Paternalism and the doctor–patient relationship in general practice

BRIAN MCKINSTRY

SUMMARY. This paper is a brief introduction to the subject of paternalism as it occurs in general practice. A definition of paternalism is provided and the four main types of doctor–patient relationship within the paternalistic spectrum are described. These relationships are illustrated with examples from general practice. Some of the extensive literature on paternalism is reviewed. It is concluded that paternalism is rarely justified when treating patients of sound mind and then only where restoration of the patients' autonomy is the main aim.

Keywords: doctor–patient relationship; patient autonomy; patient rights; doctor responsibility.

Introduction

THE concepts of paternalism and autonomy within medicine have interested medical philosophers and ethicists for the last 50 years. Little has been written on how the subject relates to family practice, but the general arguments which hold for other branches of medicine are also relevant to family practice.

Before discussing the rights and wrongs of paternalism in medicine and reviewing some of the extensive literature on the subject, some examples of the doctor–patient relationship will be given, illustrating the range of the paternalistic spectrum.

Dworkin defined paternalism as:

> 'The interference with a person's liberty of action, justified by reasons referring exclusively to the welfare, good, happiness, needs, interest or values of the person being coerced.'[1]

A more detailed definition is given by Gert and Culver[2] (Figure 1) in which the paternalist is aware that his or her action would be opposed by the patient if the patient knew about it, and that the paternalist must have some expectation that in the long run the patient will agree that the action taken was correct.

Many of the proponents of paternalism in medicine have not used such specific definitions. They describe as paternalism occasions when the doctor assumes consent for various aspects of treatment, for example when the doctor feels he or she does not need to ask the patient first. However, a doctor behaves paternalistically when he or she realizes that consent for treatment is not or would not be immediately forthcoming, but proceeds with treatment for the good of the patient.

The doctor–patient relationship

Four examples of the doctor–patient relationship are outlined:

B McKinstry, MRCP, MRCGP, general practitioner, Blackburn, West Lothian.

Submitted: 12 July 1991; accepted: 7 October 1991.

© *British Journal of General Practice*, 1992, **42**, 340-342.

X is acting paternalistically towards Y if, and only if, X's behaviour correctly indicates that X believes that:

- X's action is for Y's good
- X is qualified to act on Y's behalf
- X's action involves violating a moral rule with regard to Y
- Y's good justifies X acting on Y's behalf independently of Y's past, present or immediately forthcoming free, informed consent
- Y believes, perhaps falsely, that Y generally knows what is for his/her own good

The paternalist must have reasonable expectation of Y's eventual consent.

Figure 1. *Definition of paternalism, by Gert and Culver.*[2]

Autocratic doctor

In this relationship, the doctor has little regard for the opinions of the patient. The patient has come to consult the expert with a problem, for example hypertension; the problem has clear solutions to which the general practitioner will rigidly adhere. Questions from the patient about the treatment are considered irritating as they signify a lack of recognition of the general practitioner's abilities, or a sign of ignorance on the part of the patient. Should the patient not choose to have the treatment, it is the patient's loss. The doctor believes that the patient is fortunate to have the benefit of expert advice and the patient is being ungrateful if it is not accepted. For such doctors, patients exist for the sake of medicine rather than medicine existing for the sake of patients.[3]

Paternalistic doctor

In this relationship, the general practitioner listens to the patient, believing that a doctor who appears to listen is a more effective doctor. The general practitioner genuinely wants the best for the patient, but believes that patients often need to be guided firmly through the decision making process as they do not always know what is best for them. The general practitioner is prepared to answer questions about the illness and will even acquiesce in certain less important suggestions. For example, a general practitioner treating a patient with hypertension would be willing to make several changes in therapy for the patient. However, if the patient suggested stopping the treatment, the general practitioner would feel justified in exaggerating the possible unpleasant sequelae of this action, citing for example that 'you would almost certainly have a stroke', even though the general practitioner knows this to be untrue. This is justified in the doctor's mind as he or she considers that the long term interests of the patient would be better served by the patient having the treatment despite its unpleasant side effects, regarded as minor by the doctor.

In this relationship the general practitioner clearly sees him or herself as being in a superior position. Despite the apparent

flexibility and acquiescence, when important decisions are to be made the doctor feels justified in overriding the patient's wishes. The doctor may subscribe to the view that patients do not have sufficient knowledge to make good decisions or that when they are ill they are less capable of this.

Doctor as agent

In this relationship, the doctor does not see him or herself as being in charge, but considers the patient to be the final arbiter of all important decisions. The general practitioner will explain to the patient the likely results of different treatment options and why one treatment is preferred to another. However, the doctor does not believe that it is necessary to explain every decision made, assuming the patient's consent for what the doctor considers to be minor decisions. Sometimes the doctor will be mistaken because the correct questions were not asked, but he or she would never knowingly deceive the patient. For example, the general practitioner might give a patient a depot contraceptive without fully explaining the medium term infertility it could cause. However, the general practitioner would never deceive the patient into taking it because he or she felt that it was best for the patient not to have more children for the forseeable future. The doctor would be quite prepared to explain all of the decisions made if the patient wanted this.

The doctor acting as an agent does not give an illusion of control to the patient since it is assumed that patient is in control. Decisions may be discussed to a greater or lesser degree, depending on the patient or even with the same patient at different stages of an illness. The influences on the decision making process will be the general practitioner's communication skills, the general practitioner's knowledge and experience of the patient, the patient's knowledge and experience, the patient's personality, the nature of the problem and the time the doctor has available in the consultation.

If a patient were to ask for a treatment of which the general practitioner did not approve, for example, an obese patient wanting slimming pills, the general practitioner would explain honestly why they could not be recommended. If the patient persisted the doctor would not feel duty bound to prescribe them. This highlights the difference between allowing fully informed rational patients to harm themselves, for example by not taking antihypertensive therapy, and helping patients to harm themselves, for example by prescribing slimming pills. The general practitioner would point out that the patient was free to seek another opinion.

At its most extreme, this relationship may be one in which the doctor or patient insists on discussion and agreement of all stages of the consultation and treatment process, as happens in some countries with surgical or chemotherapeutic treatments. Usually this has arisen because of legal problems in the past rather than a genuine desire to involve patients in decision making. One of the skills of the modern doctor is to ascertain how detailed an explanation a patient would like.

Patient yielding autonomy

The patient who yields autonomy, for example, 'doctor I'm in your hands', has been considered to be a problem by some authors. However, to deny the right of the patient to do this might be interpreted as paternalistic. Doctors who carry out the patient's wishes by making the decisions are not acting paternalistically, but as the patient's agent or enabler. If the patient makes it clear that he or she does not wish to discuss the treatment and understands that by doing so, he or she may miss out on some benefit, then the doctor, acting as the patient's agent, would respect this.

It could be contended that the majority of consultations in general practice are those in which the doctor is acting as agent or enabler. Occasionally, all general practitioners will act paternalistically, perhaps for example by over emphasizing the dangers of cigarette smoking to someone who smokes two or three cigarettes a day, or even autocratically when they are in a bad mood. Some general practitioners may consult in some of these ways more frequently than other general practitioners.

The rights and wrongs of paternalism in medicine

One of the major problems in discussing the doctor–patient relationship is the simplistic view that there are only three elements involved: the doctor, the patient and the illness. The view describes a relationship pertaining to relatively inexpensive and low technology medicine where other outside influences hold little sway.[4] Nowadays the doctor has many other considerations, apart from the less noble influences such as personal remuneration, prestige and convenience, such as the effects of treatments on the community at large and the patient's own immediate family. Should a general practitioner prescribe a marginally better but more expensive drug, for example domperidone, for a patient with nausea rather than an adequate and less expensive alternative, for example metoclopramide, knowing such behaviour will diminish the overall effectiveness of the health service for which the doctor works? Here, the good of the patient may be 'minimally' sacrificed for the good of the community. It is hard to conceive of a consultation where financial constraints are not a consideration. This makes work much harder for the paternalistic doctor than for the autocrat who pays less regard to the patient anyway, or the doctor acting as agent who should tell the patient of financial influences and of divided loyalties.

The central debate about paternalism is whether doctors are justified in making decisions about patients' treatment to which they know the patients would object if they were properly informed. Also, whether they are justified in carrying this treatment out because they believe that the patients' long term interests would be served by it and that eventually the patients would agree that the doctors' action had been correct.

Many would say no. If one accepts the premise that everyone is of equal value, then everyone's rights should be equally respected. The patient's interests are served by giving him or her the right as a human being to say no. Paternalism, therefore, is essentially dehumanizing. Modern thinking would not condone a paternalistic attitude in politics. Most citizens would be affronted if they thought that their government was acting against their wishes, however well meaning. Mills[5] argues that each person is the best judge of his or her own happiness, and that autonomous pursuit of goals is itself a major source of happiness, so happiness could seldom be generated by action which thwarted or disregarded the goals of others, or took control of achieving these goals. Kant goes further, saying that it is the duty of all human beings to express their autonomy.[6]

Komrad,[7] however, argues that autonomy is not granted to all individuals, the most striking examples being children and mentally ill or handicapped adults. Here, decisions have to be made for them. A 10 year old boy with insulin dependent diabetes who has decided that he no longer wishes to test his blood because it hurts his fingers is likely to be overruled by both doctors and parents. In the future, if he is spared the complications of diabetes, he may well be glad that the doctor forced the treatment upon him.

Komrad considers there to be degrees of autonomy, suggesting that illness causes a loss of autonomy.[7] This loss is not absolute, and paternalism must fill the vacuum that is left. Komrad

gives the example of a diabetic patient who is admitted to hospital in a comatose state and is treated 'paternalistically' and then has his autonomy restored when he is discharged from hospital in control of his insulin therapy and diet. However, it is incorrect to state that because the patient is unable to give consent his treatment must be paternalistic. The doctor in charge of his case had no reason whatsoever to believe that the patient did not want treatment; the doctor was therefore not acting paternalistically, but as the patient's agent. If the patient had been admitted with a note saying that he no longer wanted to have insulin therapy and did not wish treatment, then to treat him would have been a paternalistic act.

An example from general practice might be the case of a patient who is in danger of sinking into an abnormal sick role. The patient has been off work for some time and the general practitioner feels that the patient would be better off returning to work, but the patient resists this. The general practitioner refers the patient to the regional medical officer as a therapeutic measure, knowing that this is against the wishes of the patient but in the firm belief that the patient will benefit. This is a paternalistic act with which many doctors will be familiar. The aim is to restore the patient's autonomy, the only justification for paternalism.[4]

The concept of degrees of autonomy has been criticized by Matthews[3] who states that doctors giving degrees of autonomy to patients only take into account their patients' wishes when they concur with their own.

O'Neill[8] recognizes that consent for every aspect of treatment is not necessary, but that consent must be obtained for fundamental aspects of actions or proposals. Where autonomy has been lost, decisions should be made in the context of what the patient would have wanted rather than what the doctor thinks is best. An example might be of a depressed patient who has for many years refused cervical cytology. If the patient is thought to have severe depression, such that she cannot make her own decisions, then with all the usual safeguards it is reasonable to force her to have treatment for this. It would be quite improper, however, to use the opportunity to perform a cervical smear.

The final question must be why should decisions on medical treatment by an ill person be considered differently from other decisions that person must make in life? If the person is considered reasonably capable of the latter or at least considered to have the right to make a decision, why should this right not be extended to medical treatment? Doctors may be able to claim superior technical knowledge, but they must realize that their ethical or moral skills cannot be considered better than those of the patient.[9]

Paternalism is difficult to practise. It is difficult to be sure what is best for a patient.[10] It is difficult to know when one is acting in the patient's interests and not in one's own, at least in part. The paternalist will also be left with the responsibility of these decisions when things go wrong. Paternalists say that they are prepared to live with these risks, but unfortunately it is usually their patients that have to live with these mistakes.

Conclusion

Paternalism is rarely justified when treating patients who are sound in mind. If it is practised, then restoration of the patient's autonomy must be the main goal. Autocracy could only be justified in extraordinary circumstances, for example on a battlefield where time lost explaining may mean lives are lost. Most doctors probably act as their patients' agent or enabler. The degree to which general practitioners consult patients and explain their decisions is related to the personality of the doctor and the patient, their communication skills, the type of problem, and the time available in the consultation. Assessing how much explanation or involvement a patient would like is an important part of all consultations.

References

1. Dworkin G. Paternalism. *Monist* 1972; **56:** 64-84.
2. Gert B, Culver C. The justification of paternalism. In : Robison W, Pritchard M (eds). *Medical responsibility.* New Jersey: Humana Press, 1979.
3. Matthews E. Can paternalism be modernised? *J Med Ethics* 1986; **12:** 133-135.
4. Siegler M. The progression of medicine. *Arch Internal Medicine* 1985; **145:** 713-715.
5. Mill JS. On liberty. In: Warnock M (ed). *Utilitarianism.* London: Fontana, 1972.
6. Kant I. *Groundwork of metaphysic of morals.* New York: Harper and Row, 1958: 108.
7. Komrad M. A defence of medical paternalism: maximising patients' autonomy. *J Med Ethics* 1983; **9:** 38-44.
8. O'Neill O. Paternalism and partial autonomy. *J Med Ethics* 1984; **10:** 173-178.
9. Gillan R. Paternalism and medical ethics. *BMJ* 1985; **290:** 1971-1972.
10. Buchanan A. Medical paternalism. *Philos Public Affairs* 1978; **7:** 370-390.

Acknowledgements

I should like to thank John Howie, Mike Porter and Ken Boyd for their constructive criticism.

Address for correspondence

Dr B McKinstry, Ashgrove Health Centre, Blackburn, West Lothian EH47 7LL.

Royal College of Physicians of London

DIPLOMA IN GERIATRIC MEDICINE

The Diploma in Geriatric Medicine is designed to give recognition of competence in the provision of care for the elderly and is particularly suitable for General Practitioner vocational trainees, Clinical Assistants and other doctors working in non-consultant career posts in Departments of Geriatric Medicine, and other doctors with interests in or who have responsibilities for the care of the elderly.

The next examination will begin on 13th October 1992. Application forms, together with the necessary documentation, must reach the College by Friday, 4th September 1992.

Candidates must either have held a post approved for professional training in a department specialising in the care of the elderly, or have had experience over a period of 2 years since Full Registration or equivalent in which the care of the elderly formed a significant part.

Further details and an application form may be obtained from:

Examinations Office
Royal College of Physicians of London
11 St Andrew's Place
Regents Park, London NW1 4LE