Paternalism in Medicine – From Patients to Professionals

MEDICAL PATERNALISM IS DEAD

"Loktor, why you never explain huh?"

In the last decade, we have declared the death of medical paternalism. Previous ethical approaches dictated that the doctor solely shouldered the massive responsibility of the patient's health. Correspondingly, the patient was expected to express blind faith in his or her physician's abilities. There was little information on medicine available in the public domain and where present, information was rarely complete. The advent of the Internet and the rise of the educated middle class has paved the way to patient autonomy and shared decision-making. Informed patient consent is the new black. We have entered a brave new world where patients make all their own decisions and have kindly absolved us of the agony of deciding for them. As a profession, we are ready to embrace our new roles as the patients' allies and advisors; those of us who believe otherwise are fossils.

OR IS IT?

"Lor-kun, you decide and tell me lah."

Except that hasn't really happened. The Internet has brought a flood of information that is as likely to misinform as it is to educate. Google has equally taught my mother that exercise is good for her and that her sinusitis is actually severe lead poisoning that will lead to death in days. (It, at some point, also convinced her that paracetamoxyfrusebendroneomycin is a real drug). Patients now have university degrees but still can't remember the names of their medicines. Medical treatment has gotten ever more complex and difficult to understand. Courts remain sceptical in cases in which patients allegedly make an informed choice of medically improper treatment and patients still expect that physicians will make the best choice of medically proper and indicated treatments. The physician who chooses to eschew his "paternalistic" duties completely does so at his own peril.

This reflects a general societal consensus on what constitutes acceptable medical care. Despite their desire to know more, patients have not absolved us of our responsibility to decide what constitutes the best treatment for them. This makes sense, because much of medicine involves experiential knowledge. For example, the traumatic process of resuscitating a patient cannot be described in clinical language to someone who has not undergone it before. Simply telling a patient's family what intubation is like doesn't give them any better an idea of what it actually involves until they've seen it themselves.

And so, paternalism in medicine is much like the cough syrup addict that just won't stop visiting your clinic for more. Despite consigning ourselves to signing endless reams of consent forms and scribbling long paragraphs of documentation stating what we've explained to patients, paternalism remains around in every corner, and in each and every decision we make.

PRIMUM NON NOCERE?

"Can't remember lah. You check computer can?"

Perhaps it's time we acknowledged that the problem is a lot deeper than simply filling out a consent form. The fundamental problem is that our traditions have long cast the role of the physician into a paternalistic role. Paternalism presents itself to our profession in a myriad of subtle ways. Consider these tightly held pearls of wisdom:

"First, do no harm"

"To heal sometimes, to comfort always"

"A doctor's heart is like that of a father's and a mother's" – a Chinese saying

These sayings imply the physician's power to help or harm at will and also the underlying assumption of a physician's moral authority to comfort in severe emotional distress.

Consider the long years of study and experience that place great knowledge and power in the hands of the physician; that can never quite be transmitted to a patient in a five-minute conversation.

Consider the pride with which we take in our treatment successes and the devastation that failure wreaks upon us – as if we, and not nature, were the final arbiters in a patient's life and death.

Consider also the almost disciple-like way we learn our skills: the hierarchical, almost military-like nature of relationships within our fraternity, between the senior and junior; generalist and specialist; and ministry, medical council and professional.

In considering all these things, we see that nothing in our profession is truly free of paternalism. Paternalism is a part of not just our attitudes and paradigms of thought, but often manifests as authoritarianism inherent in our patient-doctor relationships, professional relationships, career advancements and daily communication. Some might even argue that a healthy dose of paternalism keeps us passionate about protecting the welfare of our patients.

Yet paternalism becomes ever more socially unacceptable and, arguably, the protection it affords inevitably encourages some degree of disability. For example, the National Electronic Health Record has made it unnecessary for our patients to learn their drug names, molly-coddling of medical students can lead to undertrained house officers, and over-reliance on specialist care can deskill generalists and increase the costs of healthcare.

FAKE IT TILL YOU MAKE IT?

"Talk nicer can or not?"

The first step to addressing the problem is recognising the depth to which paternalistic attitudes penetrate our paradigms of thought; our learning, working and leadership styles; and even our daily communication. Sometimes, I wonder if there ever was a profession whose propensity says things as disagreeable and patronising as ours.

To our patients: "Don't eat that. Your control is poor. Your diet is bad."

To our students: "I know all of you together can get an MBBS distinction, but each one of you will FAIL miserably."

To our juniors: "You all are the strawberry generation. Do first, ask later."

To our colleagues: "You didn't do this. Audit. Account for."

All of the above are phrases that are largely not delivered in malice, but out of a genuine desire to correct and guide. Yet I've never seen any of these nagging make a difference; rather, more progress is made when a relationship of positive reinforcement and trust is established. Perhaps even if we're not ready to change our paternalistic paradigms of thought, let's begin by addressing our patterns of speech, till the day comes when we finally believe what we're saying when we tell the patients that *it really is their choice.* ◆

PROFILE

TEXT BY

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Dr Alex Wong is a private practitioner of medicine whose second kid is due in February, which makes him wonder if having children is compatible with the practice of medicine. He believes that ethical private practice is possible but accepts that he has delusional views at times and writes in an effort to try and distinguish these from reality.