Medical Responsibility And Authoritarianism

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EUGENE J. ALEXANDER, M.D.*

(Foreword: The pleasures of group practice, such as we have at Henry Ford Hospital, are several; and one which may not readily be apparent to an outsider, is the uniquely satisfying and educational experience of daily luncheon conversation with one's friends and associates. Our topics may be as varied as at any luncheon table, but often they are directly related to the practice of medicine. For instance, what began as a facetious discussion between Dr. Schimek, Dr. Davidson, and Dr. Dill, about a "graph" to compare "What the doctor thinks he knows," with "What he actually knows," at different phases in his medical career, provoked the quite serious comment from Dr. Dill that, at the Ford Hospital, we can keep aware of the scientific advances in medicine, simply by listening, at lunch, to what our friends — specialists in fields other than our own — have to say. With this, I heartily agree. And what a pleasant way in which to learn! The fine art of conversation may be dying out in the living room, drowned perhaps by alcohol and the din of the television set in the background; but conversation which is stimulating, thought-provoking and informative, while at the same time being enjoyable, as listener or participant, still lives in the dining room on the 17th floor of the new Clinic building of the Ford Hospital. Personally, whenever I have been mulling a problem over in my mind, I introduce it at lunch, and usually get it clarified. May I here present a sample?)

I had felt troubled after reading an eloquent and persuasive discussion by a psychologist, George A. Kelly, to the effect that the medical profession does not do good psychotherapy because it is handicapped by assuming "medical responsibility" for the patient. The implication is that responsibility and authority are inseparably linked, and that authoritarianism is inimical to growth. Individuals may seem indecisive and appeal to us for direction, yet they are more "autonomous" than they appear. They could make those decisions, with reasonably good judgment, if we did not go beyond our position as doctor and cut their wavering short, by telling them what to do. By so doing, we foster their dependence and immaturity, and hinder personality growth.

When I had described this viewpoint, those present were quick to rise to the defense of the medical profession. We do not assume authority over the patient. It is thrust upon us. The patient and his family appeal to the doctor, almost as if he were the one who made the patient sick: "What are you going to do about it, doctor?"

Dr. McIntyre commented that, indeed, this attitude of laying the problem in the doctor's lap is often present. However, early in his psychotherapeutic relationship with an individual patient, he makes it clear that it is the patient who will be "doing" something. What may be wise or healthful for the patient to "do" could be discussed, but the decisions to act and the responsibility for carrying out the actions would remain with the patient. Dr. McIntyre told of an incident which had helped him to define, in his own mind, the relative role of doctor and patient. Early in his medical training, while rotating through the Dermatology service, he had once felt cornered by a patient's demand that he "do something." Dr. Menagh had helped him escape the feeling of

*Division of Psychiatry.
being pressured by the patient, by commenting, "I never grew a single cell on anybody's hide but my own."

This is a quotable restatement of Dr. Ambrose Pare's famous observation, "I dress the wound; God heals it." We tell the patient how he may aid nature in curing himself, but we need feel no sense of frustration, of personal failure, or of insult, if the patient chooses not to aid, but to hinder nature.

However, while we may not intend to assume an authority over the patient, we may unwittingly do so. I reminded the group that, for example, we may word our advice as commands. We say, "You must not smoke." Unless the patient asks us, we may not explain the exact degree of harm (as in Buerger's disease) or the exact degree of discomfort (as in the scratchy throat about which the anxious patient is complaining) which may result from failure to follow our advice. Dr. Noshay agreed, but felt that experience teaches us to avoid that error. The longer he practices, the more he finds himself explaining the reasons for the suggestions he makes, thus leaving the patient free to choose, with full awareness, whether the gain, on the one hand, is worth the inconvenience, on the other hand, connected with following the doctor's advice.

If the wise doctor, as each of us present assumes himself to be, consciously avoids authoritarianism, then how are we to explain the rebellious feelings we get when the patient starts telling us how he wants to be treated? I remember hearing a doctor say that if a patient asks him for a specific one of the new tranquillizing drugs, it so annoys him that he is certain to prescribe a different one. When a new patient begins his relationship with me by asking for electric shock treatment, I feel a prejudice against that treatment for that patient arising within me. Dr. Noshay told of a patient to whom he gave histamine treatment for multiple sclerosis, not when the patient demanded it, but only later, after it was made clear that he, not the patient, had ordered it.

Dr. Dickson summed it up by remarking that the patient's request for a specific treatment should not, in logic, constitute a contraindication to the treatment; yet we seem to feel that it does. This sounds like a jealous guarding of authority, as if we have to show him who's boss.

Dr. Dickson went on to make the point that authority has its usefulness. He told of a small child who, meeting a permissive adult, became more and more anxious until the adult finally wisely said, "No." Anxiety is quieted by strong leadership.

As I left the luncheon table, I was stimulated by Dr. Dickson's last point to remember the time when I had my acute appendicitis. I had somewhat atypical symptoms, so that to me the diagnosis seemed uncertain. How comforted I felt, when Dr. Fallis, without a trace of hesitation or apparent doubt (I wonder how much he felt internally) announced that operation was necessary. Yet this decisiveness, necessary in a good doctor, is not the same thing as authoritarianism. Had I been a Christian Scientist, and refused the surgery, I feel sure that Dr. Fallis would have been equally decisive, but not authoritarian. He would have said: "Very well, then; you are likely to die without surgery, in my opinion. I cannot be 'responsible' for you. I urge you to seek other competent advice, but the decision is yours."

The last word on the subject had neither been said at the luncheon table, nor has
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It has been written here. The generality is established that the doctor's leadership can be used, like any other of his tools, for healing or hurt, depending primarily upon his individual skill and judgment. And the conversation has further indicated some subtleties which could justify the attention of almost any doctor. Can he recognize when his relationship to the patient has become more authoritarian than he himself thinks it should be? Can he recognize the reasons in him, or in the patient, why it became so? And does he know what to do about it?

SEQUEL

THE DISSATISFIED PATIENT

A doctor may have a too-authoritarian relationship and yet remain comfortably unaware of its existence. Neither he nor the patient feels like complaining. If, on the other hand, the patient is ignoring the doctor's "authority," or attempting to give orders to the doctor, both the patient and the doctor are unhappy. Dr. Dickson, at a later luncheon conversation, told me of such a patient, who finally, in a huff, signed herself out of the hospital. If the patient thus chooses to terminate the relationship, to "fire" the doctor, there is, of course, little we can do; but should the doctor ever terminate it? Should he resign from the case, if the patient is uncooperative, disobedient, dissatisfied and critical? The mere fact that the patient exhibits these traits is additional evidence of rebelliousness toward authority, which is an emotional disorder, for which treatment is desirable. Therefore, if the doctor withdraws from the case, for whatever reasons, he may be doing the patient psychological harm by missing a treatment opportunity.

Of course, no one enjoys criticism; but if a doctor reacts over-emotionally to a patient's criticism, it may be, so Dr. Dickson suggested, because he felt "threatened" thereby. This term is used in its psychological sense — a danger to one's self-esteem, which (according to the Sullivanian school of psychiatric theory) causes anxiety, which then may be converted into anger and other emotions; and these emotions then may cloud the doctor's judgment.

However, before we speak of the psychological "threat," we need to remember that there is a realistic threat to the doctor, in the uncooperative patient. He may die, and we may be blamed for it. Under such circumstances, to allege that the deceased was uncooperative is not only a feeble defense, but also in poor taste. One does not speak ill of the dead. Since in my work as a psychiatrist, I seldom am "responsible for" patients in danger of dying — they risk their comfort, not their lives, in disobeying me — I decided to ask Dr. F. Janney Smith for his opinions. He said that the problem seldom comes up, in a severe form. The patient's minor deviations from the recommended program are a matter for discussion and repetition of the advice, but not for terminating the relationship. However, if there were extremely flagrant deviations from his advice, seriously endangering life, he agreed that it would be necessary, in one way or another, to disclaim "responsibility" for the patient. If one cannot protect the patient, he must protect himself. Relatives expect us, quite illogically, to "make" the patient do what he should. If he is in serious danger through his disobedience, we are obligated to use every means at our disposal — including the "rejection" of the patient, objectionable as it may be psychologically — to influence him.
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Such situations being rare, we can return to the idea that the doctor who is overly angered at his patient's foibles feels that way because of being psychologically "threatened." In medicine we have no clear-cut, objective measure of whether or not we are doing a good job. If the motor runs smoothly, the mechanic has proved himself; but if the patient gets sicker, this is no proof of the doctor's lack of competence. We should not be judged entirely by our results; and the esteem or disesteem in which our patients hold us is a highly inaccurate standard. We must, by and large, judge ourselves. Dr. Dickson summed it up in the word, "confidence." The doctor knows, by constant comparison of his work with that of other physicians, what his capabilities are, and becomes secure in his feeling of confidence in himself. His self-esteem is then not damaged by the patient; he does not become emotionally upset, nor does he need to defend himself by arguing with the patient, or by dismissing him.

I objected to the word "confidence," and offered instead a word that, at first glance, seems to be just the opposite — "humility." The thought is that, in a given instance, my best may not have been as good as some other doctor, hypothetically, could have done, but it was the best I could do. Of course, by "confidence," Dr. Dickson does not mean to imply conceit, "I never make a mistake;" and by "humility," I do not mean to imply uncertainty and doubt, a feeling that he made a mistake just because the patient alleges it. Probably Dr. Dickson and I are saying the same thing; and our next luncheon conversation may be on semantics rather than medicine. He is stressing the absolute necessity that the doctor know his business, and know that he knows it; and I am stressing the need to listen tolerantly to a point of view which you "know" is incorrect. Since you don't know everything, it is always possible that even the uneducated can teach you some small point; and even if he teaches you nothing, you may understand better why he thinks as he does. Understanding why people think incorrectly is psychotherapy.

BIBLIOGRAPHY

1. Doctors of the Henry Ford Hospital mentioned or quoted herein: Dr. Robert A. Schimek, Associate Surgeon, Department of Ophthalmology; Dr. Harry O. Davidson, Associate Physician, Department of Pediatrics; Dr. J. Lewis Dill, Surgeon-in-Charge, Division of Otolaryngology; Dr. William C. Noshay, Chief, Section of Neurology; Dr. Laurie C. Dickson, Jr., Physician-in-Charge, Medical Clinic #3; Dr. Frank R. Menagh, Consultant, Division of Dermatology; Dr. Lawrence S. Fallis, Surgeon-in-Chief; Dr. F. Janney Smith, Consultant, Division of Cardiology.