Editorial

Any More Cordials to the Drooping Spirit? Professional Ethics, 1847–1989

For the physician should be the minister of hope and comfort to the sick; that, by such cordials to the drooping spirit, he may . . . counteract the depressing influence of those maladies which often disturb the tranquility of the most resigned . . . .[1] (1847 *Code of Ethics* of the American Medical Association.)

Two small anecdotes, 28 years apart, illustrate how far the terms of ordinary clinical discourse have strayed from the quaint language and assumptions of our nineteenth century forebears. The first comes from a 1960 cartoon by Jules Feiffer:

I woke up one morning and I couldn't breathe. So, of course, I figured it was psychosomatic. A free-flowing withdrawal from unhappy visions. After that I developed a heaviness in my chest. So, of course, I figured it was psychosomatic. A masochistic act of self-reproval toward my body. Then I got this gosh-awful sneeze. So, of course, I figured it was psychosomatic. An acting out, through germs, of my latent hostility towards society. Naturally, I grew worried about my emotional well-being. I went to see a psychiatrist. He told me I had a cold.[2]

The second occurred about a year ago in my practice. A sophisticated, young businesswoman seemed unusually worried about a 4-day illness that began with a sore throat, proceeded to nasal congestion and sneezing, then to a feeling of congestion in her chest, plus a dry cough. She had already consulted another physician twice for the illness. He had obtained a throat culture and a blood count, which were normal, and prescribed an antihistamine and aspirin. Nothing helped, so she consulted me, saying, "I don't understand whether this is allergy or sinusitis, and why I am not getting better."

I could see her reddened nares from across my desk, and my formal examination showed only inflamed turbinates, with a clear nasal discharge. After a bit more conversation, I asked, not entirely without guile, "How is it you have not been able to identify this illness as a cold?"

"I never get colds," she replied, "and I never feel this bad."

Later, as we both stood up to take leave, she responded to the barb in my question saying, "You must find it amusing to have people come in here with colds."

"Not amusing," I replied, "but sometimes surprising."

A Widening Rift

Between these two accounts, there lurks a widening rift of assumptions, attitudes, and behaviors affecting both physicians and patients. Although both are about a common, benign, and self-limited illness, they dramatize the changing terms of medical encounters in the last 3 decades, when the contract has become the dominant form of medical exchange. The first is humorous, but the second has a nasty quality that, even after allowing for the idiosyncrasies of the participants, shows how physicians and patients bring a new set of emotional baggage to their meetings. Only Woody Allen sees any humor nowadays, and his is rather macabre.

In passing, it is interesting to observe how obsolete the psychosomatic model of illness has become. Even though we all believe, in some sense, in the reality of stress, and most moderns think of their lives as stressful, few welcome the attribution of stress to their own symptoms. The relations must be obvious and immediate—a death in the family, a divorce, the loss of a job, or some other misfortune or accident. There is not much understanding about how a remote experience or relationship could have anything to do with a present illness. The psychoanalytic theories upon which such inferences rested are long since passé in medicine, even though they still have currency among novelists, dramatists, and historians. What is discouraging about this passing of ideas, which are sometimes useful, is that no new or better ones have arisen to explain what is idiosyncratic, irrational, absurd, and tragic in human experience. But this is a digression.

What is new and different about physicians and patients that makes their meetings tense, sometimes hostile, and ungratifying? Patients, properly, do not want to be treated as children, yet they have not given up their childlike, even magical,

dependency upon medicine-as-a-whole. They trust individual physicians less but medical power more. If Doctor A is not able to provide prompt and satisfactory diagnosis and treatment, surely, Doctor B, C, or D will do so. It is a matter of finding the one who can put everything right.

If the patient is not to be regarded as a child, or at least as dependent, then, what else? An innocent victim of circumstances? Hardly, when lifestyle characteristics account for so much medical care. Patients want to be treated as consenting adults; as canny consumers who want their medical care fast and efficient—no nonsense and straight from the shoulder. They value these features more than they resent high costs. But, also, they want it wrapped in a package of real or imagined nineteenth century virtues, courtesies, and style. No one would use the archaic language of the 1847 *Code of Ethics* today, but patients also want physicians who are ministers of hope and comfort, who are not above an occasional "cordial to the drooping spirit."

If so, what is the supposed source of such attitudes, emotions, and behaviors among physicians? Can they be extorted by the use of increased competition, accountability, and litigation? Surely, the biggest extravagance in modern medicine is the overuse of services and resources by the worried well and those with benign, self-limited problems, whose demands, expectations, and media-generated fears create less sympathy than resistance, perhaps, even contempt, in the most conscientious physicians, the very ones who might be most capable of well-reasoned clinical judgment and reassurance. The tugs-of-war about tests, procedures, and drugs go on apace whenever physicians and patients meet.

Perils of Honesty

On the other hand, physicians are not yet comfortable with what Szasz[3] called our new roles as experts, whose chief duty is "an unqualified obligation to tell the truth," letting the chips fall where they will. Furthermore, he asserted:

> The belief that doctors are their patients' agents—serving their patients' interests and needs above all others—seems to me to be of a piece with mankind's basic religious and familial myths.[3(p 2)]

Szasz disallows physicians' claims for "benevolent altruism," "total virtue," and "impartial goodness" in response to the patients' presumed helplessness and dependency on the grounds that such claims "obscure the conflicts of loyalty to which the [physician] is subject." Physicians as experts have a primary loyalty to the truth of their science, and as practitioners, they are agents of whoever pays them. These basic loyalties rarely become explicit.

Few human relationships, expert or otherwise, can tolerate that much honesty. In the tradition of medical practice, patients must be handled, more or less, with kid gloves, taking into account their sensibilities, wishes, and actual conditions of illness, if any. The trick is to know how much. The power to decide "how much" is itself a problem for honesty. Most physicians have given up the big lies and genteel deceptions of our ancestors, such as concealing cancer, calling it by a different name, or hiding a bleak prognosis. We do not prescribe inert placebos, meaning those in which we ourselves do not believe; but we have not given up all dissimulations, euphemisms, and little white lies. We do not tell patients when we find them tedious and boring; how trivial we find many of their complaints; how we dread their headaches, backaches, fatigue states, and nerves; how repulsed we are by their "refractory" obesity; how inane we think it is to worry about cholesterol when one has not lost weight, exercised, and given up smoking cigarettes; how we hate it when they do not comply with our recommendations; how we resent their denials, misrepresentations, and withholding of information. I find it hard to confess here that I sometimes have such feelings, and I have no intention of sharing them with my patients.

A recent issue of *The Family Therapy Networker* was devoted to the clinical ethics of family therapy. In it, Doherty[4] cleverly exposed five "innocent" deceptions: (1) telling a father that you have a son the same age as his, when this is not the case; (2) telling a mother that you have consulted with colleagues about her daughter's problem, when you have not; (3) complimenting a family on their ability to communicate, when this is not what you believe; (4) giving "paradoxical directives" to a family; and (5) expressing false "worries" that the family is changing too fast. These deceptions are not different in kind from what also happens in ordinary medical practice.

The Unfinished Transformation

How should physicians think about patients nowadays that medical parentalism is out and patient

autonomy is in? Are we all ready for a new era of adult-adult medical relationships wherein the patient is a sophisticated, informed consumer; the physician is a competent, accountable provider; and the differences that arise between them about quality of care are settled by recourse to tort law? This evolution seems well under way and who can gainsay it? On the surface, at least, it appears to be a move in the right direction, inevitable in any case, and consistent with democratic and egalitarian values. No more authoritarianism, benevolent despotism, or hocus-pocus on the part of the physicians; no more superstition, credulity, and dependency on the part of patients; everything open and aboveboard. We will conceal nothing between us and expect no quarter when one side of the bargain is not kept or when things do not work out to either's satisfaction.

My experience in practice suggests that the Utopian transformation is not completed. We are in the midst of it, not yet clearly comfortable with it, and it generates a good deal of uncertainty and dissatisfaction. In theological language, we are caught between the "no more" and the "not yet"; the older order has passed away, but the new order has not fully come. How, then, are we to conduct our lives during this interregnum? Perhaps, there is still time to think about what is happening, even to modify it, or at least to develop an interim ethics (is there any other kind?) that will help us to make the transition with a modicum of style and grace.

There can be no doubt that physicians in my generation inherited a legacy of professional style from the nineteenth and early twentieth centuries that saw doctors and patients as unequals in their relationships with each other. To put it bluntly, patients were treated as children, fractious, rebellious, and impulsive, who did not act naturally in their own self-interests, who needed to be threatened, cajoled, wheedled, deceived, and otherwise controlled for their own good. The burden of the relationship rested mainly with the physician who plied a great deal of mystery along with a little science. At its worst, this style abused and exploited, often for base motives, such as keeping the patients from other doctors. It is remarkable how much of the earliest AMA codes of ethics were devoted to relationships among physicians, with precise rules about the processes of consultations, care of another doctor's patients in an emergency, and distribution of fees between them. Even casual contacts with another doctor's patients were eschewed. Competition was no stranger to our forebears.

There is also a section in the 1847 *Code of Ethics* about the patient's duties to the doctor, left out of subsequent revisions but, perhaps, in need of resurrection today. The patient was enjoined to select a properly qualified physician, to trust him (sic), to disclose all information that might bear on the illness, to pay, and, finally, to be grateful. At its best, this style rested upon the benevolent good will of the physician, the availability to go when called, nonabandonment, and charitable concession of fees under improvident circumstances. There were strong appeals to the physician's moral integrity and responsibility, with many oughts and shoulds, plus a strong appeal to the honor of the profession. Such appeals did not exclude lying, deception, secret-keeping, placebos, and protection of incompetent physicians; but all these derelictions were justified for the good of the patient as the physician interpreted it, or for the greater good of a proper collective professional image. If the reputation of one physician crumbled, all physicians believed it to be a threat to themselves.

It is my belief that, in spite of modern changes, physicians are still playing by the old rules, because the values from which the rules derived, and upon which they depended, have not been replaced by different values. Values change more slowly than circumstances. Even so modern a writer as Edmund Pellegrino sees the fundamental act of medical practice, from which the axioms of a philosophy of medicine arise, as "suffering humanity seeking cure at the hands of a physician." The truth is that much of a modern physician's day-to-day work has little to do with suffering humanity. It's hard to identify suffering in check-ups, administrative visits, health maintenance, patient-generated referrals, prescription refills, telephone calls, and filling out insurance forms. It's hard to see suffering in noncompliance, denial, second or third opinions, lack of full disclosure, and doctor shopping. Suffering humanity has been replaced by supermarket humanity, shopping the best deals on its own terms.

Cushing's Advice

Granted that things are not so black and white as I have described them, and that a minority of patients still qualify as suffering humanity, what are the new wellsprings of compassion, generosity,

virtue, and service? The old values had religious roots, but where are the roots of a thoroughly secularized medicine? Can they be nourished by the ideals of competence and accountability in a market economy? What, besides these, motivates a physician to go the second mile, to spend 1 or more hours putting a complex clinical story together, to enter into a relationship that is loaded with negative emotions, to bear the pain of the relationship, and to work towards personal understanding and reconciliation? It is less remarkable to me that physicians and patients are becoming personally detached from each other than that many physicians remain committed to the old virtues.

Cushing foresaw our dilemma in 1926 in a graduation address at Jefferson Medical College titled "Consecratio Medici."[5] He said:

> Dr. Thomas Percival thought these matters of sufficient importance to write a book about them for the benefit of his son on his entry into medicine; but for the most of you who have never heard of Percival and his code, they are left to be learned in the bitter school of personal experience; and many a promising career may come a cropper from misunderstandings of professional ethics, the chief tenet of which, after all, is proper observance of the golden rule, not only in our dealings with our patients and our professional brethren, but with society in general.

Cushing saw that the golden rule was the least and the most that we can do. It is what binds us to the humanity we serve, and what we can wish for ourselves in the hour when the tables are turned, and we ourselves become consumers rather than providers. I, for one, will settle for that.

G. Gayle Stephens, M.D.
University of Alabama-Birmingham
Birmingham, AL

References

1. Leake CD, ed. Percival's medical ethics. Baltimore: Williams & Wilkins, 1927, Appendix III:220.
2. Feiffer J quoted by Bart P. Vocabularies of discomfort. J Health Soc Behav 1968; 9:188-93.
3. Szasz T. The moral physician. Center Magazine, 1975; March/April:2-9.
4. Doherty W. Unmasking family therapy. Fam Ther Networker 1989; 13:34-9.
5. Cushing HW. Consecratio Medici. Boston: Little, Brown, 1940:6.