CHAPTER II: UNDERSTANDING MEDICAL PRACTICE

In the first chapter an attempt was made to clarify the basic concepts involved in the discussions of applied ethics in general and bioethics in particular with a view to provide clear guidelines for the present discourse on ‘medical practice’. The present chapter traverses issues which at one level may be deemed to be the exclusive domain of medicine but at another level, the concerns defy any attempts to limit the discussions. One of the important characters of understanding medical practice is its domain of application. The subtle attempts by each discipline interacting in the medical practice, to make it the exclusive concern of one profession, denies the topic of its problematics. The old saying, “medicine is too important to be left in the hands of physicians alone”, mutatis mutandi can be said of moral philosophers - “ethics is too important to be left in the hands of philosophers alone.”

Understanding Medical Practice From ‘Medical Malpractice’

For understanding medical practice, it may be useful to reflect on the idea of ‘medical malpractice’, as many questions of medical ethics and health care arise in the context of ‘malpractice’. This is particularly so when one reviews the law of medical malpractice. Societal attempts to control the professions related to medicine and health care, has led to legislating the medical practice. Such legislations have come to be known as negligence law. In short, “lack of or failure to use professional skill and care, the rubric generally invoked to indicate medical negligence, (is) recognized .... as a ground of liability”. From the Code of Hammurabi to early English common law to
modern principles of contract, physicians are deemed to be liable for their acts of commission and omission. Contemporary law accepts lawsuits against the medical practitioners on the basis of the argument that there is an implied contract. At first in America and later on in other countries, "the contractual obligation to possess and exercise ordinary professional skill and care was transformed into an obligation not to be negligent to the patient to whom, by the law of negligence, the physician owed a duty of "due care"."\(^3\) The concept of "due care" has become central to discussions in medical ethics and its consequent legal provisions. A physician who does not keep up with the advances in the medicine, may cause the disability or death to a patient as certainly as if he neglected the patient. Because, when a man claims to possess special knowledge or skill (that of a physician) and upon such a claim offers his services to the society, he is liable to be prosecuted in the court of law if he fails to render services due to neglect. In legal terms, the whole idea is summarised in the concept of "due care" which is the "care" the society expects each person to meet his obligations to other persons with diligence.\(^4\)

'Medical malpractice' is measured in terms of failure to use "due" or "reasonable" skill and care. Generally three parameters are used to judge "due care". A physician is judged on the basis of skill he has in comparison with other physicians in the same city/place. Two, the physician is compared to the degree of care and diligence shown by other physicians in their professional discharge. Three, if the physician claims to be a specialist, he is judged by the skill he possesses matching his claim for being a specialist. The problem of objectively defining what is customary practice, difficulties
in acquiring and presenting expert opinion from fellow professionals regarding negligence, etc. have made difficult application of "due care" in negligence law. In broader terms of medical ethics, professionals, namely the physicians, should find ways and means of eliminating medical malpractice. It may be due to the failure of professional associations and of state sponsored professional councils, that the society is compelled to legislate and resort to legal proceedings whenever negligence is suspected. What is of importance is that "professional negligence" may at times border on fraud and cheating. But the areas of professional negligence may be such that they do not necessarily raise legal liability. This is particularly so because medicine is "an art struggling to be a science" which to a large extent depends upon intuition of the physician (in spite of the fact that there are large number of sophisticated diagnostic techniques), and has internal ethical standards more exacting than the law requires. It is the reluctance on the part of physicians to testify critically against one another's acts of negligence (what has come to be known as the 'conspiracy of silence') which is primarily responsible for the governmental interference and frustration among patients and 'judicial activism'.

The physician enjoyed a high status in the society and trust from the patients because of his knowledge and skill in treating the patients, caring and nurturing them. In recent times, there has been awareness among the people, including scientists, that the physicians are not necessarily the most knowledgeable ones in health care. The limitations of physicians as experts in the field of medicine is becoming more and more evident due to the fact that science and technology is becoming widespread and public
by and large is increasingly involved in the same. Consequently, patients have on the one hand expressed their desire to surrender themselves unconditionally to the physician in trust; on the other hand they are sceptical and critical of the healing mechanisms and the avowed expertise of the physician. As David Mechanic puts it: "While they (patients) desire a trusting relationship, they are frequently untrusting and demand greater representation, information, and voice in decisions making. Obviously, patients and physicians vary a great deal, and there are no simple generalisations that adequately describe the variability that is evident."

**Nature Of Medical Ethics**

Understanding medical ethics essentially constitutes an inquiry into the objectives of medical ethics. And this is possible if we reflect on the concrete medical situation, its problems, possibilities and dangers. In fact, every decision in medical context is a moral decision in which the good of patient, his or her relations and physician is involved. Most problems in medical ethics arise from the conflict between the 'image' of physician or 'what a physician ought to be' and what the physician is. A physician is not (or should not be) a mere technician, disposing off medicines and machines towards the palliation or removal of disease. Physician ought to relate to the whole patient-person. According to moral theologian Bernard Häring, medical ethics represents "a systematic effort to illumine the ethos and elaborate the perspectives and norms of the medical profession ... and the morality of the physician lies in the subjective personal realisation of the proper approach to his profession, his living the fullness of his ethos. It is the physician's capacity to act according to a well-informed
conscience and to make concrete decisions with an upright attitude, and with insight and discernment.\textsuperscript{96}

Medical ethics to a large extent depends upon the level of sensitivity of physicians\textsuperscript{7} in a certain culture and the nature and structure of a health-care system. The level of ethical sensitivity reflects in the dominant cultural values. In a society highly individualistic, based upon dominant values such as efficiency, material comforts, affluence, technological progress etc. an ethics programme will reflect the same values. In our own culture where values are based upon a hierarchy of class and caste, the medial practice may reflect these values. McCormick calls for counter-cultural correctives to overcome such anomalies. Secondly, the nature and structure of health-care system and governmental policies also influence the medical ethics. A health-care system that does not recognise the privileges of rich versus the poor, and instead recognises all individuals as equal and are eligible for the same health-care, is less depersonalising.

In spite of there being specific cultural differences in approach to medicine and health care, there are certain universal presuppositions in all medical practice whether ancient or modern, western or eastern. "Sanctity of life" is central to all medical practice. In ancient Egypt and Persia, the practice of medicine is prescribed in holy books, where, in the struggle between good and evil, the physicians are pitted on the side of good. In the Arab world, the medical practice is based upon Biblical and Koranic prescriptions. In Caraka Samhitā, the physician is warned against sins of thoughts, words and deeds.
That life should be protected, body should be healed and made into 'whole' and suffering be reduced till such time 'God' wills otherwise, is the philosophy behind all medical practice. A study of the various codes of conduct and oath/s taken by physicians reflect the metaphysical or religious foundations of medical practice. The Oath of Hippocrates begins with “I swear by Apollo ... and all the gods and goddesses, making them my witnesses,...” In the Oath of Initiation (Caraka Samhita), the first clause reads “The teacher then should instruct the disciple in the presence of the sacred fire, Brāhmaṇas and physicians”. In Advice to a Physician, Haly Abbas (Ahwazi), the Persian physician of 10th century, begins: “The first advice is to worship God and obey his commands,...” Although in modern times, explicit reference to God is avoided while framing codes or declarations, the language of such declarations clearly envisage a more-than-worldly attitude towards patients. The Declaration of Geneva, for instance, begins saying: “I solemnly pledge to consecrate my life to the service of humanity”. McCormick recognizes ‘sanctity of life’ as the basic value in the practice of medicine on basis of which every decision is taken. With the development of medicine by way of life-sustaining and resuscitative devices, ‘sanctity of life’ as a value seems to be threatened. Conceptually, the debate regarding ‘sanctity of life’ has led to recognition that it is not merely physical life that is important, but the quality of life that is sustained. It is important at this stage to recognise that the value ‘sanctity of life’ even questions the idea of ‘preservation of life’ at any cost.
Objectives Of Medical Ethics

There has been a mistaken understanding that medical ethics is same as the code of conduct laid down by various bodies of professionals or institutions. The Code of Conduct is insignificant compared to the content of medical ethics. Code of Conduct deals with items such as address advertising, billing procedures, self-aggrandisement, conflicts of interest, professional courtesy, public and media relations, use of secret remedies and healing methods, physical appearance etc. which are often seen as more ‘important’ issues by the professionals. Even the watch-guard agencies are often called on to settle issues related to these items in the codes rather than take up the more fundamental ethical issues.

The fundamental ethical issues facing the medical practice have also been directly or indirectly incorporated in the various codes of ethics such as Code of Ethics of American Medical Association, International Code of Medical Ethics of World Medical Association, Medical Ethics of British Medical Association, etc. Expressed in general terms, these codes make it incumbent on the part of the physician that he or she should preserve human life, should be good citizens, prevent all forms of exploitation of patients, promote the highest quality of health care without discrimination, perform duties accurately and objectively, continue to grow in the knowledge of medicine, render service under all conditions and circumstances, promote harmonious relationships with other professionals and expose those who are unethical and incompetent, protect welfare, dignity and confidentiality of patients, etc.

It is obvious that what is said to be code of ethics for physicians, is same as what is
expected of all humans beings. And since the medical context is common to all humans, medical ethics cannot be the exclusive concern of physicians. Therefore, the implementation of medical ethics seems to be the bounded duty of every one involved in the medical practice, be he a patient, paramedic, administrator, public citizen or physician.

The objectives of medical ethics education will depend upon the cultural, geographical and economic conditions of the society. In the U. S. A. the Commission on the Teaching of Bioethics identified four goals of medical ethics education, depending upon to whom the education is meant. The first goal is to help students “to identify and define moral issues in a biomedical context”, the second goal is to develop “strategies for analysing moral problems in medicine”, the third goal is to relate “moral principles to specific issues and cases”, and the fourth goal is to train “a small group for careers in bioethics”.13

The first three goals are meant for all humans who have to take informed decisions regarding moral issues relating to their treatment or health care. It is appropriate that the physician at one level be recognized as not the primary decision maker and at another level one who helps the patients to make decisions regarding their treatment. It necessary in this process that all individuals are capable of recognizing the ethical implications of their decision making processes. The physician must be able to recognise the distinction between technical questions and moral questions. It is only
when a physician is capable of understanding the ethical dimension of medical care that he can guide the patient in making the morally right decision.

Some countries (particularly developed western countries) have recognized the need of a counsellor or consultant who is educated and understands different theories and strategies for resolving ethical conflicts within medicine. Again, the physician must be equipped with knowledge so that he can decide to what extent the information regarding a diagnosis be given to the patient. The same applies to paramedics and others. This task can be carried out only if the physicians, paramedics and others have knowledge of the systems and are capable of relating principles to cases. One of the objectives noted above is to train specialists who will engage themselves in teaching medical and bioethics in universities and professional institutions.

McCormick claims that a medical ethics programme will depend upon what is recognized as the purpose of such a programme and how one assesses the contemporary medical situation. There are a whole series of presuppositions for such a programme that need to be explicit or clarified before any attempt is made to implement a medical ethics instruction. As mentioned earlier, the most important among them is the idea of what a physician ought to be and what is medical ethics about. McCormick adds to these a whole set of presuppositions which take into account the cultural prerequisites, the political system, etc. Although at one level, medical ethics will have the universalistic character, at another level it will be contextualised within cultural parameters of the society. How medical policies and
decisions are made, the structure of health care system, level of ethical sensitivity, assessment of strengths and weakness of medical students are some of the parameters that have to be taken into account for a medical ethics programme.

One of the most fascinating aspects of McCormick's study (not expressed in most of the discussions by other authors - orthodox or liberal, religious or secular) is that he attempts to lay down a definite programme wherein we can carry out a "dialogical process that includes: communal discussion of a rational kind that attempts to reinterpret the meaning of these values in a new set of medical and cultural circumstances" so that cultural, geographical and barriers of time are overcome and at no stage there is breakdown in communication between the moral philosophers or community by and large.

The value of 'sanctity of life' together with the value and meaning of sexuality and family, the value of the personal physician-patient relationship, and individual and social justice in health-care delivery are the values McCormick recognises as the central tenets of a medical ethics programme. The discourse on sanctity of life that occurs practically in every bioethical issue, determines the nature and development of bioethics, whether religious or secular.

Many of the issues that have been highlighted in the medical ethics programme is related to meaning of sexuality and family as the same determines the quality of life we lead. Contemporary moral discussions in general and bioethical discussions in
particular are influenced by the developments in biomedicine and biotechnology. The separation of procreative processes from sexual relationships has resulted in various possible scenarios. The traditional moral philosophy and theology seem to be most affected by the separation between sexuality and family, namely, separation of sexual expression and procreation through effective contraception, etc. and achievement of procreation apart from sexual expression as in the case of *in vitro* fertilisation.

The relationship between physician-patient has been the most discussed topic in medical ethics. Detail articulation of this unique relationship is available in most of the Codes of Medical Ethics, ancient or modern. The relationship is appropriately summarised as that of 'dependence and trust' as the physician deals with not only illness and disease but deals with the person with desires, hopes, fears, worries, etc. Confidentiality, understanding, concern, empathy, honesty, trustworthiness, kindness, are some of the essential tenets of such a relationship.

McCormick and others while highlighting individual and social justice in health care, point out to two 'rights': the right of the individual for proper health care and the physician's right to autonomy. Within these two 'rights' there arises the ethics of group practice, voluntary medical work for the poor, fee structures, racial, class or caste discrimination in medical education and hospital care, etc. There has been considerable consternation among the professionals as well as policy makers regarding the physician's right to autonomy. While on the one hand physician's autonomy is said to have led to growing malpractices in the field of health care, one should remember
that the loss of autonomy will lead to more serious consequences such as third party intervention in the physician-patient relationship and the subsequent dangers associated with it, legal processes that one will have to undergo and the subsequent waste of time and energy on the part of the professional, lack of interest in specialisation and consequently disinclination on the part of professionals to promote advancement in medicine, governmental involvement and subsequent lack of personal initiative on the part of the physicians or health providers. 17

Medical ethics programme in brief has to take into account multiple perspectives, patients, relation of patients, physicians, administrators, policy makers and public by and large, but not necessary in the order stated above. But if the interest of patients is not deemed primary, the medical profession as a whole will suffer. In fact, most, if not all, medico-moral problems arise due to skewed approach, in which the patient is treated as less significant in the overall health concerns.

Concern For Health And Health Care

The concern for health and health care presupposes an understanding of who or what is eligible for health care. It also presupposes a unique relationship between the healer and the patient. A clarification regarding the context in which health care system functions is also necessary to formulate a medical ethics programme.

The involvement of public in the health care decision making is seen as a positive outcome of growing consciousness of health care among the public. Besides, the
development of democratic systems throughout the world has led to policy decisions depending upon the opinion of majority citizens who participate in the democratic processes. What is significant is the felt need on the part of policy makers to promote health of its denizens. McCormick's analysis of moral responsibility for health, discusses eight aspects that should be kept uppermost in mind while arguing for a bioethics programme.

Responsibility for health depend upon our understanding of what constitutes health which has undergone change in the history of medicine. Besides the evolution of the concept of health from identifiable degenerative process, statistically defined concept, concept based upon functional inability to the modern definition of total well-being, there are at any given time various conceptions of health depending upon the societal process. One of the features of contemporary understanding of health is that it is linked up with 'unhealthy' demands made on the society by way of cosmetic surgery, etc.

Cultural priorities also determine one's conception of health. There are according to McCormick, two types of structures, viz. operational (laws, welfare system, tax system etc.) structures and ideological (societal, economic and political beliefs) structures, that determine health care system and its functioning. Health is very much affected by the life style of the people of the society, by the emphasis the society lays on leisure, sports, etc. Another offshoot of the cultural priorities is public morality. In a society that has developed secondary values based upon the interest groups of
various individuals, there is danger of individuals (patients) being mistreated. McCormick points that under such a system where group practice, insurance coverage etc. function, the poor, retarded, elderly patients are likely to suffer most.

One of the most important distinguishing mark of contemporary health care and medical ethics is the shift from concern for life as life to quality of life. The question today is not merely preservation of life or avoidance of disease, but what type of life. This dimension of quality of life gains prominence particularly in the case of comatose patients, extremely defective new-borns, mentally retarded children, etc. To what extent health care should be extended to such ‘patients’ is a dominant moral question. Compounded with this is the problem of magnitude of the health system. Contemporary health care system has grown so large by way of number of patients it caters for and the detail regulations governing it, that an individual is more often treated against his will or without his or her permission. The lesson that the medical community has learnt from the famous Karen Ann Quinlan case is that when a health care system grows large, it tends to be indifferent to patients’ desires and interests. Patients and guardians of patients are made to struggle to subtract themselves from the systematic or institutional treatment and to assert the fact that when a patient enters a hospital or puts himself in the hands of the physician, he engages his services and does not abdicate his right to decide his own fate.

McCormick refers to moral conviction as one of the dimensions of responsibility for health. He refers to ‘sensitivity’ and ‘emotional involvement’ of individual members of
the society, which is particularly important in the case of health care of elderly, infants, retarded and the poor. "Passions", points out McCormick, "is the beginning of any true moral responsibility and therefore of responsibility for health. It is the inner identification with the suffering and the downtrodden. It is that personal start up that gets us off-center a bit - self-center - and propels us to examine our consciences, comforts and priorities."¹⁸ That culture and social factors play a very significant role in determining the health care system and medical ethics is obvious from comparative studies available in various journals of bioethics and biomedicine.

**Ethnomedical Studies Of Medical Ethics**

The ethnomedical studies of medical ethics have been pointing to the fact that there are no universal claims in the healing or health care system - the claims are to be understood in terms of social customs and traditions. There are two ways this can be elaborated: one by comparing different societies and traditions and two by conducting a comparative study of different systems of medicine.

Ethnomedicine studies medical practices in different societies, taking into account the social and cultural factors. These include belief systems, attitudes, behaviour and actions relating to illness and attempts to deal with it. Ethnomedicine analyses primary concepts of medical ethics and attempts to understand their meanings in the specific societal context. Further, it evaluates how these concepts function and how the health objectives of the society is realised. Horacio Fabrega discusses "the objects of concern (e.g. illness, disease), the culture-specific conceptualisations about them (e.g.,
explanatory models, theories of illness), the values and symbolic meanings surrounding illness and how these develop and are manifested (e.g. semantic illness networks, idioms of distress), the persons who treat illness (e.g., practitioners, shamans), and the social practices and institutions that embrace all of these (e.g., social relations of sickness, mode of production of medical knowledge) ...medical ethics, the precepts and standards of how practitioners should conduct their work given their status in the society.\(^\text{19}\)

Ethnomedical perspective presupposes cultural relativism and consequently on the basis of variation in beliefs, feelings, behaviours, traditions, social practices etc. of the diverse people's and societies, argues for culture specific 'medical ethics'. As Fabrega argues: "The critical 'objects' that medical practitioners deal with, namely, persons and illnesses, are culturally constituted and epistemologically related: viewed generically, illness is a state of social/psychological/moral disarticulation, and healing is the process designed to undo this."\(^\text{20}\)

Fabrega, after conducting a comparative study of culture specific medical ethics observes that contemporary European societies are dominated by the biomedical theory of illness, identified as: "the real or possible existence of an underlying state of disease (disordered physical-chemical or physiological systems) ... all important in the professional conceptualization".\(^\text{21}\) In such a model of understanding illness, lay theories (what bioethicians will recognise as patient perception of illness) are neglected. Fabrega, like phenomenologists points out that "physicians pursue their
tasks by developing an alliance with the person ill and attempting to conduct a
dialogue with him/her about a disease, which is seen as housed in the abstract and/or
objective body. To the patient, on the other hand, the behavioural and
phenomenological illness is the key concern, and it is part of his/her subjective body. In
short, the body of the person and the body the physician diagnoses and treats are in
some ways ontologically distinct.22

That the actions of the physicians are not merely directed towards alleviation of
suffering due to illness and that physicians carry social functions such as disability
determination, social policy related diagnosis, decisions regarding isolation is obvious.
But many actions of the physicians have social and political implications. These
implications have been legitimised by Government when a particular specific tradition
of medicine is accepted as the tradition leading to exclusion of other traditions.

All systems of medicine (of elementary societies as well as contemporary advanced
societies) recognize sanctity of life, and hence are aware of the potential to exploit,
neglect and do wrong. This potential to do wrong is a moral problem inherent to the
system of Western biomedicine which treat life functions as mechanical ones ignoring
the social and interpersonal aspects of the individual. This attitude of Western
biomedicine in general and medical practice in particular has led to problems
confronted by bioethics. In words of Fabrega , Western biomedicine has demonstrated
that it has the "capacity (1) to alter the way bodies function as well as (2) the way in
which lives can be sustained and lived; (3) to promote ugly and traumatic terminalities
of life; (4) to transform images of persons who live as less than whole objects, and (5) to create possibilities for human experimentation.\textsuperscript{23} In view of far reaching consequences of biomedicine and medical practice, medical ethics will have to involve not only physicians but also sociologists, politicians, economists, religious persons, community representatives, and moral philosophers. In fact, physicians form a very small segment of persons involved in the medical practice and have limited understanding of problems and issues involved in biomedicine and biomedical and ethical issues.

As much as social scientists have a significant role to play in the biomedical processes and its consequent ethical developments, physicians have a distinct social role to play within the context of medical practice. In fact the historical, social and cultural dimension of medicine is not an incidental one, it is essential to the ethical problem and its resolution. Robert B. Pippin\textsuperscript{24} while analysing the problem of social authority of the physician pointed out that the physician has the "authority" what to do and what not to do with the patient, make decisions regarding the state of the patient, for e.g. whether he is serious, whether he will recover from illness etc. And in order to exercise this authority, the physician should be knowledgeable about the drugs and treatment, must be able to diagnose the illness, be able to determine who is sick and who is not. Certain actions of the physician are permitted by law. For example, dispensing drugs and medicines, certifying extent of injuries etc. are recognised and accepted by law. In short, a physician has authority not only because he is authorised or permitted to intervene in the case of an ill person, but more significantly because "of a belief in the
physician’s superior expertise, and because of some sort of trust that a physician will make use of such expertise beneficently, in consideration only or mostly of the patient’s welfare and/or autonomy, and not for a mere profit, or in consideration only or mostly, of the outcome of some peer panel’s evaluation…”

The social authority the physicians enjoy depend upon the willingness of the society to ‘create’ positions of authority, and provide ‘legal sanction’ in some cases. Evidence suggests that physician’s social authority has undergone a dual transformation due to advances in biomedicine and patients’ awareness of his own right of self-determination. Advances in biomedicine have led to ethical dilemmas that ‘defy’ easy resolution and calls for deeper moral considerations regarding the status of patient and the nature of treatment. Societal awareness of such radical changes in the norms of treatment and its implications has resulted in patients’ (guardians’) demand for more meaningful and significant involvement in the treatment of the patient as they have the fundamental “natural right” to know, accept or reject treatment dictated by the physician. Compounded with this ‘right to information’ regarding one’s illness and treatment, is the awareness of undesirable changes observed in the medical practice by way of illegal and forced organ transplants, female foeticide, post sex determination tests, admissions on payment of huge capitation fees, redundant referrals, second opinions, unnecessary caesareans, etc. All this has led to, on the one hand creation of legal provisions specifying areas of social authority, and on the other hand sanctioning of restrictions in order to curb the growing tendency on the part of physician to misuse authority.
The question of social authority tends to be more specific if we reflect upon the nature of social reality that medical practice is. Medicine in general and medical practice in particular is not problem solving activity wherein sickness is looked upon as a technical problem faced by the patient who is considered like a malfunctioning object or machine. It is a kind of social reality, wherein physicians, patients and interested others participate. Mark J. Cherry defines medicine as a social reality that "casts patients and physicians into nests of social expectations, treatment obligations, duties, rights and goals" and "medical judgement is not simply descriptive or even evaluative, but performative."26 The performative character of medical practice can be observed from the concept of disease. Disease is not, as physicians tend to believe, objective entity or with a single universal definition. As Cherry puts it: "To use the language of disease is to place patients within a particular set of medical and social expectations"27. The classic example of alcoholism and nicotine addiction as a disease that is open to diagnosis and treatment as in the case of other diseases, highlights the nature of involvement of social meanings in the medical conceptualisation of reality. Alcoholism and nicotine addiction as drug addictions are serious health problems understood within the framework of social expectations and value presuppositions. The cultural differences of the physicians, the varying moral and evaluative presuppositions in the understanding of alcohol consumption or smoking tobacco as a moral defect, a recreational activity or an expression of personal freedom, result in significant changes in the approaches to disease in medical practice. Medical practice is thus seen to include wide range of considerations, medical, moral, social, religious etc. In brief, the social reality of medical practice is "constructed within the interaction of physicians,"
Another important dimension of medical practice is the interpretative character of illness and disease. In the first chapter, there have been attempts to show how ‘objective’ illness diagnosed by the physician is different from ‘perceived illness’ by the patient. At this stage, it is pertinent to analyse what constitutes ‘objective’ illness and how objective it may be. The debate regarding the nature of medical diagnosis poses the question whether diagnosis without physicians is possible. The ‘standard view’ that physicians are indispensable for diagnosis of illness/disease has been questioned by many scholars. James G. Mazoué in “Diagnosis without Doctors” studies the arguments put forward by various exponents of ‘standard view’ and concludes that although the existing diagnostic systems do not make a definitive diagnosis, it is not technically or practically impossible to develop such a diagnostic software. He further hopes that the pace of current research if maintained will ultimately develop a software that challenge “the physician’s traditional role as the primary locus of medical decision making.” Mazoué while challenging the ‘standard view’ studies technical difficulties, semantic problems, practical issues and valuational concerns which form the basis of arguments in favour of ‘standard view’. The technical difficulties expressed regarding the existing diagnostic programmes, namely, that they are unable to understand the pathophysiological causes of a disease process, temporal evolution of the disease process, failure of mathematical models to take into account the interdependence of clinical parameters, and unable to recognise the involvement of multiple disease
processes in clinical presentation, according to Reggia and Peng, do not exclude the possibility of developing more comprehensive models of diagnostic reasoning. Secondly, ‘standard view’ believes that the existing diagnostic programmes cannot get meaningful information from patients without the involvement of a medical practitioner. There is, in short, a semantic gap between the medical world and the diagnostic tools. It is only the involvement of human interpretative mind (of medical practitioner) that can bridge this gap. Mazoué argues that new programmes, some of them are already in use, are expected to clarify the ‘fuzzy’ medical terms and eliminate the uncertainties surrounding their use. Thirdly, the practical difficulties encountered to create a centralized knowledge-base for diagnosis by computer will make it impossible to implement such a programme. Such a programme will not be cost-effective, will be vulnerable to tampering, and incapable of controlling inconsistent information. Mazoué responds to these practical problems by arguing that all the three difficulties listed above can be effectively dealt with. The diagnosis by computer, the ‘standard view’ argues, cannot account for the ‘correct’ clinical decision that the practitioner has to make. Such a decision does not depend merely upon diagnosis, but also on estimate of success, benefits, costs and risks and also the patient’s perspective of illness. The above valuational concern has not been taken seriously by the anti ‘standard view’ theorists, who even dismiss the concern for patient’s perspective by arguing that the persons who assist the patients in making medically informed decisions do not have knowledge regarding the pathophysiological causes of disease.
Randolph A. Miller, while criticising Mazoué’s critique of ‘standard view’ points to different definitions of ‘diagnosis’ which cannot be accounted for. A simplistic definition of diagnosis as ‘the placing of an interpretative, higher level label on a set of raw, more primitive observations’ may justify ‘anti-standard view’ as automated systems will outperform medical practitioners. Defining diagnosis as “a mapping from patient data (normal and abnormal history, physical examination, and laboratory data) to a nosology of disease states” is an inadequate description of diagnosis. A more exhaustive definition is that diagnosis is “the process of determining by examination the nature and circumstances of a diseased condition” The diagnostic process requires that the physician knows about the patient’s life history, the state of the person before the illness and after the illness as well as the patient’s response to the illness he is suffering from. All this analysis cannot be undertaken by an automatic system, it does require a physician to undertake this task.

Mazoué’s claim that “we are fast approaching the point at which it would be more correct to refer to human-assisted computer diagnosis rather than computer-assisted diagnoses made by practitioners” is based upon the man-the-machine model. Human diagnosticians (physicians) play an important role in interpreting the history of the patient, the impact of illness on the patients’ life, etc. This cannot be undertaken by a machine (computer) however sophisticated it may be. It is difficult to visualise “human-assisted computer diagnosis” becoming a reality for the next decades, since there are limitations as far as the functioning of the machines vis-à-vis diagnosis is concerned. As of now, there is no software that can make diagnosis and consequently
replace the physicians. It is granted that computer based diagnostic support systems would add to the list of facilitating techniques, but cannot carry out the essentially interpretative activity of diagnosis. 'Diagnosis' is an art of interpretation that is acquired through a long process of apprenticeship under the guidance of experts or senior colleagues. For that matter, even medicine as a whole is regarded as an art trying (sic. pretending) to be a science. The essential nature of medical practice, from diagnosis to treatment, is the unique interaction between the physician and the patient.

**Physician-Patient Relationship**

Rapid changes in medicine and medical practice has compelled professionals and non-professionals to rethink about the nature and function of physician-patient relationship. The traditional moral issues (hitherto seen as objective and universal) seem to seek change in perspective. For instance, there seems to be accepted consensus regarding the right to accept or reject treatment after the much debated Karen Ann Quinlan case, compelling physicians to question their commitment to preserve life at all costs. Similarly, after the spread of AIDS, there is radical questioning on the question of confidentiality of the medical information and the role of physician in this regard. Are the physicians to continue to keep confidential the medical information regarding AIDS at the cost of exposing other individuals the risk of infection?

One of the central issues that dominate discussions on medical ethics is physician-patient relationship. Every Code of Ethics devotes considerable part to this
unique relationship the features of which seem to render medical practice ethical or unethical. The physician-patient relationship is described in terms of dependence and trust. As McCormick points out, “doctor treats not only a disease or a wound, but also a person with human hopes, desires, fears, failings, and worries.” The understanding nature of this relationship is intimately bound with the medical practice, so much so that the medical practitioners are weary of governmental or legislative intervention. Eric J. Cassell describes the characteristic features of physician in therapeutic relationship. The physician has the technical expertise, training and experience together with the system of reasoning, knowledge and care because of which medicine is capable of removing the mystery surrounding the illness. Secondly, the physician’s interpretations of illness are culture determined and hence the patient and physician are bound within a belief system. Such a belief system is true for the period but invariably inadequate as science progresses. Thirdly, the physician consciously or unconsciously addresses to issues in the healing process which go beyond the casuistic doctrine. He brings in the system of relationship, personal, moral and other concerns for the patient. Fourthly, the physician’s capacity to be involved in technical as well as moral aspects of the medicine affords him to legitimise the role of patient as ‘sick’ person in the society. His decisions makes it possible for the sick to re-enter the society as healthy person. And finally, physician in his continuous and at times long interaction with the patient, transmits his beliefs to the patient. Different physicians may transmit different beliefs to the patient and in turn be influenced by the beliefs of the patient. There is, in other words, a mutual influencing between patient and physician in this therapeutic interaction.
The patient in therapeutic relationship with the physician seems to depend upon his upbringing from infancy wherein he learns to recognise and express those symptoms which are seen as problems by the physicians. Secondly, the patient being unable to lead a normal life enters into relationship with the physician with honesty, sincerity and trust and makes his body accessible to the physician in ways one does not accord access to strangers. Thirdly, the patient bestows on the physician the monetary benefits that are in consonant with his work. Fourthly, as a matter of control the patient seeks second opinion from specialists, questions the diagnosis and treatment so that there is compulsion on the part physician to review, consult and improve his knowledge.

The problems related to physician-patient relationship has implications for other issues such as patient's right to be informed, confidentiality, canon of informed consent, etc. Some of these issues shall be discussed in the next chapter. The physician-patient relationship is strictly governed by the code of confidentiality. The Hippocratic oath refers to confidentiality as "whatsoever (I) shall see or hear in the course of my profession, as well as outside my profession in my intercourse with men, if it be what should not be published abroad, I will never divulge, holding such things to be holy secrets." Confidentiality has come under strain in recent past due to various changes in societal conditions and medical practice. The introduction of group practice, referrals, taped or recorded interviews with patients, etc. all contribute towards dissipation of confidential information the patient provides to physicians. Secondly, the hugeness of the system, mechanisation and depersonalisation of health care, etc. is
another cause of undermining of confidentiality. Thirdly, the involvement of paramedics and non-medical personnel in collection and preservation of medical records, creates a situation in which confidential material reaches to people other than physicians. The above changes in medical practice leads to 'deprivatisation' of physician-patient relationship. But the most important of all these changes is the 'casual' attitude on the part many physicians while dealing with confidential information.

Contemporary medical practice has changed from being 'private practice' to 'impersonal' hospital based public health care system wherein physicians do not or need not interact with the patients. Besides, there are areas of human development where there is felt need of confidentiality vis-à-vis relations of patients in the new social order. For example, adolescent children do not wish that their parents know about their health problems such as resultant from their sexual behaviour. The question is whether the physician should keep information regarding the minors confidential from the parents. Or, should the physician keep confidential the information regarding heart problems of a pilot from the security or that an individual is HIV positive from the fiancé of the person. These are not merely moral dilemmas but issues that go to the very centre of physician-patient relationship. Another important aspect of the physician-patient relation comes out of the Karen Ann Quinlan case. The parents struggled to subtract their daughter from jurisdiction of the physicians, who kept physically alive brain dead Karen with extraordinary life systems to which she was plugged in. The main question in the case was whether the physicians have the right to
treat the patient unasked? The ending of the case only reasserted the fact that an individual has an obligation to care for his health, and consequently the right to basic health care. But when an individual approaches a physician for treatment, he does not abdicate his right to decide his own fate. The implication of the case is such that the subtle physician-patient relationship underwent changes. Patient's right to self-determination vis-à-vis physician was upheld whereby it was felt that the position of physician was weakened.

Some professionals in the field, however, seem to have different approach to this issue. Any negotiation with a particular patient regarding his or her treatment, will involve the physician in negotiation with the profession itself. The professional may argue that if a patient wants to be treated, he or she better not ask questions, and in this way would get the best of treatment and the physician will have time to treat other patients. Such an attitude among the professionals clearly asserts the autonomy of the profession and raises serious questions regarding the fundamental freedom of the patient to choose treatment. But in a system wherein physician dominance over the patient is reinforced, it is necessary that a balanced approach be followed.

More light will be thrown on physician-patient relationship if we turn our attention to physicians as professionals and their perceived role. As professionals, physicians are interveners in the basic concern of man, namely, death, deformity and disability. It is not surprising then that the role of healer in the primitive society and physician in the contemporary society seems to coincide. The healer in the primitive society (where the
distinction between physical illness and spiritual decay did not exist) acted not only as a physician but also as a priest. Contemporary medicine seems to have become so powerful that it appropriates to itself the role of taking care of life and death, to such an extent that almost magical properties are assigned to it.

The more sober members of the profession see their role as meeting the health care needs of individuals, meeting the health care needs of societies, gain income, prestige and respect from the profession, creating future professionals and 'create' and acquire new knowledge for the benefit of mankind. The goal of 'doing the best' for the patients or avoiding unnecessary harms justifies the practice of experimentation and consequently advancement of knowledge of medicine. Engelhardt points out that these objectives of medical profession is the "utilitarian understanding of the obligations ... intertwined with the focus on individualistic and often deontological obligations to particular patients." 43

While discussing the notion of social authority of the physician we have seen how such an authority is based upon societal/legislative sanction and the healing capacity of the physician. Social authority of the physician also affects the physician-patient relation in a significant manner. Although some sort of uncompromising respect for the patient, however illiterate or superstitious and irrational he may be, is the basic presupposition of medical practice, there is however some form of domination which does not go along with the respect for the patient. In fact patient is situated in a condition of uncertainty wherein patients have unsuspected trust on all that is related to medical
practice and physicians. This trust reinforces the authority of physician vis-à-vis the patient. But such an authority as a representative of institutional power (political, social or economic) would render the physician-patient relationship suspect. It would be, therefore, necessary to distinguish between the legitimate authority of the physician and other forms of authority linked to maintenance of power or class interest with or without involvement of physicians.

One of the issues that has become focus of attention in physician-patient relationship in recent times is the understanding of body from women’s point of view. It has been a source of controversy whether the understanding of body that is available in the bioethical discourse in general and in the context of therapeutic relationship in particular is a gender bias understanding. It is the sex-role stereotypes that seem to determine the physician’s attitude towards women patients. This is clearly reflected in the health care practices and even the cultural reflections of certain communities. It is not that women patients outnumber men patients in the general health care system because women have longer life span than man. The most crucial distinguishing mark between men and women, namely, women have to perform a positive ‘life-affirming feat’ of bearing and nursing children, is often regarded as an illness rather than a normal human phenomenon. Physicians seem to be influenced by folk lore and primitive societal norms while dealing with changes that occur in woman’s body both as a preparation and actual performance of life-affirming feat. Feminists have even highlighted the fact that there are more men in the medical profession than women and this is so even in specialised field of gynaecology.
The traditional model of physician-patient relationship is viewed by feminists as based upon sex-role stereotypes which sees man as aggressive and rational, agentic (self-protecting, self-asserting, self-expanding) as against women being passive, emotional and communal (participating in society). This labelling of man and woman seem to find its expression in physician-patient relationship, wherein physician is aggressive, rational and agentic and patient is seen as passive, emotional and communal. The physician-patient relationship is temporary whereas the man-woman relationship is more permanent. The characteristic feature of medical practice in this relationship is that it tries to negate itself in the process of healing the patient, making him whole, improving his status, removing the inequality. In other words, it attempts to make itself unnecessary (redundant) by healing the patient. Feminists recognize another feature of physician-patient relationship comparable to the relationship between genders. In words of Mary B. Mahowald, “just as a man needs a woman so as to express his (hetero)sexuality, so the doctor needs a patient in order to be a doctor and vice versa. But the woman or the patient is essentially a receptor of the other’s strength or expertise or sexual drive. Accordingly, “complementarity” here describes a fundamentally inegalitarian relationship: the woman and the patient are similarly passive and vulnerable.”

We have seen how paternalism practiced by physicians ignores the patient autonomy and consequently reinforces inegalitarianism wherein physician becomes independent agent and patient dependent communal. It is obvious that the paternalistic model is inadequate and threatens patient autonomy leading to many of the moral issues faced by modern medicine. Alternatively, patient autonomy
model with its emphasis on informed or proxy consent, is also inadequate as the roles get reversed thereby questioning the autonomy of medical profession and health care decisions. Mary B. Mahowald proposes ‘collaborative model’ as alternative to paternalism and patient autonomy model. In most general terms, collaborative model envisages that physicians respect the autonomy of the patient and patients respect professional autonomy of the physician. This model on the one hand rejects the idea that the physician is solely responsible for patient and consequently he is superior to the patient, on the other hand, recognizes usefulness of patient’s experience and reflection for the medical practice. Patients while asserting their right to self determination in health care matters, recognize that the health professionals are endowed with knowledge and expertise that is beneficial to them and any questioning of this expertise may undermine the profession. In short, physicians and patients “manifest both passivity and aggression, emotion and reason, community and agency - all of the attributes stereotypically assigned only to one sex or the other.”

One area of bioethical concern that has been left out from the mainstream discussions is “chronic illness”. At one level chronic illness is understood as a grade of illness, at another level it must be recognised as a distinct type that calls for a distinct approach. In terms of numbers more people suffer from chronic illness than illness leading to sudden death or rapidly progressing fatal illness. Some chronic illnesses are related to old age where there is distinct reduction in physical and intellectual abilities. The most important characteristic of chronic illness is increasing and permanent dependence on physicians and others for survival. The problem of chronic illness has been accentuated
by the fact that there are more and more elderly people living in this world than ever before because of advances in medical technologies. This has led to a large population of elderly people all of whom have to be considered as suffering from "chronic illness" and which calls for a new public health policy with increasing and prohibitive costs.

Addressing to the questions of understanding the meaning of chronic illness and the ethical implications thereof, B. Jennings, D. Callahan and A. Caplan demanded special attention and support for chronically ill patients so that they can live a meaningful and satisfying life. They argued that the lack of proper understanding of chronically ill patients is due to the model of medical enterprise we have developed based upon acute illness. The above authors identified three related models to the autonomy paradigm on the basis of which medical practice has so far been articulated. "Medical model" defines illness as a sudden threat to the individual who is normal and healthy, and medicine has to intervene to remove this threat. Secondly, "individualistic model" of person recognises individual as autonomous or free from external constraints, and prior and independent of social milieu. And finally "contractual model" which sees that a patient (who is rational and self-interested) when threatened by illness makes a contract with the physician and temporarily submits to his authority in order to be cured from illness. The three authors had concluded that the dynamic and transformational aspects of chronic illness requires that we change the notion of patient autonomy and physician's duty to respect or enhance autonomy. In brief, the autonomy paradigm was regarded as inadequate for chronic care.
It is true that there has been tremendous strain on health care services, particularly during the last decade of the century. The situation both in the developed and underdeveloped countries is going to be more acute during the next century. The demographers predict that there would be large populations (almost one third of the total population) who are senior citizens most of whom with problems related to old age and chronic illnesses. Governmental agencies have demanded that professionals and others re-examine or revise our understanding goals of medical practice particularly vis-à-vis medicine.

Daniel Moros and others while pointing out that the autonomy paradigm is itself misconstrued, the distinction between acute illness and chronic illness is not as radical as it is made out to be. In words of Daniel Moros: “The doctor provides acute care to many individuals - some young, presumably ‘normal’ and healthy - others elderly, independent but fragile - some with ongoing, identifiable but at the moment quiescent illness - others struggling with active disease and disability, and in this latter group new difficulties may be part of the ongoing disease process ... or some unrelated problem.” For example, a person with pulmonary disease develops an acute pneumonia or when a trauma or burn case after undergoing amputation undergoes reconstructive surgery for years, a woman treated for carcinoma of the breast, has a relapse after many years and has to undergo long drawn treatment. The above cases clearly demonstrate that the distinction made by Jennings, Callahan and Caplan between chronic illness and acute illness is unacceptable. A distinction between chronic illness and acute illness may be made on the basis of costs and/or benefits to
the patient and implications to the society - but no new ethical implications can be drawn from such a distinction. 51

Further, the above autonomy paradigm does not present the true nature of physician-patient relationship. The intensity and complexity of interaction between the patient and physician cannot be explained by simplistic contractual view expressed by Jennings, Callahan and Caplan. Again, medicine and medical practice (in spite of its limitations and abuses) cannot be measured in terms of consumerist criteria. A physician is not a professional contractor that offers his services for a fee to a medically literate or illiterate client. The terms ‘service’, ‘consumer’, ‘contract’ etc undermine the medical profession and is capable of imbibing suspicion in a rather unique physician-patient relationship. Whether the notion of autonomy model allows physicians to limit or restrict the extent of health care calls for reflection within the general ambit of rights and needs. There may be conflict between the rights of the patient and that of physician regarding the extent of medical intervention, but to assume on the basis of ‘autonomy principle’ that physicians can or may decide to intervene or not to intervene or to what extent they may intervene, is the source of the malpractices and abuses in the profession. It is precisely because of this that one is compelled to believe that “medicine is too important to be left in the hands of doctors alone.”
NOTES

1 Roy A. Sorensen in "Rationality as Absolute Concept", while trying to define what is "rationality" had proposed that a negative model of understanding may be more enlightening than a positive articulation. Sorensen recognised many concepts in ethics are better explained with negative 'definitions' of the nature of 'what a thing or concept is not'. For instance, 'health' is understood in terms of absence of diseases, 'peace' in terms of absence of violence and 'liberty' in terms of absence of coercion and obstacles. (*Philosophy*, Vol. 66, No.258, 1991, pp.473-486.)


3 Ibid.


9 The exception to all this would be *Oath of Soviet Physicians*, approved by Soviet Union in 1971 which makes no reference to any religious beliefs or practices.


11 It is important to distinguish between Code of Ethics and code of conduct. The code of conduct is essentially meant to protect the professional interest of its members and ensure that no services rendered are inappropriate to the profession. It insures that other professionals in the field do not get bad reputation due to malpractices by some. Bernard Häring distinguishes between *ethos* ("comprises of those distinctive attitudes which characterise the culture of a professional group in so far as this occupational subculture fosters adherence to certain values and the acceptance of a specific hierarchy of values"), *ethical code* ("concrete effort to ensure definite norms" to foster and guarantee the ethos), *medical ethics* ("represents a systematic effort to illumine the ethos and
to elaborate the perspectives and norms of the medical profession") and \textit{morality of the physician} (physician's capacity to act according to well-informed conscience and to make concrete decisions with an upright attitude, and with insight and discernment"). (Bernard Häring, (1972), pp. 24-25)

It is obvious that there is overlap between ethical concerns and nonethical ones in the discussions of medical ethics. Bernard Häring's distinctions though significant at one level, are best understood in terms of twofold concerns observed in the discussions on medical ethics, namely, those expressed in Code of Ethics and Code of Conduct.

Developments in biomedicine, biotechnology and medical technology in the recent past not only highlight the need for rewriting of the medical ethics codes, but calls for rearticulation of the problems and issues which were deemed to be unquestionable truths. The ‘factual’ presuppositions of many ethical codes based upon certain metaphysical beliefs undergo changes, there is need of reorganizing our knowledge of what constitutes the moral practice. \textit{In-vitro} fertilisation in late sixties and cloning in recent times, has ‘undermined’ the metaphysical presuppositions of human sexuality and family.


Ibid. p. 21.

Ibid. pp. 24-29.

Ibid. pp. 29-30.

Ibid. p. 45.


Ibid. pp. 594-95

Ibid. p. 609.

Ibid. pp. 609-610.

Ibid. p. 612.


Ibid. p. 420.


Ibid. p. 361.

Ibid. p. 368.


Ibid. p.564.

Ibid. p.565.


Cf. Ibid. p. 583.

Ibid.

Ibid. p. 588.


Ibid. p. 255.

Robert B. Pippin points out that (a) conscientiousness about patient autonomy, (b) a general good faith dedication to fairness and social justice in the institution of health care, and (c) a general watchfulness about various forms of bias and prejudice already built into the language or discourse of health care negotiations, are the salient features of the authority the physician exercises over the patient.(1996), p.432.

In this chapter, the feminist perspective that is being referred to is only in elation to physician-patient relationship. No attempt is made articulate the complex problems that gender studies have thrown up and the vast literature that has developed around this theme.


Historically, liberal feminism discourages paternalistic model and consequently disfavours patient autonomy as it would result in lack of respect for women physicians. Radical feminism advocates patient autonomy exclusively in the context of women on the ground that women should care for their health, this is particularly in the case of reproductive processes. The socialist or Marxist feminism favours the collaborative model.


51 Cf. Ibid. pp. 168-175.