DISCUSSION PAPER

Paternalism and the doctor–patient relationship in general practice

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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.'

A more detailed definition is given by Gert and Culver (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:

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.

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.

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
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. 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 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.

Komrad considers there to be degrees of autonomy, suggesting that illness causes a loss of autonomy. 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 Matthews3 who states that doctors giving degrees of autonomy to patients only take into account their patients’ wishes when they concur with their own.

O’Neill8 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


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