

Phenomenological approaches to the doctor-patient relationship

Dr Pierre Mallia

Scholars largely agree that there is a need today for a comprehensive philosophy of medicine (Pellegrino, 2001; Wildes 2001). It is with such a foundation that we analyze moral dilemmas generated by medical technology, such as genetic technologies and the uses (and misuses) of genetic testing and screening. In this respect however there is profound disagreement on what a philosophy of medicine should look like. The socially constructed philosophy as proposed by various authors including Kevin Wildes and Robert Veatch contrasts with the teleological approaches as proposed by Edmund Pellegrino. I shall briefly look at both here, bowing admittedly in favour of a teleological approach, using the basis of genetic testing as a reason to why an ontology of the doctor-patient relationship is, in my opinion, the best approach for a comprehensive philosophy of medicine, even in the post-modern world we live in.

Post-modernism and medicine

Michael Bury (1998) distinguished between postmodernism and postmodernity. 'Postmodernism' as a term points to the way events and products interact with each other in the cultural sphere where they can hardly be separated. We watch the 'news' of what is happening in Afghanistan whilst we wait to see if our lottery ticket has come up - technologies of news and lottery-play hitting our minds with equal force. 'Postmodernity', on the other hand, is the foundation of this postmodernism. It is the social and technological processes that underlie and interact with postmodern cultures. Globalization, the endless expansion of modern capitalist economic forms, seems unstoppable with European countries debating whether they should form a union or not to survive. Commodities strive to find themselves in every part of the globe, and it is this infrastructure which forms the basis for genetic technologies.

Direct-to-consumer advertising of genetic testing in fact is a profound result of a post-modernist culture, whose aims are monetary rather than teleological of a medical community striving to seek a cure the ill or prevent illness. (Chandros) Hull and Prasad (2001) object to the use of advertising to promote a genetic test for a breast cancer gene (BRCA). They encounter the advert whilst leaving a performance of a play which involves a tale of an oncology ward. The play is an adjunct, a warmer, towards an advertisement which, they say, misguides women by suggesting they contact the company directly about its BRCA1/2 genetic test rather than talk to their health care providers about genetic testing, their personal risk of breast cancer, and the potential usefulness of the test.

We are entering an era in which ever more genetic tests will be integrated into clinical practice and a direct-to-consumer increase in advertising is expected. Adverts misguide and give broad truths – ‘whiter than ever before’. Whilst it is a small cohort of women who should be interested in doing the BRCA1/2 genetic tests, the adverts Hull and Prasad refer to are broad and directed to *all* women. It reads: “If you could discover your risk for a second breast cancer or for ovarian cancer, would you? Chances are, you would. Such is the promise of (this test). It reads your genetic code to determine whether you possess the altered genes that dramatically increase your risk of breast and ovarian cancer. Knowing your family history is neither enough, nor is it always accurate” (Ibid., p.34). Whilst uncertainties surround this genetic test, the advertisement claims to ‘dispel fears’. Conversely the test can hardly ‘provide hope’ when in fact the follow-up for a positive result is really uncertain, other than having a radical mastectomy (Idem). One needs to question therefore whether socially constructed theories, that is, those theories which allow the goal of medicine to be defined only by forces within the public sphere, are justified. It is undisputed that large corporations can have a big say in policy and they may influence the philosophy and ethics of advertising to ascertain the telos of medicine to fit into their own economic telos. One need therefore consider these socially constructed theories.

Socially constructed theories

Social construct theories, as put forward by Wildes (2001) propound a philosophy of medicine whose ontology is constructed by social phenoma rather than by what is solely deemed as the traditional teleology based on fundamental ontology of medical practice. It may be disconcerting, however, to evaluate what socially constructed theories really imply. Tristram Engelhardt for example is a proponent for a principle of 'permission'. In a world where we cannot find a secular moral foundation, he argues that disagreeing moral agents may come together and agree upon a course of action which is acceptable to both (Engelhardt, 1994). Yet who are the moral agents involved when it comes to offering genetic testing to the public or when decisions on population genetic screening with directive counselling is advocated as has been the case for Cyprus (Hoedemakers and ten Have, 1998)? Is it perhaps the industry reaching a moral consensus with the medical profession? And at what stage does the consumer, in this case the patient, come in? Since advertising is directed towards the potential patient, it would seem that the only motivational effort to involve the consumer in this moral debate is by 'educating' him through the means of adverts, which may be as misleading as they are intent on promoting profits. In this case, who is the voice for the consumer? One may also ask, whose side does the medical profession take when coming into symbiotic relationships with market forces? For in order to serve its goals, medicine has had a long standing relationship with industry.

Yet the very viability of genetic tests requires a great number to be done in order for their production to be economically viable to a company. The medical profession is called upon to 'test' greater numbers of people, the motive becoming profit margins rather than offering hope. Subtle coercion, as the above-mentioned advert telling consumers to go directly to the company instead of the health care professional to get proper advise, acting on induced fears, will draw larger numbers to do the test than is actually necessary. A test for this could be to ask how many people do such companies in fact advise that the test is not for them? Yet such numbers may be needed to make the test viable.

Wildes, arguing against Pellegrino's and Thomasma's (1993) teleological approach, calls for a socially constructed approach to bioethical issues (Wildes, 2001). He says that Pellegrino's basis of the philosophy of medicine on the doctor-patient relationship is too narrow in addressing the crises of contemporary medicine to have to do with these fundamental questions on the nature of medicine and its goals (Ibid., p.74). He accuses Pellegrino of assuming what he wants to prove – that there is a nature of medicine and from this to construct a philosophy of medicine. But perhaps Wildes confuses the 'nature of medicine' with the 'philosophy of medicine'. Nevertheless he argues that medicine is practiced in a social context and that the 'art' of medicine is to capture this social context as a social philosophy and social science.

Wildes' however fails to show why the social construct theory is better than a teleological approach in the formulation of a philosophy of medicine. Perhaps Pellegrino's rebuttal of Wildes argumentation is in showing how social construction allows for no permanent theory of medicine and therefore no stable ethics of the profession. Pellegrino argues that, "these (professional ethics) can become victim of a socially aberrant society as was the case under German national Socialism, Maoist China, Stalinist Russia or Imperial Japan. In each case, medicine was redefined as an instrument of social and political purpose, and the physician was made a social functionary. Medical ethics itself became the ethic of social purpose" (Pellegrino, 2001: 177). It is very difficult to play down such a strong statement, by its very factual and historical nature an unconcealed truth. Whilst Wildes thinks that the moral boundaries beyond medicine would act as deterrents to these kinds of situations from happening again, he does not realize, as Pellegrino indeed points out that these same moral boundaries would be socially constructed and thus subject to the same pathologies that distorted medicine and its ethics in the first place and therefore can provide no guarantee. What if, as pointed out above, medical ethics comes to be directed more by economic canons than by the needs of the patient? If policy relieve doctors of their primacy towards the sick person in favour

of a higher 'social goal', then a social constructed philosophy of medicine would be entirely "extrinsic to the ends of medicine" (Pellegrino, 2001, p. 178).

Robert Veatch by contrast has pioneered an approach which undresses the doctor of any say in the mission of medicine. In one of his latest contributions (2000) he persists in attacking the Hippocratic oath and the American Medical Association's (1903) position that a physician should be mindful of his or her mission and of the responsibilities they must incur in the discharge of their duties, especially where it comes to social pressures. Veatch argues that physicians cannot know what the patient's best interests are and cannot be expected to know what is medically beneficial. The participation of the patient means that the patient knows better and that the physician is in no position to be mindful of requests (Ibid., pp. 705-707). Whilst Veatch's upholding of patient rights is to be commendable, he unfortunately persists in equating these rights against what the physician considers patient benefit. But with this reasoning, a physician will not have the possibility to refuse, or at least persuade against, a genetic test to a patient who is impressed by advertising thinking she actually needs the test. Not all women need to do the BRCA1/2 test, yet advertising induces them to believe so. Is it not the onus of the physician to explain this to the patient? In situations where physicians are gatekeepers of funds, or even in situations where they act solely on principle, has not a physician a right not to participate in this patient's faulty perception of things, especially if the latter, out of fear or ignorance, persists stubbornly in requesting such a test?

The answer to these quagmires may indeed be found in the phenomenology of the doctor patient relationship. Heidegger, in his existential philosophy (Heidegger. trans 1962), never intended to discuss ethics, let alone the goals of medicine. Yet as applied philosophy, his basic notions can be applied to everyday relationships, as it is a discursive ontology of man's existence. That existence is found in every encounter with other beings, one of which is indeed the encounter

between a patient and a doctor, each having an ontology in their own right. There are ample sources today which attest to an inherent ethics in Heidegger's philosophy. Frederick Olafson (1998) notes that although Heidegger never dealt with questions of normative ethics, there was, in *Being and Time*, a very harsh critique of the whole question of 'values' as objective criteria for the guidance of our lives. These were declared to belong to an anonymous public mode of selfhood, what Heidegger referred to as 'Das Man' (Olafson, 1998, p.3). Joanna Hodge (1995) for example confesses to read Heidegger as revealing the process of the questions of metaphysics and ethics in their simultaneous search of 'what it is to be human'. Heidegger, she says, works in the restricted conception of ethics as concerned only with the relationship of human being to being human. He reveals the universalization of ethics in the globalization of technology but does not endeavor to move from the question of 'what it is to be human' to negotiating what it means for humans to be together (Hodge, 1995, p. 27). Hodge argues there is an urgent need for a retrieval of the notion of ethics from a metaphysical fixity, and that the elements of this are to be found in Heidegger's work but if we stop solely at the question of 'what it is to be human', we risk limiting ourselves in these metaphysical 'fixities' and, in the name of ethical differences, "people are massacred, distinct groups subjected to genocide. Ethics ceases to be a set of questions about what it takes for human beings to flourish. Ethics becomes a set of issues for which there is offered a global, indeed a final, solution in all its horror" as was the case for the death camps. Moreover, "the actualizing of metaphysics in technology reduces the question of ethics to a question about the nature of human beings in terms of usefulness and productiveness" (Ibid., p. 27).

If we cannot hope for a comprehensive ethics of humans from Heidegger's work however, we can hope for a better understanding of authentic description of the ontology of the doctor-patient relationship. Through this ontological foundation we can find a means of preventing medical technology, and genetic technology specifically, from overwhelming human nature and finding usefulness in the nature of medicine, rather than in post-modern drives and economic canons.

The ontology of the patient, the doctor and the relationship

Heidegger spoke of the coming together of beings, of authentic relationships and modes of being-with and of leveling down of relationships. Of course he spoke of these in a general and *primordial* sense, but nevertheless in such a manner as to allow one to extrapolate and take these into particular relationships. We are thrown into a world in which illness forms an important part and hence also some form of resultant relationship between one being and another because of this illness. Societies have different characters to represent their healers – from witch doctors to present-day doctors. But the common character of these encounters remains that of one seeking help, attention or counseling, and that of the other seeking to provide what is asked for. A doctor finds his identity in the relationship, just as much as the patient finds help and possibly a cure. A person *becomes* a doctor not simply by acquiring, therefore, a degree in medicine, but within the clinical encounter; in being-in-the-world (of the doctor and patient).

Yet just as Heidegger questions the authenticity of relationships and the leveling down which occurs in encounters, we can see a parallel leveling down of relationships in the clinical context. He explains how in reality this possibility of empathy, of fullness of relationship fails to hold. In coming towards patients as ‘entities with a disease’ or ‘entities with symptoms’ to be interpreted there has been or may be a doing-away with the necessity of true empathy with the sufferer or troubled patient. Even if used, it is seen as superfluous (Beauchamp and Childress, 1994, p. 375) and the total possibility of the relationship does not occur in most everyday relationships. In the medical environment which handles many patients every day this leveling down is seen in the uniformity of medical management; in the conformity of medical education, in hospital administration and construction etc. “Distantiality, averageness, and levelling down, as ways of Being for the ‘they’ constitute what we know as ‘publicness’. And we can safely say that Medicine has indeed become a form of ‘publicness’.

‘They’ in the sense of the present argument can be taken as the medical community. In its becoming uniform and in its averageness, ‘they’ (the

doctors) do this and this in such and such a situation. This is the existential state of doctors, of the medical community, today. Each doctor may take on a 'they'-self instead of the potential *authentic self*. This dispersal is the 'subject' of that kind of Being (doctor's-Being) which we know as concerned. This 'they' describes (or dictates) the way in which doctors should interpret the world.

Now far from it to suggest that medicine today is in a crisis with respect to the treatment it provides. It is indeed an advantage that things are levelled down to protocols on treatment because experience gained through studies does not go in vain. In seeking to provide our patients with the best solutions and possibilities we rely on controlled trials and standard procedures. This however has left the unfortunate side effect of mechanizing to an extent the clinical encounter. What is important is to arrive at the correct diagnosis. The cost has been a loss in the art of medicine as a humanities profession besides a scientific one (Lown, 1996).

Truth concealed

One can argue therefore that technologically advanced societies, protocols and post-modern ideas of libertarian attitudes may have concealed the true nature of the doctor-patient relationship. All of these concealing factors are not wrong in themselves. Indeed they have given power to the patient, reduced paternalistic attitudes, which in themselves were a concealment of a hidden agenda for the clinical encounter, and allow us to treat the masses in approximately the same optimal manner – at least to our knowledge.

Open to beings and to our own being possible, we nonetheless relinquish this openness in exchange for the security of whatever 'they' say is true.

Presupposed in such truths of faith or science or even the universality of life, however, is a kind of opening or openness by virtue of which something can and does show itself and let itself be seen. To *let*

unconcealment *show itself*: this is perhaps the most succinct formulation of the task of Heidegger's thinking, at the heart of which stands his formulation of Freedom. Untruth is errancy. Man's own freedom allows him to sway into errancy; and conversely it is this same freedom which allows him to un-conceal truth.

Thus looking at the post-modern consumerist society, ever ready to sell products to those who would have them, we can begin to realise the danger of the symbiotic relationship between industry, an evil necessity, so to speak, and medicine. To speak of industry as 'evil' is indeed unfair, because it is biting the hand that feeds you. After all medicines come through industry, but it is an undisputed fact that production of drugs depends also on market forces and therefore on the numbers the drug sells.

Yet this has resulted in a relieving of the responsibilities of the doctor-patient encounter on when a test is to be done. We now view diseases in numbers. For a company to find it viable to produce a genetic test, it also must see the incentive of making as much profit as possible. Tests are thus marketed to the public; people told to get advice not through their physicians but directly from companies. In this context it is more than obvious that the prime, if not the sole, aim of the company is financial. Will companies market also that test for which there are no numbers in terms of patients or will it market tests similar to BRCA1/2 for which they can raise awareness amongst the general public? Wise investment does not necessarily coincide with disease incidence and distribution.

On the other hand to ask companies to look at the phenomenology of the doctor-patient relationship calls for a laugh in the face to say the least. But if we persist in trying to ground the philosophy of medicine in a socially constructed context, then it will be more difficult to argue in favour of the benefits of allowing choices to occur within the doctor-patient relationship. What results is a market force, albeit based on a consumer right to know, in which people are induced out of fear into carrying out a specific test, and not because they really need that test.

This has nothing to do with disease or with the philosophy of medicine; it is only allowing one to take advantage of innate fears which everyone can have of being ill or becoming ill, bypassing in the process any form of clinical encounter. What is needed therefore is a thorough understanding of a philosophy of medicine in the nature of the doctor-patient relationship.

The balance of the argument is whether we would have our health care providers tell us that we are at risk and therefore merit doing some genetic tests, or whether we should allow the media and industry to instill in us a fear, always based on lack of complete knowledge, to induce us solely into falling into a trap to do the test.

Conclusion

At the end of the day medicine is based on the clinical encounter. If there is to be a philosophy of medicine it has been suggested that it should start at this level. There are nevertheless incentives to make profit from medicine; a factor which become of increasing importance in genetic testing. These 'goods external' are tolerated because they allow the advancements of 'goods internal' to medicine – the hope of providing a cure and promoting public health. Any advance in genetic testing therefore must answer to this basic question: Is this test a contribution to the goods internal to medicine; or is it primarily seeking the goods external using the goods internal as an excuse to marketing the test. The best place to answer this question is within clinical encounters. It may take nerve to tell the large corporations what to do and how to market their products, but not doing so is allowing ourselves to be led evermore by market forces outside the clinical encounter. It is for this reason I conclude that it is difficult to perceive of a socially constructed theory and that the answers to who should do genetic testing are best sought within the ontology of the doctor-patient relationship.

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