibility for academic choices, there will be patients who want the sharing of medical information but not the responsibility of shared decisions. This is a fact with which doctors will have to deal constructively. As doctor-patient relationships more and more approach model three, doctors will increasingly earn their appellations. They will have to be doctors in the fullest sense; they will have to teach *(docēre)*. What they will teach will be responsible care of one's own health.

The future appears to hold great challenges for the doctor. Coping with the fruits of the biological revolution, with community demands for better care and with model three patient relationships will require a special kind of person. It is the responsibility of medical education to see to it today that we have these individuals when we need them tomorrow. If what has been said here is at all correct, medical education will have to emphasize new skills and sensitivities. Behavioral sciences and humanities will have to take their places with the natural sciences and the clinical training. Techniques for effective informational and affective communication will have to be taught. Ethics will be a central concern. Above all, medical schools will have to become places where idealism and humanitarian commitments are nurtured and can grow. That this is not already the case today portends ill for tomorrow. Medical education today increases cynicism and decreases attitudes of idealism and humanitarianism.[5] This is not compatible with the demands of model three.

Beginning with three models of the doctor-patient relationship presented by Szasz and Hollender and also to some extent by Veatch, I have argued for the normative priority of the model of mutual participation. For reasons both utilitarian and deontological, there is a moral directionality in the doctor-patient relationship. Doctors, as doctors

and as persons, have the obligation to move their patient relationships toward model three. This may, indeed, place greater burdens on the patient and on medical educators as well as the doctors. These burdens will have to be shouldered if we are to cope with the biological revolution, the demands for greater lay participation in the decisions of the professions and our duties as doctors, patients and educators.

REFERENCES

1. Szasz, T. and Hollender, M., "The Basic Models of the Doctor-Patient Relationship," *Archives of Internal Medicine* 97 (May), p. 585.

2. Veatch, R., "Models for Ethical Medicine in a Revolutionary Age," *Hastings Center Report*, Vol. 2, No. 3 (June, 1972), p. 5.

3. E.g., Korsch, B. and Negrete, V., "Doctor-Patient Communication," *Scientific American*, August, 1972, p. 66.

4. Ben-Sira, Zeev, "The Function of the Professional's Affective Behavior in Client Satisfaction: A Revised Approach to Social Interaction Theory," *Journal of Health and Social Behavior* Vol. 17 (March, 1976), pp. 3-11.

5. Reinhardt, A. and Gray, R., "A Social Psychological Study of Attitude Change in Physicians," *Journal of Medical Evaluation* 47 (February, 1972), p. 112.
