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Society and the Balance of Professional Dominance and Patient Autonomy in Medical Care

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Through "Bioethics with a Human Face" Carl Schneider crafts a lens to view in sharp and clear focus the nature of the bioethics' debate, the central linchpin of patient autonomy in these discussions, and the limits encountered when intellectual debates confront empirical reality in the world of medical decision-making.[1] As the end point to his arguments, Professor Schneider asserts that social institutions inevitably shape the nature of future medical decisions; the fascination lies in exploring *how* particular social institutions will influence their specific character.[2] This ending point presents my starting point, for it raises a paradox. How could the same set of social institutions, or perhaps better said, the same socio-historical context, produce two paradigms—biomedicine and bioethics—that so clearly oppose one another?

The simple answer is an historical one. The rise of American modern medicine at the turn of the last century heralded a professionally dominant class of medical practitioners never before seen and so set the stage for the later appearance of the new discipline of bioethics which stands as a counterpoint to this incredible power over health, illness, and healing.[3] The more complex but more accurate and useful answer lies in taking a sociology of knowledge approach to understanding the modern medical profession, the bioethics discipline, the interaction of the individual and society, and the general nature of intellectual debates. Both biomedicine and bioethics developed as a response to social problems. The development marked, reflected, and addressed inherent societal tensions, particularly regarding the balance of expertise and individualism. Both were set within the larger paradigm of modern society which shaped the range of possibilities for the terms of a modern, science-based medicine and the discourse surrounding the problems that bioethics addresses. Further, both reflect the rhetoric of innovation through exaggeration, particularly in intellectual debates that promote and accompany the development of paradigms and the adoption of social policy that follow from them.

I will pull the lens back even further than Professor Schneider does, back beyond an overview of bioethical literature and its connection to modern medicine and patient preference. I argue that biomedicine and bioethics

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1. Carl E. Schneider, *Bioethics With a Human Face*, 69 IND. L.J. 1075 (1994).

2. *Id.*

3. While much of this discussion draws from and is relevant to modern society cross-nationally, I restrict my comments to the situation in the United States.

represent socially constructed phenomena shaped by individuals engaged in intellectual debate, actual practice, and political action, who confronted real problems of life and death in the context of industrial society. In this light, I extend Professor Schneider's striking synthesis of intellectual debate and empirical reality in bioethics in three ways.

First, in light of characteristic tensions in modern society, a socio-historical understanding of the rise of the modern medical profession and the bioethics' discipline requires a link to both larger structures of power and cultural values. This contextual view requires neither notions of conspiracy nor functional imperatives; rather, it requires a more subtle and sophisticated view of social change and social structures. Second, difficulties associated with the centrality of the autonomy principle arise not only from specific findings which show a clear disjuncture between what bioethicists argue people want and what people in fact tell us they want, but also from the underlying view of how individuals make decisions. This takes discussions of medical decision-making into the current, lively debate in social science disciplines about the utility of decision-making. Bioethics, implicitly if not explicitly, views it as a rational calculus process. Finally, these considerations raise questions regarding the utility of centralized autonomy in bioethics. These questions arise not because centralized autonomy in bioethics fails to connect significant portions of present reality, as Professor Schneider persuasively documents, but because it represents a crucial mismatch of the problems and issues that may loom on the threshold of the twenty-first century. In essence, I argue that the quest for patient autonomy may be misguided, given what social scientists, particularly sociologists, theorize and have begun to document concerning contours of the new, transitional form of society we are in, be it labeled post-modern, post-industrial, neo-modern, or otherwise. Each of these arguments are dealt with in a separate section below.

I.

Professor Schneider convincingly argued that the dominant theme in modern bioethics thinking is patient autonomy. The question is whether this is something unique to the bioethics paradigm or whether it was a natural and consistent, though not fated, occurrence given the socio-historical context which called for a discussion and even a nascent discipline surrounding medical ethics. Bioethics surfaced in response to the sheer power that the modern medical profession gained through its virtual monopoly over the healing arts. Practitioners of "regular" medicine (as the precursors to the practitioners of "scientific," "Western," "modern," and "orthodox" medicine were called) convinced those in powerful societal positions to make the practice of a certain sort of medicine, "germ-theory" medicine, *the* profession of medicine. While the *terms* of medical work—for example, the actual organizational and financial arrangements for the practice of medicine—varied from country to country, as Eliot Freidson argues, the keystone to professional dominance lay in control over the *content* of medical work—for example,

decisionmaking regarding the definitions of "disease," "medicine," "qualifications," and "monitoring").[4] Autonomy and self-regulation were the key principles in the societal contract that was enacted.

In this classic, now standard, understanding of the rise of modern medicine, the public indeed played a role. To attain its preeminent position, the profession *did* require state legitimation through licensing requirements, the primary purview of elites. But it also had to achieve *consulting status*, that is, lay acceptance of this type of medicine. In reality, the public's power was limited to veto power. Like the politicians who crafted the legislation and the industrialists who underwrote the building of scientific medical laboratories and treatment facilities, the public was persuaded. This was no small feat since many people, including much of the upper class, ascribed more to homeopathic cures than the purgatives and bleeding practices that regular physicians practiced early in twentieth century American medicine.[5]

Little need exists, however, to see this as a conspiracy of a profession against the laity. Rather, the historical evidence suggests that the social contract with the modern medical profession was a practical solution to new problems in a new society. This does not negate that it was, as Larson contends, a professional project of the new middle class;[6] rather it highlights that the larger social context, specifically, industrialization and urbanization, set the stage for the major players in new political and economic arrangements concerning health, illness, and healing. The social construction of the institution of medicine, described in ideo-typical form by Talcott Parsons,[7] occurred within a societal context that emphasized a new scientific knowledge, a culture of progress, and a larger societal theme of American individualism. Others have argued more eloquently than I that this fit between the ideologies underlying the germ theory and modern society allowed the state to agree to a virtual—though in no country, total—monopoly.[8] It also allowed the state to reject more holistic and often more prevention-oriented schools of medical thought like homeopathy, naturopathy, chiropractic therapy, and even the more broadly focused modern medical approach of the German social physicians such as Virchow.[9] The biomedical paradigm saw "disease" in a very rational, mechanistic, decontextualized, and ultimately conquerable fashion. In opposition to earlier and more diverse forms of medical care, the original germ theory formulation focused on the disease in

4. ELIOT FREIDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE (1970).

5. There has been some debate over how the public's role actually played out historically since most of the early, dramatic "victories" in modern medicine came well after the establishment of professional dominance. *See* John B. McKinlay & Sonja M. McKinlay, *Medical Measures and the Decline of Mortality*, *in* THE SOCIOLOGY OF HEALTH AND ILLNESS: CRITICAL PERSPECTIVES 10-30 (Peter Conrad & Rochelle Kern eds., 3d ed. 1990).

6. MAGALI S. LARSON, THE RISE OF PROFESSIONALISM: A SOCIOLOGICAL ANALYSIS (1977).

7. TALCOTT PARSONS, THE SOCIAL SYSTEM (1951).

8. *See generally* E. RICHARD BROWN, ROCKEFELLER MEDICINE MEN: MEDICINE AND CAPITALISM IN AMERICA (1979).

9. *Id.*

the body in the bed.[10] This medicalized and micro view of disease allowed both physicians and industrial capitalists to ignore larger features of this new society that might produce injury, disease, and death (for example, the precarious working conditions in early industrial enterprises) in favor of the search for particular microbiological agents.

This bargain, however, was not struck without cost. As Talcott Parsons contends in his original treatise,[11] "we" agreed that physicians would serve as the societal medical experts with a functionally specific, objectively neutral, and scientifically based stance to treatment and to patients. In turn, "we" agreed to be cooperative and compliant with the physician we freely chose. Expertise demanded compliance and brought patient dependence after the initial exercise of choosing a particular practitioner. As we handed over our trust to the modern profession of medicine, so too we became less knowledgeable about medicine and our values about life and death. The contract, at its very base, established social inequality between expert and layman and set up a basic paternalism.

If one takes Kai Erikson's view that culture is characterized by key "axes of variation" which represent the countervailing and essential contrasts of a society,[12] then one might be tempted to see this original arrangement as sliding too far toward dependency, with the physician as "do-er" and the patient as simply the one being "done to." Given this contextual frame, it is no surprise that, as Szasz and Hollender contend, the major form of the physician-patient relationship is "guidance-cooperation" with the physician as the expert and the patient as the cooperative but deferential participant.[13] If the role of bioethics is to oppose whatever basic dehumanizing tendencies exist in the modern medical approach, then, as Professor Schneider contends, autonomy is one of the central features of the bioethics discourse for good reason.[14] Not surprisingly, the empowerment and the reassertion of the patient as the individual decision-maker form crucial elements in discussions. Conceived within the same social frame, bioethics recognizes the inherent violations of individualism celebrated generally in modern society and particularly in modern American society. At its core, the drive for professionalism contradicts the ideologies of individualism and equality that stand as the hallmarks of modern, industrial democracies.

But, as the debate surrounding the rise of professions overemphasized the virtues of the beneficent and neutral expert and swung the pendulum to the extreme for the rights and duties of expert authorities, the bioethical paradigm swings it to the other extreme, overblowing the desires and the need for patient autonomy. As Professor Schneider argues based on his foray into

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10. *See generally* RAYMOND S. DUFF & AUGUST B. HOLINGSHEAD, SICKNESS AND SOCIETY (1968).

11. PARSONS, *supra* note 7, at 428-79.

12. KAI T. ERIKSON, EVERYTHING IN ITS PATH: DESTRUCTION OF COMMUNITY IN THE BUFFALO CREEK FLOOD 82 (1976).

13. Thomas S. Szasz & Marc H. Hollender, *The Basic Models of the Doctor-Patient Relationship*, *in* DOMINANT ISSUES IN MEDICAL SOCIOLOGY 174-76 (Howard O. Schwartz ed., 1987).

14. Schneider, *supra* note 1, at 1086-90.

grounded theory, systematic empirical research suggests that this basic tenet of bioethics stands contrary to patients' desires to shoulder that individualistic burden.[15] Decisions are often too complicated, even for patients who consider themselves highly educated or intelligent. Considering that a basic aim of medical school is, according to Renée Fox, to "train for uncertainty" (for example, physicians must come to identify routinely what they do not know that is known, what is not yet known, and to demarcate the line between the two), it is easy to comprehend this reaction from patients and their families who rarely confront these life and death decisions.[16] It is similarly easy to understand why patients would want a shoulder to lean on and a professional trained to stand in a more knowledgeable and objective position of strength.

In sum, bioethics and biomedicine were formed on the fault line defined by the tension between the individual and modern society. The intellectual struggle to deal with this tension, to this point, takes a view of patients and practitioners as individual, rational actors weighing the costs and benefits of action. I now turn to the use and wisdom of this view, consistent with modern society.

II.

This intense focus on autonomy should both strike a familiar cord and send a shiver up the spine. It recalls the fundamental tension between the individual and society, whether one chooses to see society as a peacemaker of separate, self-interested individuals or as an iron cage restricting individual liberty and action. Notions of whether individuals are, should be, or want to be autonomous decision-makers is the focus of a lively and sometimes heated debate in the social sciences. This type of rational choice-based approach dominates theory and policy discussion in areas like health care.[17] It is used implicitly by most modern social theorists and by most people as part of a common sense psychology invoked to understand what they and others do.[18] Not suprisingly, from a sociology of knowledge perspective, this economic psychology matches the worldview of most people living in modern, industrial societies because it emphasizes three phenomena. These are: the ultimate importance of agency (whatever structural constraints may exist); the conjoint nature of modern society, autonomy, and rational thinking; and everyday notions of the inescapable need to balance pros and cons.

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15. *Id.* at 1090-92.

16. Renée C. Fox, *Training for Uncertainty*, *in* THE STUDENT PHYSICIAN 207 (Robert K. Merton et al. eds., 1957).

17. *See* David Mechanic, *The Role of Sociology in Health Affairs*, *in* HEALTH AFFAIRS 85 (Spring 1990).

18. For a thorough and recent treatise on the rational choice approach in socio-science see JAMES S. COLEMAN, FOUNDATIONS OF SOCIAL THEORY (1990).

Yet, even those social scientists adopting the rational choice perspective have had to reconsider basic conceptual elements.[19] Work spanning the spectrum from ethomethodology in sociology to institutional economics shows that people do not generally act as autonomous individuals weighing the costs and benefits of possible decisions. Even revised approaches strip individuals from society by portraying them as alone, outside of the social interactions that make them who they are. Almost without recognition, it removes the dynamics of decision-making and plucks the decision from the discussions and social context in which individuals create and maintain their lives.[20] Despite its focus on the family as the decision-making unit, the bioethical paradigm falls into the same traps.

Discussion within the social sciences bears directly on the weakness of a patient autonomy model. The autonomy paradigm rests on an assumption of what people want and how they behave in decision-making circumstances. Despite the interest of rational choice theorists to make simplifying assumptions about the nature of individuals and of bioethicists to subscribe to this view to strengthen their arguments, a common bias exists. This bias reflects how people in modern societies *ought* to act, at least according to intellectuals who then must argue about how things should change.[21] The social science that Professor Schneider so stunningly organizes points clearly to two facts. First, patients do not necessarily want autonomy. Second, patients involved in decision-making for medical care acknowledge the larger structures in which their lives are embedded. In their social networks, individuals recognize or fail to recognize problems, find the limits of their social resources (their own and their physician's), and find a way to evaluate the outcome of their actions. Individuals are social and pragmatic, not isolated and ever-consciously rational. Individuals appear to want involvement in the social process of decision-making for themselves and their families. This desire occurs under the structural condition that individuals believe that physicians are experts but are not infallible and are not necessarily aware of other, non-medical factors that might be important in a particular case. Patients want information and the option to have a voice in their own health care decisions. They also understand the specialized knowledge and skill of physicians. Even when national polls have documented skepticism and rising loss of confidence levels concerning the medical profession in general, patients report very high levels

19. See, for example, the new "public choice" school in political science or "socio-economics" in sociology. Elinor Ostrom, *Microconstitutional Change in Multiconstitutional Political Systems*, 1 RATIONALITY & SOC. 11 (1989).

20. For a summary of this debate and a suggestion for an alternative view relevant for medical phenomena, see Bernice A. Pescosolido, *Beyond Rational Choice: The Social Dynamics of How People Seek Help*, 97 AM. J. OF SOC. 1096 (1992).

21. The bias makes further assumptions about what physicians want and how they behave. For physicians in clinical decision-making, consultations in professional networks are built into the routine of daily life. "Hyperationalism," to use Professor Schneider's apt term, applies not only to how bioethics stereotypes patients, but also to how it stereotypes practitioners.

of satisfaction with *their* doctors.[22] They have bought into the social contract of professional dominance, perhaps to one degree or another, but bought into the culture of expertise nonetheless. In essence, people want the tools of medicine to be at the disposal of their values. They do not want autonomy; they want self-determination. While some physicians may truly believe that their job is to lay the information at the doorstep and wait for an answer, this approach has the latent function of tapping into a desire on the part of a medicine besieged by threats of malpractice, to avoid responsibility by extending freedom.

In sum, patient autonomy in bioethics, the notion that decisions should be made by the patient given all pertinent medical information, rings of naivete regarding how patients and physicians enter the social process of decision-making.[23] This notion characterizes medical decision-making, both by the profession and by the public, as a rational calculated process. Neither is accurate. In the real world, people reject the paternalistic prescriptions of bioethicists designed to counter the paternalistic prescriptions of physicians.

III.

Even if autonomy represented the realities of medical decision-making, the question remains whether it would be a wise program for the future. In my opinion, the central question is not, as Professor Schneider contends, whether there are holes appearing in the fabric of the bioethical paradigm.[24] The bioethical paradigm represents one patch in an intricate social quilt, one that reflects a contrasting theme in the overall design. The crucial questions surround the strength of the larger social quilt, which may be worn, or its connecting squares, whose fraying may weaken the power and relevance of current thinking in bioethics. A focus on the unravelling of these parts of the larger mosaic helps one to understand the problems in the bioethical paradigm. In particular, two issues arise.

First, there may be holes in the biomedical paradigm patch, where even the extraordinary promise of modern medicine is limited by things which cannot be altered (like death), by chronic diseases that do not fit neatly in biomedical understanding, and by technology, which (in the spirit of the Kuhnian approach) has produced many of the problems that bioethics and biomedicine now confront.[25] Bioethics faces a "crisis" because the phenomena it seeks to aid or to confront are in crisis. Second, the quilt's border, the paradigm of modern society which orders the unique patches, may itself be threadbare.

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22. *See, e.g.*, JAMES A. DAVIS & TOM W. SMITH, GENERAL SOCIAL SURVEY, 1972-1993: CUMULATIVE CODEBOOK (National Opinion Research Center 1993).

23. For an extreme and conservative view, see IVAN ILLICH, MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH (1976).

24. Schneider, *supra* note 1, at 1077.

25. *See, e.g.*, RICHARD A. MCCORMICK, HIDDEN PERSUADERS: VALUE VARIABLES IN BIOETHICS 5 (Poynter Center ed. 1993) (noting the reaction against paternalism and the flowering of patient autonomy).

This is not a pessimistic statement predicting doom or a yearning for days gone by. It simply acknowledges the likely similarity between the transition from agrarian society to industrial society and the current transition to some newer form of social life. The transition at the turn of the last century emphasized the conditions that made individualism and autonomy the essential bases of the polity, the economy, and the medical sector. The current transition, which social scientists are struggling to describe and understand, may grant autonomy to such a degree that the countervailing call in medicine, in social institutions in general, and in bioethics in particular, may be for more integration and for community-based decision-making. Autonomy may become yesterday's issue as it is replaced by the need for social connections so strained by the complexities and pace of contemporary society.

Modern medicine confronts a complicated situation: a loss of confidence by the public, a loss of key control in the content of medical work in the face of utilization review, and a loss of theoretical power in the face of chronic illness—in general, an erosion of professional autonomy. Medicine cannot sustain the "guidance-cooperation" model under these conditions. Rather, it has been forced to move in many situations toward Szasz and Hollender's model of "mutual participation" in which physicians and patients together chart the course of care.[26] Neither the paternalism of professional dominance nor the paternalism of patient autonomy are viable in the face of current circumstances. These simplistic views have rhetorical utility for intellectual debate; they are less helpful in improving the situation of physicians and patients as they confront serious health and illness issues now or in the future.

We need to reject the view of clinical and medical decision-making as atomistic, rational-choice processes. Instead, we should consider physician and patients to be partners in a dynamic, interactive process of decision-making fundamentally intertwined with the structural rhythms of social life. A bioethical view that links individuals to each other, to their community, and to the larger social system offers a more complicated but realistic and useful foundation to set the terms of the debate. Rather than simplifying the task or diminishing the importance of bioethics, this view presents a challenge. It is easier to build an ideo-typical form of medical decision-making when one starts with individuals (whether patient or physician) as puppets of some abstract contract or as calculating individualists. Seeing them shape and shaped by society, using cognition and emotion to live their lives, makes the task more difficult. It is true, as Professor Schneider argues, that no viable alternatives have been extensively or persuasively developed to this point.[27] But as the early paradigms of modern, industrial society and modern scientific medicine fall by the wayside, the crucial conditions open for the production of new knowledge, for rethinking, and for innovation. Bioethics stands, hopefully, on the threshold of scientific revolution.

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26. Szasz & Hollender, *supra* note 13, at 176.
27. Schneider, *supra* note 1.