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Beyond Adversity: Physician and Patient as Friends?

Stephen G. Post, Ph.D.[1]

Much distinctively American medical ethics in the last two decades has been conceptually framed in adversarial terms: patient versus physician. David J. Rothman partially explains this adversarial framework. If he is correct, the contemporary movement in medical ethics begins in 1966 with Henry Beecher's expose' of abusive human experimentation in the United States.[1] Certainly research on human subjects has shown physicians at their worst, leading to the conclusion that first and foremost, patients must be protected from their doctors.[2] No doubt in many cases patients need protections.

More recently the adversarial fires have been fanned by the legal profession, whose writings on medicine and law are largely shaped by the only language that our tradition of 17th-century political- and legal-philosophical debates condones: individual rights over against society. Scholar attorney George Annas represents this approach in his "basic American Civil Liberties Union guide to patient rights."[3] Patients do have rights, and the legalistic approach to the physician-patient relationship serves a purpose.

Much of current philosophical medical ethics is formed in response to major legal decisions, and is shaped by a liberal individualistic philosophy of the self that emphasizes patient autonomy and rights. There is thus no serious treatment of nonadversarial themes, like trust and friendship in the physician-patient relationship, except to dismiss them as potentially paternalistic. For example, in his writing on the physician as "stranger," Robert Veatch indicates deep suspicion of classical friendship models. The modern healthcare system, he argues, treats the patient

[1]Correspondence should be directed to Stephen G. Post, Ph.D., Center for Biomedical Ethics, School of Medicine, Case Western Reserve University, Cleveland, OH 44106.

anonymously, allowing little opportunity for the trust of friendships to develop. Veatch is right that trust requires continuity of relationship and sufficient time to express caring attitudes. But more centrally, Veatch is suspicious of the friendship model on the grounds that it threatens patient autonomy because of inherent paternalistic tendencies.[4] Building on Veatch's concerns, Patricia Illingworth points out that patients do not necessarily desire friendship with their physicians, and that friendship is a morally dangerous imposition risking "psychological oppression." The satisfaction even of authentic patient desire for friendship is categorically wrong because "its satisfaction would diminish autonomy."[5] Illingworth acknowledges that "medical literature abounds with reference to the friendship metaphor and theme," and that the friendship model is taken for granted as preferred. However, she is remarkably unimpressed with this abundance.

There is no need to provide an overview of the legal and philosophical literature: the standard medical ethics textbooks almost all begin with a section on patient autonomy framed by an individualistic philosophy of the self that strips the patient of any essential relational components. An autonomous decision thus must be a monadic one, without the value-influence of physicians. Meanwhile, major philosophers outside the medical ethics field have attacked the "abstract and ghostly" philosophy of the self that underlies so much of our American approach to autonomy, for no decision is ever autonomous if that means free of influence by others.[6] This phenomenological reality should be acknowledged. But instead, many medical ethicists seem almost Sartrean in worldview, for Sartre believed that the dominant fact of human social experience is "the look," which he described as the desire of person A to manipulate and enslave person B. The philosophers are right that any *blind* trust in physicians is dangerous and therefore to be avoided, but a *discerning* trust seems to be a condition of all meaningful human relationships.

It is important that patients have rights of self-determination. Yet the adversarial framework so convenient for a litigious society seems to have created unnecessary patient distrust, an almost total intolerance of physician error, defensive medicine, a rift in communication, and an unprecedented number of malpractice suits. It has stripped away moral agency from those who practice the healing art and have the practical wisdom to assist patients in making good choices, although patients should have the final say. Much overtreatment and futile practice in health care occurs not because physicians request it, but because patients or their family members who want everything done despite the protests of the physician (I frequently observe this in medical intensive care units).

In the case of an elderly woman in the persistent vegetative state whose husband insisted that she be maintained on a respirator, the objections of the physicians to providing futile technology were dismissed by the courts as a violation of patient rights.[7]

With respect to patient and physician, this is an era of broken covenant. Distrust may in some circumstances be a virtue, but it is more frequently harmful in human relationships. Yet the advantages of the friendship model of the physician-patient relationship remain considerable: expanded dialogue, shared uncertainty, better patient education and understanding, better compliance, fewer unwarranted malpractice suits, and mutual respect for moral conscience. The monadic autonomist may assert that the rights of patient conscience are imperiled by trust, and that much cunning paternalism begins the moment a physician says he or she is a friend. On the other hand, so much opportunity for an ethics grounded in communication and reliability is gained if an obvious fact of human experience is acknowledged: distrust is the beginning of moral failure. The philosopher Paul Ricoeur, with whom I studied, distinguishes the "hermeneutics of suspicion" from the "hermeneutics of retrieval." Suspicion of trust is necessary in order to transcend the consciousness Ricoeur calls "first naivete." But then trust must be retrieved or recovered, although with a new critical consciousness Ricoeur calls "second naivete." I would urge attention among medical ethicists to the constructive unfolding of suspicion into retrieval.

AUTONOMY IN FRIENDSHIP

Patient autonomy and rights could be presented within a less adversarial framework, one of greater mutual trust and confidence. But to discover this framework, it is necessary to look at medical ethics as it has evolved in a cultural context different from our own. In point of fact, Illingworth is correct that prior to our modern era friendship was an important model for the patient-physician relationship. It still is in the southern European countries such as Spain and Italy, where the influence of classical philosophy provides an alternative to our American philosophical and legal heritage. I acknowledge that in these countries, where the necessary hermeneutics of suspicion has not yet deeply occurred, there is considerable paternalism in medicine.

Particularly in Spain, discussion of friendship and medical ethics necessarily begins with the ancient Greeks and Roman philosophers, for whom *philia* (Latin *amicitia*) or "friendship" was the central paradigm of the moral life. (*Philia* is distinguished from *eros* or sexual expression, a

distinction that some American psychiatrists may want to explore.) In Plato's *Lysis* and Aristotle's *Nicomachean Ethics*, friendship is the crucible of the moral life.[8] The form of friendship that Aristotle recommends is noninstrumental, i.e., another person is never to be used as a means. Aristotle states that "a friend is another self," and that the highest form of friendship is "reciprocated good will" (*Nic. Eth.*, 1155b). Friendship, continues Aristotle, is not egocentric, because it "seems to consist more in loving others than in being loved" (1159a).

In Greco-Roman writings, friendship came to define the ideal physician-patient relationship, at least according to Plato, who refers to physicians as friends of their patients (*Lysis*, 217a). Because friendship presupposes freedom, Plato writes that a physician "does not give his prescriptions until he has won the patient's support, and when he has done so, he steadily aims at producing complete restoration of health by persuading the sufferer into compliance" (*Laws*, 720d). Seneca elaborated on friendship as the most satisfactory physician-patient relation (*De Beneficiis*, vi 16). There is no suggestion that friendship inherently tends to violate respect for the patient's freedom.

The contemporary and highly influential Spanish historian of medicine and ethics, Pedro Lain-Entralgo, highlights the importance of friendship to the physician-patient relationship in Greco-Roman medicine: "Rather than a provision of technical help, rather than diagnosis and therapy, the relation between doctor and patient is — or ought to be — friendship, *philia*. For the ancient Greeks, this *philia* was the basis of the relationship."[9] Entralgo contrasts *philia*, with its roots in benevolence, and *eros*, with origins in visual pleasure: the art of hearing characterizes friendship, while sight is appropriate for *eros*. Attentive listening is the chief mark of love. His conclusion is that "medical *philia*," characterized by listening and communication, should continue to define the physician-patient relationship.

Entralgo can be interpreted as committed to patient freedom of choice within an ethics of communication. Autonomy is understood less individualistically than in America medical ethics, and trust is not immediately suspect. Entralgo's writings are widely read in Mediterranean countries.

James F. Drane, a former student of Entralgo, offers an important American introduction to the model of "medical friendship." Drane states that "The affective dimension of the doctor/patient relationship has all the generic notes of an ordinary friendship: there is pleasure in one another's company, confidences are shared, and there is an exchange of benefits."[10] Drane suggests that patient affection "has great potential benefit for the physician. Good doctors are aware of the affection and

love they receive from their patient-friends." He indicates that care, confidentiality, beneficence, honesty, respect, and forgiveness have been traditionally understood as aspects of friendship.

There are physician medical ethicists in this country who have attempted to recover something similar to the friendship model of Entralgo and Drane. It is to Edmund D. Pellegrino that we must look for specific discussion of trust. Pellegrino supports a model of "beneficence in trust" that respects patient autonomy within the context of communication and a common pursuit of the patient's good, thus avoiding what he terms "moral atomism."[11]

Jay Katz defends a model in which physician and patient are moral agents, reaching "a mutually satisfactory recommendation."[12] Rejecting individualistic definitions of autonomy as insufficient, Katz contends that the right to self-determination can only be properly exercised by "attending to the processes of self-reflection and reflection with others." Physician and patient engage in a dialogue centered on patient well-being and interests, consistent with a patient autonomy that in the final analysis holds trump. Yet Katz does *not* suggest that a friendship model is acceptable, and he is suspicious of trust. In response to a question I posed to Katz regarding friendship, he suggested that trust is dangerous and that many physicians have wrongly violated patient autonomy in the name of friendship.[13]

If in the libertarian-autonomy model the patient's first words determine a decision as soon as they are spoken, in the friendship model it is with these first words that the ethics of conversation begins. Medical *philia* includes respect for patient autonomy; it also includes respect for the physician as a moral agent who must sometimes seek to persuade the patient but who should not coerce.

A DIFFERENT MEDICAL ETHICS

American medical ethics has recently been criticized because "a principles and rights-based approach to discussions of moral dilemmas has sustained and reinforced a pervasive reductionism, utilitarianism, and ethnocentrism in the field."[14] A more phenomenological approach, open to the lessons learned from other cultures, is needed. Whether the field of medical ethics in the country is open to such an approach is unclear.

Medical ethicists might consider the renewed emphasis on friendship as a fit topic for discussion in moral philosophy.[15] Philosophers find the abandonment of friendship increasingly difficult to justify. But as one philosopher of friendship argues, "Contemporary moral philosophy in the

Anglo-American tradition has paid little attention to these morally significant phenomena."[16] Yet self-determination in friendship is more likely to result in good judgment than the strictly individual exercise of reason.[17] Trust, the proscription against abandoning friends, mutual moral agency, and respect for the other as equal are contributions that friendship can make to the physician-patient relationship.

David N. James provides a defense of friendship in medical ethics, as a rejoinder to Illingworth. He proposes "that trust between doctor and patient is a moral good in the therapeutic relationship and that this trust has enough similarities to trust between friends to make a model which develops these similarities well worth exploring."[18] Drawing on Aristotle, James concludes that because friendships should exist between free and equal persons, the friendship model can serve as a criticism of physician paternalism.

But the recovery of trust and friendship consistent with autonomy represent a swing of the pendulum away from the extreme of adversarial-autonomy and adversarial-rights. Is this a possibility in our culture of distrust? Are we stuck with adversity and distrust? Is a more harmonious future impossible? If we are to go beyond adversity, it will require physicians to demonstrate to each and every patient an attitude of personal care and compassion, so that trust might be recovered. The pressures of time, technology, and money work against the kind of care that creates friendship.

I find some faults in friendship an acceptable model for the physician-patient relationship. Friendship entails a mutual disclosure of the self that the patient may prefer to avoid, and that the physician may consider unprofessional and inappropriate. Illingworth rightly contends that no patient should have to approach a physician with friendship in mind. Yet the caring that is associated with compassionate friendships is a significant value, as is the notion of a discerning entrustment. Friendship, medical *philia*, does suggest some values that merit serious philosophical consideration.

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