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Democracy and the Patient-Physician Relationship

by

James Richard Pehling

A.B. (University of California, Berkeley) 1989

A thesis submitted in partial satisfaction of the

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of the

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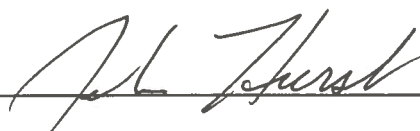

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Spring 2001

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Dedication

This thesis is dedicated to patients everywhere who seek healing with uninterrupted expression of their citizenship and personhood. May democracy flourish in every decision.

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"...humanity is attained by self-determination and by other-determination in mutual dependence" – Paul Tillich

"The relationship with each patient and coworker in the medical hierarchy is a test of one's character; one must always struggle to affirm in these interactions the kind of world in which one believes." – Martin Shapiro

"Every physician is at the core also a patient, and every patient a healer." – Jay Katz

Introduction

Why democracy?

When I began nearly three years ago to consider the implications of democracy for medicine, the popular reaction to my topic was usually one of perplexity. Democracy is thought variously to be a set of political procedures, a governmental system, or a social theory. Medicine is generally cast as a set of practices, some scientific, some not, relating to the maintenance and recovery of health. Given these characterizations, it is perhaps not surprising that democracy and medicine are viewed as strange bedfellows.

Narrowing my consideration of medicine to the key area of the patient-physician relationship has not led to any readier acceptance of democracy as a relevant concept. Democracy is thought to apply to macroscopic, social structures rather than to dyadic relationships between client and professional. Thus at the outset of the present work I confront an uphill rhetorical course, in which I must justify not only the application of democratic theory to the ostensibly apolitical sphere of medicine, but to the microscopic encounter between patient and doctor as well.

I have thought that choosing the topic of physician-patient relations as the starting point for work on the subject of democracy and medicine was a bit reckless. It seemed the usual understanding of democracy would lend itself better to analysis of larger scale, sociomedical phenomena, such as patients as a group, the pharmaceutical industry's impact on US medicine, or the internal politics of the hospital, to name a few possibilities. And yet, to begin with an individual physician and patient also seemed to take the human by the hands. This relation is at the core of medicine. Others, however

germane their substance and severe their impact, are epiphenomena. To begin with the patient-physician relationship is to begin with that which is logically - and historically - prior to everything else in medicine.

Moreover, the venue of the patient-physician relationship is also the one in which I will be most able, in the short term, to have an impact. In just over three months, I will once again be working in a hospital, after a hiatus of nearly three years. I expect to confront once again clinical medicine's substantially antidemocratic face, but this time it will be as a student in training to be a physician, rather than an interpreter. From this new vantage, I anticipate greater responsibility for what goes wrong and right in patients' encounters with the medical system. Exploring the topic of democracy and medicine has been one way to gird myself for this confrontation. I thought that if I could construct some philosophic shield for contesting the democratic vacuum in medicine—the subversion and outright suppression of patient preferences, the discouragement of dialog, the restriction of participation in medical decisions—I would be on better defended ground to offer resistance and alternatives. Perhaps more honestly, in writing on this subject I am, to use Rian Malan's memorable phrase, "looking for a way to live in this strange place"¹: looking for a way to work, and live, in the strange, and often oppressive, terrain of the medical encounter.

This terrain has historically been dominated by power disparity, secrecy, and technicality. The proficiency of physicians in the biologic-technical sphere has been projected forcefully to the center. There are sound reasons for this, including the success of the biomedical model in advancing curative, palliative, and preventive medicine.

However, this progress may have occurred at the cost of nontechnical aspects of the relationship. Rigorous application of the biomedical model, as opposed to a more holistic biopsychosocial model, has relegated the human body in the guise of its various organ systems to an array of medical specialties. I believe a consequence has been the neglect of the human dimension of care. Patients are of course not merely aggregates of symptoms, nor are they simply persons seeking cure for one or several ills. They are, in the ideal case, persons in the fullest sense of the word, with perspectives, values, and lives that transcend the narrowness of the professional encounter.

Why, as a classmate once asked, did I begin with democracy as an overarching principle? Growing up in the United States, I was frequently confronted with an ideology that extolled the virtues of democracy. The absorption of this led me to a presupposition that, as a system of government, democracy was unparalleled in goodness. Writing this thesis has caused me to reexamine some of these beliefs, but with the same conclusion. Democracy has value for its fundamental justice: the making of decisions equally by those affected by the decisions.

The ideal outcome of democracy in government is the reflection of the popular will in social action. By incorporating preferences from all participants, democratic decision making synthesizes individual perspective into collective behavior and policy. This is not to say that the synthesis of multiple desires into a coherent whole is a trivial task. Indeed, I believe the deliberative process by which this is accomplished is the fundamental task and challenge of democracy, and one which itself has manifold benefits in terms of public education and refinement of policy, as I will explore. But with success

in this task, the outcome is one which produces a just representation of the people's collective mind. Such a resolution has a legitimacy beyond that of any other, because those subject to a decision have themselves rendered the decision. Assuming a just and inclusive process, this result is optimal.

A legitimate governance through deliberative process is only one of the benefits of democratic practice, however. The process itself generates more than a result representative of the decision makers. In carrying out the components of this process - learning, reflecting, discussing, and resolving - the participants are changed. They become experts in the issue at hand, more knowledgeable of the other perspectives in the community, and skillful in synthesis and compromise. The process itself, when successful, generates a stronger, more self aware community, and citizens of greater competence and independence of thought. They know their ability to shape their own lives. This is why, I think, Heta Häyry writes, "autonomy and self-determination are valuable in themselves, since they belong to the primary elements of a good and happy human life."² In democracy there is thus a promise of human fulfillment.

A central conflict of life, however, is the disjunction between ideals and reality. As John Hurst observed, we are faced with "learn[ing] to live democratically in a society dominated by institutions that are typically autocratic, from the family, to the school, to the church, to the workplace".³ This disjunction made me reflect on whether the pronounced lack of democracy in everyday life is reasonable, perhaps an indication that democracy should reasonably be consigned exclusively to the realm of political

governance, or whether there is a hypocrisy here, possibly a deliberate restriction of democracy's ambit to contexts far distant from those in which most live their lives.

I believe it a mistake to consider democracy merely a prescription for a set of political procedures, applying to the relations between citizens and their government. That it may be, but construed more generally, democracy is a philosophy regarding the just allocation of decision making power. To reduce it to political procedure, or to the act of voting, is to delete most its substance. Democracy has ramifications extending beyond the conventionally political to the social, economic, and even interpersonal environment. Arguably, democracy does not exist without certain preconditions in each of these, and indeed, without expression in each of these. As Anne Phillips has written, "Wherever there are decisions, there is an issue of democracy."⁴

Why might democracy be more than a set of practices germane to the traditional, governmental sphere? The fundamental answer is democracy's basic premise that decision making be shared equally among those affected by a decision. There is no a priori constraint that limits democratic process to a single sphere of human social experience, and indeed, it would be difficult to formulate one from the premise that just decision making is shared decision making. To limit democracy's extent would be to affirm the legitimacy of decision making processes that, for example, deleteriously affected persons with no ability to participate in deciding. For this reason, democracy might be said to be an infectious philosophy, in that it asserting it in one social sphere automatically provides the moral basis for its application in all others.

I believe that the universality of *deciding* as a human activity, in combination with democracy's prescription for inclusive decision making among those affected, is the basic reason democracy is applicable to multiple social spheres. There is another aspect beyond the democratic injunction of participatory decision making, however, that brings implications for society as a whole. This relates to prerequisites for the realization of the democratic process. It goes without saying that meaningful participation in decision making cannot exist if, for example, one group is purposefully excluded from the venues in which collective deliberation occurs. Regressing from this extreme and simplistic example, one can imagine further impediments to democratic process that might tarnish its legitimacy, if not abolish it entirely. These could include such things as inability of a group, or person, to speak in public, excessive demands on one's time, and ill health, to name only a few. The last item is itself representative of a slew of materialistic requirements of human life, including air, water, and food.

Lack, or perhaps more trenchantly, maldistribution of any of these is corrosive of democracy. In the "optimal" case in which the privation in question is experienced uniformly by a group attempting to exercise democratic decision making, the quality and effectiveness of the process will at the very least be compromised. If the privation is experienced unequally throughout a community, the integrity of the process is essentially lost, because of democracy's injunction that all affected persons participate equally. In the case of illness, if half a community were suffering from a terrible plague and the other half not, it is likely that any decision making process would be vulnerable to outcomes unfavorable to the ailing group. I do not mean to imply that this is a foregone conclusion,

but merely that an optimally functioning democratic process involves persons each functioning at comparable levels of health, and ideally, good health. Health is therefore in some sense a material prerequisite for democracy, because it permits full participation. This led to my initial research question of the implications of democratic theory for the institution of medicine in a democratic society. How would specific institutions in our society operate in the context of a society that was thoroughgoingly democratic in Anne Phillips' sense?

Why democracy and medicine?

I have argued that democracy ought to extend throughout a society first because of its universalism and second because of certain prerequisites to its realization. At this point I consider medicine and how it meshes with these criteria. In the contemporary United States, medicine is a major industry, with colossal economic inputs totaling more than 1T\$ annually and overlap with nearly every sphere of life. The number of persons directly employed in the health care sector, as physicians, nurses, pharmacists, optometrists, and numerous ancillary personal approaches 4 million.⁵ This figure does not even include the prodigious workforce operating behind medicine, in the fields of applied and basic research, medical teaching, insurance, and manufacture of pharmaceuticals and medical equipment. Medicine purports to restore and maintain human health, a commodity I have advanced as prerequisite to democracy and one whose importance as an individual and social good is uncontested. Medicine additionally serves as a source of ostensibly objective judgment, concerning such socially important variables as the fitness to attend school, the ability to obtain indemnity for accidental

death, and the right to receive supplemental income at public expense after a work related injury.

A cursory examination of medicine in the US, however, shows it, like many institutions, to be profoundly undemocratic. Funding for health care services is based substantially, though not entirely, on policies created by corporations that, while technically "public", operate far beyond the immediate influence of the persons affected by these policies. Relations among health care workers is perhaps most succinctly characterized by William May, who described the physician's "professional hegemony" as being "well-nigh total over other health professionals."⁶ The individual person's encounter, as a patient, with a physician is still one in which much of the medical decision making is carried out behind a curtain of technicality and secrecy, behind which the person cannot see the wide ambit of her options. All these examples reflect inequalities that impede or abrogate democracy, both in the immediate sphere of the individual patient's life, and in the larger social sphere. Given the importance of medicine socially, economically, and practically, the question from a pragmatically democratic perspective is less whether medicine should be democratic, but how it could *not* be and still have democracy extant in the larger society.

What would a democratic medicine look like? The question can be applied to multiple levels in medicine's vast hierarchy, one of which is the topic of this work. The answers are subject to future study, but I would like to make certain speculations based on conviction of what democracy *cannot* be. A democratic medicine would not feature a health care finance system in which 42 million people were excluded. It would not

prioritize corporate profits for the few over access to lifesaving medications for the many. And it would not rely on the professional dominance of physicians as the primary, or exclusive, agents of health care for individuals. Speaking affirmatively, a democratic medicine would help individuals foster their own healing through supportive, open relationships with health consultants who work with patients as equals.

Why democracy and the patient-physician relationship?

Because of a long tradition of considering democracy in the context of urban, state, and national populations, the application of the philosophy to smaller groups may not immediately come to mind as a legitimate, or at least obvious, example of democracy in practice. cursory reflection, however, suggests that we know in a general sense what is meant by democracy in smaller groups, and that it is quite similar to democracy in larger groups, though perhaps enjoying certain advantages.

For example, imagine that a union local of 20 workers is faced with a decision concerning which member to delegate to a labor convention. If you were told the matter was resolved democratically, you may, with reason, minimally surmise that a process was initiated, of which all 20 workers were aware, and by which a delegate satisfactory to a plurality of the participants was selected. It would also be reasonable to imagine that as part of this process, each worker considered and perhaps voiced the qualities she thought best for the delegate, and that several workers were nominated and discussed as possible candidates. Relative to a larger group, such as the population of a small city, the union local's democratic process might involve as actual participants a greater fraction of those

eligible to participate. There also might be a greater degree of direct deliberation among all participants, given the increased manageability that comes with a smaller group.

Similar scenarios could easily be defined for other relatively small groups, such as an elementary school classroom, the staff of a small office, or even a family of four people. In each case, a democratic process might be imagined that would include features of group deliberation, decision making, and action. It would further be possible to consider which processes were more and less democratic, based on such criteria as inclusiveness, breadth of participation, and openness of dialogue. From here, we might proceed to reflect on what factors ultimately are more or less conducive to a robust democratic process.

If democracy can exist in the context of groups considerably smaller than geographic populations, and indeed in conspicuously small groups, a question arises as to the smallest group in which democracy can legitimately be said to function. My claim is that a dyad (i.e., a group of two people) is the minimally sized group in which democracy can be practiced.⁷ Reflection on the notion of dyadic democracy demonstrates a principle that may be less obvious in the consideration of larger groups. In a group of two, interpersonal relationships are a key determinant of the democratic character of any decision. To the extent that the relationship between the two participants fosters open discussion, deliberation, and mutual understanding conducive to rendering a decision on a question of concern, and to the extent that decisions are actually made jointly, the relationship can be said to be democratic.

This idea, though derived from consideration of the minimal democratic community of two, is applicable to larger groups, and indeed may be more important there, since the implementation of a democratic process encounters procedural difficulties with increasing group size. In any case, however, the key point is that a certain set of democratic interpersonal norms may be defined as necessary to achieve democratic decision making. Further, any relationship may be evaluated for its democratic character based on the degree to which these norms are satisfied and lead to joint decision making, including the relationship between patient and physician.

Above I alluded to the patient-physician relationship as the center of medicine. To be sure, medicine as a social phenomenon encompasses much more, including issues of finance, workforce, public health, and medical resource allocation. In addition, the number of professionals with significant roles in preserving and restoring health far exceeds the number of physicians. Nevertheless, I advance the interaction between a person facilitating healing - frequently, though not always, a physician - and a person seeking healing as the irreducible core of medical activity.

From the perspective of physician ethics, it is certain that the relationship with the patient occupies central importance. While the Hippocratic Oath extends to intraprofessional interactions, the bulk of its provisions apply to the physician's conduct toward the patient.⁸ Other documents, such as the American Medical Association's Code of Medical Ethics⁹, the Declaration of Hawaii, the Oath of Athens, and the United Nations Principles of Medical Ethics¹⁰ make repeated, explicit provisions governing proper physician behavior within the context of this relationship, the last under the

extraordinary circumstances of patient imprisonment. Even in the contemporary milieu of the United States, debates on patient rights tend to dwell on the effect of particular insurance policies on the integrity of the patient-physician relationship.

Ethical focus is brought to this relationship for good reason. More than any other, the interaction of patient and physician defines the parameters of the patient's interface with health care. Based on the interaction, the patient may be able to share comfortably information necessary to rendering medical judgments, or not. She may obtain interventions or advice with profound importance for the restoration of health, or not. The patient may be able to participate in making decisions regarding their medical treatment, or not. Given that the fundamental purpose of the physician is to assist the patient in realizing a desired healing action, consonant with the patient's needs and values, the ability of the patient to achieve successfully the foregoing objectives is deeply relevant to the integrity of the relationship.

praxis The importance of the patient-physician relationship to applied democratic theory has a different basis. The medical encounter has pervasive ramifications in the patient's life. Most importantly, it directly influences the patient's health, and consequently her material ability to participate in public life. Beyond this, the patient-physician relationship influences the patient's ability to secure health, by either forcing her to depend on medical professionals, or educating her to make independent health decisions. Its fallout may affect her interactions with professionals generally, influencing whether she feels confident in advancing her interests or not. Finally, the medical encounter may even have a role in the patient's future disposition to effect change in the world around

her. The basis for this last claim is a model for learning effective social behavior, in which, depending on how much the patient-physician relationship fosters the patient's self image as an independent social actor, either competence or helplessness may become the lesson, with substantial impact on society at large. From the perspective of democracy, then, effects of the medical encounter may exert a substantial influence on the patient's behavior as a citizen, making the medical encounter a potential locus of democratic concern.

If democratic decision making is to flourish in the patient-physician relationship, substantial obstacles must be overcome. There are problems with the relationship that make it potentially impede, rather than advance, any deepening of democratic values and practices. Some of these antidemocratic aspects result from givens of the relationship, such as the intrinsic vulnerability of the patient as a person in distress, or the disparity of medical expertise between patient and physician. Others result from contemporary practices, including the concealment of financial interests of the physician from the patient, the legal ability of the physician to provide or withhold treatments to which the patient enjoys no independent access, and the tendency of the physician to decide for, rather than facilitate the decisions of, the patient.

It should be said that democratizing the patient-physician relationship is not completely reliant on the physician to disclose implicit or hidden information, relinquish power, and otherwise make changes in contemporary behavior. Because of the inclusive and egalitarian nature of democratic decision making, democratization requires the patient and physician both to act to alter the traditional terms of the relationship. (Indeed,

the implications of democratic theory for patient participation are troubling to the extent that they suggest the possibility of a normative *requirement* for participation, one potentially at odds with autonomy, a central value in liberal traditions.) However, because of the historic favoring of the physician side of the relationship with a considerable degree of power and privilege, to say nothing of the disparities associated with knowledge and health, it does happen that many, or even most, of the changes required for democratization favor physician change in particular.

Why democracy and the patient-physician relationship? Dyadic democracy is a somewhat hidden, even neglected, aspect of democratic theory. As the central relationship of medical practice, the dyadic interaction between patient and physician is a critical locus for the application of democracy, and indeed prerequisite to any larger project of the democratization of medicine.

Chapter 1 - A Value-based Theory of Democracy

The meaning of shared decision making

In attempting to formulate a democratic theory of the relationship between client and professional, it is important at the outset to describe what is meant by the certainly contentious term "democracy". In what follows, a basic definition of democracy and consideration of the elements of shared decision making appear. I then elaborate a descriptive model of democratic process, based on key values I consider necessary and sufficient for democracy. In the following chapter, I discuss the social implications of professionalism, and in particular of the sovereignty, or substantial organizational autonomy, enjoyed by professions in the US. Finally, I attempt to derive from the value-based theory of democracy the necessary structure of client-professional relations in a democratic society.

The essence of democracy is shared decision making among those with an interest in the decision. Carol Gould's reference to democracy's "original connotation" is the most succinct definition I have read: "self-rule by the people through a process of codetermination".¹ "Self-rule" may itself be taken as a series of steps, initiated by a group, aimed at reaching decision on a contentious issue affecting the group. "Codetermination" is the heart of the democratic process, and refers to the realization of social policy through the combined inputs of all interested parties. Implicit in codetermination is an idea of equality of opportunity to participate among the actors. The right of each individual to participate is contingent on a similar right of the other

participants. It is this reciprocity which moves democracy from the realm of the individual to that of the community, making the process of policy formation shared.

The actual decision making process, under any political system, proceeds by a series of discrete stages. These stages move policy from the stage of defining the problem to that of implementing a provisional solution. One rubric for these stages is as follows:

Agenda creation: problem definition, including identifying the issue as one of social importance, and placement of the matter on the public agenda for detailed consideration

Deliberation: discussion of the problem, the various interests involved, and possible solutions

Decision: establishment of one candidate solution as the popular solution, through a process in which at least a plurality of all citizens registering any preference at all prefers one solution

Action: implementation of the decided solution

As state above, there is no correspondence between the foregoing stages of decision making and any particular political philosophy. A given political philosophy will, however, suggest norms of conduct for each of the stages. These norms exert a profound influence on the overall character of social decision making, which will vary according to the prevailing political culture. For example, in a political oligarchy, decision making is likely to proceed secretively under guidance of a narrow caste, determined by wealth, ethnicity, or some other criterion, with deliberate exclusion of

most community members. Under representative democracy, decisions may be carried out openly but with decision makers acting on behalf of, but relatively autonomously from, community members who do not participate directly. And in a culture of direct democracy, decision making might reasonably be both open and inclusive of the community at large.

If the stages of decision making do not intrinsically support a particular philosophy, neither do they make any a priori restriction on the size of the participating community. In principle, the people contributing to a given social decision may range, like Gandhi's ashram, from the population of a village to that of the entire world.² (Though without a doubt, increasing community participation brings with it increasing technical difficulties in accommodating a progressively larger group in the process of decision.) Moving in the opposite direction, a community operating by shared decision making may be smaller than a village, and could consist of a class, a medical staff, a family, or in the extreme limit, two people attempting to resolve an issue in a manner acceptable to each.

Democracy is not tied to a particular community size any more than are the stages of decision making described. Democracy is, however, highly partisan in the character of the decision making process it requires. For a decision process to be democratic, I believe it must instantiate a particular, minimal set of values for which democracy has extremely high affinity, in that without these, it cannot be meaningfully said to exist. It is to identifying these values of democracy that I now turn.

The values of democracy: introduction

Democracy is a particular kind of decision making philosophy, unique in its commitment that power be shared at multiple stages of decision making among those affected by a decision. The emphasis on power sharing breeds a variety of prerequisite principles, or values, without which sharing may become nonexistent.

The model of democracy I advance, based on five key values, is deliberately general. Though it prescribes the character of a democratic process, it does so minimally and only qualitatively. Details of process are excluded, allowing for the possibility of a diversity of forms, all of which could be democratic and yet substantially distinct from each other. Since the goal of the present work is to derive certain implications of democracy, as a political and ultimately cultural philosophy, for the patient-physician relationship, the values model has the advantage of specifying general principles that may then be applied to a particular, in this case medical, context.

Of course, the corresponding weakness of such a model is its ambiguity in application. It is difficult to even define degrees of adherence to particular values of democracy for two different decision processes, for example, let alone to use such subtle distinctions to determine robustly which of the two is more democratic. As a result, the theory may have shortcomings in advancing one recommendation for democratization over another. Moreover, it is certain that however high a rung democracy and its values may occupy in the hierarchy of social importance, there are other, potentially competing values that may complicate efforts to secure greater democracy. This is particularly true in as ethically complicated a field as medicine.

Autonomy

Citizen autonomy is perhaps the cornerstone of democracy. This is not because of the venerable history of autonomy as a central principle in liberal thought, though it is likely that through liberalism autonomy's link with democracy has been strengthened considerably. Rather, autonomy is a prerequisite for democracy because of the latter's implicit requirement that decisions reflect the popular will. The freedom that is the essence of autonomy is necessary for both the expression of preferences and their untrammelled formation.

Autonomy is, however, progressively limited under progressively greater conditions of hardship. Need and desperation may circumscribe its expression to the point that it becomes a ghost of itself. For its adequate exercise for the purpose of democracy, then, autonomy itself has prerequisites. Chief among these are material ones of water, food, and shelter. In addition, however, autonomy as a value of democracy has prerequisites related to participation in the decision making process. For participation in deliberation, for example, a certain ability to understand information and respond verbally is needed. Similarly, in the planning of agendas, distinct prerequisite capabilities, such as the ability to allocate time and perceive the similarities between related topics might be deemed critical. Democracy, then, does not necessarily require that individual autonomy be sufficient for any person to realize any desire. Democracy instead requires, at minimum, autonomy sufficient to the tasks of shared decision making. Shared decision making involves expression of the interests and preferences of the individual members of the polity. This expression need not occur simultaneously and

at the same level; individuals may make their interests known to a representative, for example, who then attempts to synthesize and express preferences at a more rarefied level of government at a later time. In order, however, for stated preferences to accurately reflect the actual preferences of the citizenry, the citizens must be capable of autonomously articulating their preferences. The point is perhaps more easily made in light of the contrary situation. Imagine a case in which one citizen is completely beholden to another, and therefore incapable of acting autonomously. Whatever preferences the first citizen may actually state are a suspect representation of that citizen's true desires, because of the constrained circumstances under which she operates. The citizen's true preferences may go entirely unstated, or they may be edited or otherwise altered in expression in response to outside pressures. The likelihood that stated preferences *authentically* reflect actual preferences decreases for nonautonomous persons, and without citizen autonomy the authenticity of aggregate preferences as a representation of the popular will decreases as well, along with the validity of shared decision making.

One might argue that however much human fulfillment would suffer with constrained or abolished autonomy, it would be possible to devise systems of recording preferences, such as the secret ballot, that would enable even the nonautonomous person to accurately state their wishes without fear of reprisal. While strategies such as this would mitigate the pernicious effects of nonautonomy, they would not redress them entirely. The most direct objection is that in democratic decision making, the expression of preferences transcends the act of deciding (in the example at hand, voting).

Preferences may be expressed throughout the decision making process, in agenda creation, deliberation, and action, as well as in the actual act of decision. While additional corrections for nonautonomy might be introduced, they would be unlikely to even approach the ideal state of independent individuals deliberating together in a process of shared decision. This requires not only free expression, but free consideration and reflection as well, and the material and intellectual prerequisites of these. Autonomy itself is but the outcome of considerable prerequisites relating to physical and mental well being, nurtured in an environment encouraging liberty of thought and action. The satisfaction of the autonomy criterion is one route by which the establishment of democracy has ramifications in distinct, and nonpolitical, social sectors.

As suggested above, it would be mistaken to assert that the autonomy needed for authentic expression of preferences is an idealized autonomy, free from all constraint. Members of a democratic community will bring to each decision a host of concerns, interests, hopes, and even fears. These individual thoughts and feelings will influence community members, and some may become public in the course of deliberation, influencing in turn the community at large. In addition, prior decisions and acts by the community will affect the context of each subsequent decision, and of community life in general. The exercise of democracy thus occurs under substantial constraint as, one might argue, befits an interdependent community committed to live by group preferences distilled from individual ones. I think the distinction between constraints of the sort I have described, and constraints which threaten or abolish autonomy, is one between constraints acceded to voluntarily and those externally imposed. Both restrict autonomy,

but the former might be said to do so in a manner deemed necessary or salutary by the individual, and the latter in a manner contrary to the individual's preferences. The former constraints are compatible with the autonomy needed for democracy, but the latter are not.

It should be noted at this point that democracy itself directly constrains autonomy, both on principle and in practice. Democracy must be regarded as theoretically partisan, in that it has a distinct goal of shared decision making. Autonomy as a value of democracy is therefore not truthfully an end in itself, but a means to the ends of democracy. In particular, the autonomy of any citizen of a democratic community is only asserted contingent on a similar assertion by every other member of the community. This reciprocal recognition of rights, which in effect constrains all rights, has been well elaborated by Carol Gould in her reconstruction of democracy from first principles.³ At the outset, then, democracy circumscribes autonomy by asserting it for each member of the collective. One might imagine each citizen surrounded by a sphere that defines symbolically her personal autonomy. The radius of each sphere varies somewhat depending on proximity to other citizens, whose own spheres enforce a boundary on the autonomy of the individual in question.

While the abutting autonomy of other community members constrains that of any particular member, the autonomy of the individual may also be constrained by democratic decision. That is, the public sphere, containing matters of community and not exclusively personal import, may be enlarged at the expense of the individual sphere of personal autonomy. The circumstances under which the public need may abut and

constrain the personal were described by John Stuart Mill, who ruled that outside the realm of preventing the infringement of the individual on the rights of others, personal autonomy was inviolate.⁴ As Mill himself implied, however, the very question of rights is subject to legality, and thus distinct balances between public and private may be struck in different democratic communities, depending on the legal codification of rights in such communities. While universalists may assert rights transcendent over particular communal contexts, effectively setting an absolute minimum for the radius of the symbolic sphere of personal autonomy, in practice the boundary between the public and personal spheres is contextually dependent.

Returning to the theme of autonomy's importance to democracy, there is another sense in which citizen autonomy strengthens democracy, alluded to above. This is in the sense of permitting the development of a diversity of thoughts and perspectives in the community. This positive attribute of autonomy is likely not prerequisite to the existence of democracy, but rather is useful in guaranteeing that democracy is effective in producing good decisions. In *The Social Contract*, Rousseau said, "It is therefore essential, if the general will is to be able to express itself, that there should be no partial society within the State, and that each citizen should think only his own thoughts".⁵ Rousseau argues, almost paradoxically, for independence of individual thought from factionalism in the interest of generating a general will from individual perspectives. Autonomy, by allowing people to live their lives free of involuntary constraint, tends to foment development of disparate perspectives. With increasing diversity of perspectives comes a fuller and richer deliberative process, which leads to democratic decisions more

cognizant of the nuance of multifaceted reality. I shall have more to say concerning this when I discuss participation, below.

Given the importance of autonomy to democracy, particularly in an exploration of democracy's import for medicine, it is important to at least briefly consider the issue of cession of autonomy. It is problematic in either democracy or medicine for someone to cede their autonomy to someone else, and I think for substantially the same reason: the nonautonomous person is at a practical disadvantage in making their preferences known, and hence in attempting to sway decision and action in favor of their preferences. Moreover, the person to whom autonomy is ceded acquires a measure of additional power, not only over the ceder, but in the community at large, with the titular ability to speak on the ceder's behalf, potentially amplifying the importance of their own preferences. The pejorative consequences of this for democracy, per the foregoing, include a possible loss of authenticity in the popular will, and also a reduction in the diversity of voices contributing to decision making. In the context of the patient-physician relationship, the surrender of autonomy deprives the interaction of the critical component of patient preferences, and consequently raises the probability that any decision made will in fact run contrary to patient values.

These arguments suggest that cession of autonomy runs contrary to democratic values, particularly the value of equality, to be discussed below. Such cession could be banned on these grounds, through action of the democratic community. It is, however, both problematic (and ironic) to forbid the autonomous cession of one's own autonomy, in the interest of preserving autonomy! Even if it were contended that the benefits to

democracy of autonomous citizens outweighed this objection, it is even more difficult to argue in favor the logical consequence of so limiting autonomy: that citizens would thereby, paradoxically, be *coerced* to participate in the democratic process. The problem of constraint, coercion, and voluntary choice is a thorny one for democratic theory, and will be considered at greater length in the discussion of the value of participation. For the present, I leave the matter unconcluded, save to say that while the cession of autonomy cannot legitimately be banned, it probably ought to be discouraged and permitted only after cautious evaluation.

Autonomy conceptually originated in reference to self-government of Greek city states, and came to be applied to freedom of the individual person,⁶ a kind of personal self-government. It is a value of democracy because it potentiates two fundamental characteristics of democracy: the authentic expression of individual interests as aspects of the collective will, and the development of decision making wisdom through the contributions of diverse perspectives. Democracy also conceptually originated with Athens, and I believe can be applied, if not to individuals, then at least to communities as small as dyads. Democracy demands more than individual autonomy, however, and it is to additional values that I now turn.

Openness

Beauchamp and Childress define one aspect of autonomy as involving the capacity to understand information relevant to a decision.⁷ The actual availability of the information is the substance of the democratic value of openness.

Openness is, like autonomy, prerequisite to democracy because it supplies a precondition necessary for effective decision making. Information with a bearing on the interests of any one member of the community, let alone multiple members, may influence the decision making process at any level. For example, discovery of a plan by one community member to build a bridge across a river may spur a reaction from other citizens, either in support or opposition. In either case, the discovery would likely motivate the formulation of the issue as an item on the public agenda. Disclosure of further details relating to the proposal would influence the public deliberation, and could well affect any decision germane to the bridge. Finally, if the community takes any action regarding the project, subsequent disclosures may influence the policy taken, and could even lead to public reconsideration of the matter.

Information is thus the raw material of consideration and decision. The ability for the democratic community to even deliberate an issue, let alone render a good decision, is crucially dependent on the general accessibility to members of the community of relevant information. I shall first briefly discuss accessibility, and then take up the more difficult question of relevance below.

Where information is concerned, there are certainly degrees of accessibility, from the immediate to the unreachable. The degree of accessibility to relevant information necessary for democratic decision making is a function of the community in question. To take one example, in the polis of ancient Athens, information may have been sufficiently accessible merely by its being discussed among the citizens. The members of the polis were educated men of leisure, considerably supported by a large number of others

excluded on principle from participation. In this admittedly limited democratic community, the resources of the community members may well have permitted adequate time and opportunity to seek out information they felt necessary for the democratic process, solely by consulting among themselves. In another community, such as an inner city neighborhood, the level of education, preoccupation satisfying basic needs, and concern for personal safety of community members might demand considerably greater infrastructure than what sufficed for adequate accessibility in ancient Athens. Generally speaking, openness requires that the means by which information is rendered accessible are adequate to the realities of the community. If some community members, particularly those most challenged in obtaining information, are unable to satisfy their perceived need for information, while others are not, a violation of the value of openness exists.

The question of what information is relevant to community decisions again raises the issue of the boundary between the public and private spheres. I do not believe that universal disclosure of all information is required for democracy, and in fact what information must be disclosed in the interest of informed discussion will vary according to the rights formulation of particular communities and the particular issue at hand. For example, in a community with robust defense of personal privacy and a correspondingly limited public sphere, a good deal of information concerning individual members, that might otherwise affect public deliberation, will be restricted from consideration, and hence from the value of openness. On the other hand, in the same community, the personal business dealings of a public official may become subject to scrutiny if a compelling public interest in their disclosure were found.

Effective instantiation of the value of openness requires less a detailed standard specifying the nature of public information and more a *cultural disposition toward free disclosure and away from secrecy*. There is some affinity between this formulation and Amy Gutmann's concept of *nonrepression*, or the absence of restriction on the bounds of deliberation.⁸ Information potentially relevant to discussion certainly includes ideas developed during the actual course of deliberation, as well as those formulated by individuals during personal reflection. My emphasis here, however, is primarily on factual, rather than conceptual, information that could be used as inputs to all stages of the decision making process. A disposition toward free disclosure implies not automatic disclosure, but a willingness to entertain the possibility that any information, however personal, might be legitimate material for the public forum, and not to judge information on its face as permanently consigned to the private sphere. A disposition away from secrecy implies an aversion to deliberate concealment, which would encourage the perspective that most information is, if not decidedly public, then at least not so private as to be guarded as such. Together, these dispositions would promote a culture in which free access to all kinds of information would be, if not absolute, then at least the norm in many cases, and an open possibility in others. With free access to information, democracy can flourish. But as with autonomy, openness is necessary but not sufficient for democracy.

Dialog

Dialog is a self-conscious and self-referential conversation, frequently between two, but potentially more, parties. Like democracy itself, dialog is purposive. While it is

unquestionably a form of communication, it transcends the pure exchange of information by aiming to achieve mutual understanding and synthesis. The conversation that occurs in dialog is reciprocal to a high degree. Each side not only presents information to the others, but actively seeks to draw information from the others. Moreover, the content of one party's contribution is deliberately shaped by that party, in light of information received from the others. This shaping may take a variety of forms, including qualifying, expanding, and even contesting what has been said previously. Through receptive, mutual shaping by the parties involved, the content of dialog evolves creatively toward refinement and clarification. Dialog may occur in various contexts, from the entirely cooperative to the more contentious, but even in a contentious setting it cannot operate without the willingness of the participants to move toward resolution, even if the ultimate resolution is only an improved understanding of competing perspectives. It never guarantees accord synthesized from competing perspectives, but such accord is its highest and most productive result.

Unlike the two values of democracy discussed previously, autonomy and openness, dialog is more an activity than an abstraction. It therefore may seem counterintuitive to describe it as a "value". I use this term loosely here, in the sense of dialog as described above being accorded high value in a democratic system. A similar usage is intended for the value of participation, below.

Dialog is, like openness, a component of all stages of decision making, but it has a particular affinity for deliberation. Indeed, my definition of dialog is very similar to Amy Gutmann's of deliberation, referring to the Oxford English Dictionary: "on the individual

level, [deliberation] is defined as 'careful consideration with a view to decision' and, on the institutional level, as 'consideration and discussion of the reasons for and against a measure by a number of councilors'⁹. Dialog is somewhat more general, in that the synthesis for which it aims need not be decisive in character, but may amount, for an example, to an improved understanding of different perspectives on an issue, without a commitment to decide an issue or act upon it. In spite of this distinction, in the following discussion the words "dialog" and "deliberation" can be used interchangeably.

Dialog's importance to democracy is twofold. The exchange of ideas dialog engenders is an educational process and also a conflict resolution process. John Dewey described the former when he said "even such rudimentary political forms as democracy has already attained...involve a consultation and discussion which uncover social needs and troubles."¹⁰ Dialog thereby becomes a vehicle for public education, exposing what was previously unseen to the awareness of community members. In this capacity dialog serves as a conduit for information. In a similar manner, dialog may defuse conflict by specifically educating concerning what unites, as well as divides, a community. Again, Dewey: "[Democracy] forces a recognition that there are common interests...and the need it enforces of discussion and publicity brings about some clarification of what they are."¹¹ With dialog, a community is disposed to finding accord from the chaos of conflicting visions, and isolates the common elements that can form the basis of accord. I am inclined to extrapolate further from Dewey's work, and suggest that dialog furnishes a rhetorical proving ground for the testing and refinement of ideas. The measure of this

dialog thereby :

testing is not scientific experiment, but consonance with community members' interests, the desired outcome of democratic decision.

An aspect of dialog that deserves further examination is persuasion. In the presentation of information, all parties to a dialog may attempt to influence its course. The effort to influence may be motivated by a variety of interests, both individual and community. In any case, however, the manner of presentation, including such aspects as facts emphasized, the framing of issues, and appeals to ethical standards, may be turned toward achieving whatever outcome is desired. Presentation of information virtually always amounts to an effort to influence, either vigorously or subtly. Because of this malleability of presentation, it is difficult to separate the concerns of the presenter from the dialogic contribution they make, in the hope of achieving some objective standard for the provision of information in dialog. The effort to defend and convert others to one's position is an entirely acceptable activity in a democratic community, and indeed seems a natural component of the educational purposes of dialog. The question is what bounds, if any, the democratic value of dialog places on the acceptable limits of such persuasion.

One bound is on the partisanship of persuasion. While attempting to advance one's own interests is acceptable, two key aspects of dialog as I have defined it are reciprocal interaction and synthesis. If a party to dialog adopts the exclusive goal of persuading others of her position, she neglects these aspects, and the dialog is likelier to stagnate without resolution, particularly if other parties adopt positions based purely in their convictions and not on the overall content of the dialog. The democratic value of dialog therefore imposes a limit on the vigor of partisanship.

The democratic value of autonomy is itself in tension with certain tactics of persuasion, and thereby suggests additional limits to dialogic behavior. Autonomous individuals in dialog should, in principle, be able to exercise the benefits I have ascribed to autonomy, such as independence of thought and free expression of preferences, regardless of the dialog content. I nevertheless believe that certain types of persuasion can potentially threaten autonomy and discourage its exercise. The persuasive tactics I have in mind conflict with autonomy, in that they do not attempt to sway based on sincere appeal to others' autonomous conscience, intellect, and emotion. Rather, they are deliberately manipulative in attempting to limit autonomous expression and generate responses based on known weakness or sensitivity. An extreme example that is itself a *prima facie* violation of autonomy is threat of harm, expressed or implied. A less egregious example is deliberate preying on the fears of someone known to have been traumatized by war, by suggesting that support for a particular military project is necessary to avoid a repetition of the trauma experienced. A truly autonomous person is likely to see through such an attempt, but one coping with difficult memories of harm may be manipulated to a decision potentially contrary to their interests. This is not to say that each member of a community will not have prejudices, fears, and past experiences that at some level influence, and perhaps limit, their own autonomy, and that this reality is not consonant with a lived human existence. The wrong in the predatory tactics of persuasion described is that they *deliberately* aim to harness these constraints to effectively, if not actually, coerce someone down a particular path.

Another bound on persuasive behaviors results from violation of another value of democracy, openness. Openness has a particular affinity for dialog. Openness demands that most, if not all, data relevant to the issue at hand be freely disclosed and available to the community members involved. Indeed, it is apparent that dialog is hobbled in its goal of understanding and synthesis if this condition does not obtain. Deliberate concealment and deceit therefore have no place at the table of dialog. Rigorous, demonstrated adherence to openness tends to establish trust among members of community, as does dialog itself. Trust is in fact both a product of the instantiation of the values of democracy, and simultaneously a precondition for effective functioning of democracy.

In closing, dialog is a core mechanism of democratic decision making. When valued highly, it is practiced reciprocally and receptively, in the hope of achieving resolution and synthesis. Dialog thereby restricts legitimate persuasion to forms that allow honest interchange of perspectives, consonant with autonomy and openness. The benefits of dialog to democracy, like those of autonomy, are most manifold when a diversity of perspectives is generated and shared. This requires broad community participation in decision making, a topic to which I now turn.

Participation

It could be said that, like the other values of democracy discussed thus far, community participation improves the quality of democratic decision making. Indeed, it is apparent that even under conditions of great openness and commitment to dialog as a means of social learning and problem solving, the democratic process becomes hollow without mass participation. Similarly, though autonomy may be regarded as a good in

itself, from the perspective of how it contributes to the integrity of democratic process, its worth is lost without participation in same. Participation, like the other values mentioned, is necessary but not sufficient for democracy to exist. Unlike the others, however, it could be said that participation is the linchpin of the process itself. Without the others, the process will become limited and, ultimately, incapable of fulfilling the democratic criterion of shared decision making. With a complete lack of participation, there is simply no process at all.

Participation is, however, subject to gradation. The fraction of the community involved in the democratic process can range from the entire population, to a majority, and even to a minority. How much can participation decline before a democratic process loses its democratic character? This question is best answered by considering the decision making process surrounding a particular issue. Ideally, all those affected by a decision must participate for the decision to be democratic. Though this ideal standard seldom obtains in practice, there is at least a quantitative difference in the democratic integrity of a process where, for example, a single interested person does not participate out of 100 interested members of the community, and that of a process where half the interested members do not. As more interested persons decline to take part in the process, the fraction of the community invested in a decision decreases, resulting in decreased public investment in whatever action arises. This may result in decreased compliance and difficult enforcement. In addition, as participation declines from full to varying degrees of partial, qualitative losses are likely to manifest as well. Without the knowledge and interests of those absent, the process will suffer from loss of diversity and

dialogic substance, and the effectiveness of decisions reached can be expected to decline, at the very least from sheer lack of inputs. In essence, incomplete participation always deprives the democratic community of its central resource, the human resource of autonomous individuals assembling their collective intelligence and preferences to synthesize a policy acceptable to all.

While full participation in a particular decision by those affected is therefore optimal, the fact that only partial participation is practically achievable raises the question of whether some participants are more critical to the integrity of the process than others. First I should say that in discussing nonparticipation, I mean to exclude the case of citizens who wish to participate but are prevented by exogenous factors, as this is primarily a problem of insufficient autonomy. In a society of autonomous individuals, those who do not participate are those either absolutely or relatively disinclined to do so. These voluntary nonparticipants may be classified into four groups: those unaffected by the issue at hand and uninterested in the outcome, those unaffected but interested, those affected but nevertheless uninterested, and those both affected and interested.

The nonparticipation of persons unaffected by and uninterested in an outcome is unquestionably least harmful to democratic decision making. For example, imagine a situation in which the banning of snowmobiling in a community park is to be considered democratically. Those community members who neither snowmobile nor care if anyone does would have the least stake in the outcome, and presumably would have little to offer in dialog, beyond factual information that would be obtainable through other means, given sufficient openness. Persons unaffected but interested are somewhat of a paradox,

in that the presence of interest implies an effect where none should, by definition, exist. The apparent paradox is resolved by restricting "affectedness" to direct, material effects. Into this group I would classify people considered part of the community but nevertheless living a good distance from the park in question, who object to or support snowmobiling from general convictions on how outdoor space is to be used. This group's perspectives would certainly be of note for the democratic process, and yet they might be regarded as being of secondary importance to those of any affected person. (This point raises the issue of the prioritization of conflicting interests, to be discussed below where I consider the democratic value of equality.) Persons affected, perhaps because they live near the park, but uninterested in outcome are also somewhat paradoxical, in that if they are affected they might reasonably be expected to care about the outcome. Such persons may simply be indifferent to issues of noise or air pollution, finding them to be negligible problems, and negating any presumed effect. Finally, those both affected and interested might include the snowmobilers themselves, plus some of those living near the park.

To different degrees, all parties above, save the group that is unaffected and uninterested, have a stake in the outcome of a decision. (Even the most disinterested could be said to have diffuse, nonmaterial interests in the outcome simply as citizens of the larger society. For example, such persons may still wish that participation among those interested be as high as possible, on the general principle that policy should reflect popular preference among the interested.) It seems members of the three affected or interested groups should all wish to be present for a community decision on the topic of park snowmobiling, but particularly those both affected by and interested in the decision.

The presence of persons from this last group would seem most important for the democratic process to fulfill its aim of having decisions reflect community preferences, as this group's preferences would likely be especially strong and relevant to consideration. Why would people in this last group, of all four, voluntarily absent themselves from the decision making process? One might expect absenteeism from those less affected, but voluntary nonparticipation from those with most to lose or gain is an especially troubling sign in any ostensible democracy. It would likely reflect alienation from the decision making process, and raise questions of the acceptance of the process and the level of trust in its ability to produce results consonant with community desires. While I have attempted to show that any nonparticipation adversely affects the quality of a democratic process, nonparticipation by those most vested in the outcome is corrosive both in its withdrawal of highly germane content from the dialog, and in its implicit expression of distrust for the decision making process. This is a vicious circle, in that the former diminishes the democratic character of the decision making process, while the latter criticizes the process for not being democratic.

If participation is a key value of democracy, how can it be encouraged and maintained at a high level? Coercion, as discussed previously with regard to cession of autonomy, is an explicit violation of autonomy, and moreover would be unlikely to remedy any of the underlying causes of disaffection mentioned above. Distrust of the process could scarcely be ameliorated by forcing participation! In keeping with the value of autonomy, voluntary nonparticipation should be, at least initially, accepted as a legitimate action and a critique of the democratic process. Nonparticipation expresses a

tactical choice by community members to fulfill their needs by *exit*, rather than *voice*, to use the concise terminology of Bowles and Gintis.¹² It is of course desirable in democracy for the citizenry to primarily rely on voice, or participation, rather than exit. In a situation where a sizable fraction of the affected and interested population abstains from participation, efforts should be made to understand the reasons for abstention, that they might be remedied and the community reformed. Ideally, vigorous implementation of the value of dialog should permit everyone's views to be included (an aspect touching on the value of equality, to be discussed below) and should provide for viable and expeditious resolution to conflicts, including conflicts of disaffection and apathy.

There are two arguments explicitly against general participation in democracy I would like to briefly consider. The first, described but not endorsed by Peter Bachrach, is an elitist model that affirms the role of elites in protecting the democratic state from the greater community.¹³ This argument views the people at large as a threat to, rather than the embodiment of, democracy. Using the definition of democracy I have advanced, this argument cannot be taken seriously, but there is an undercurrent to it that needs direct refutation. By promoting elite social actors as social protectors, there is an implication that government requires a kind of expertise that is not commonly held by the citizenry, and that results in better governance by some standard. It is undoubtedly valid that with increased experience in democratic process, one becomes more skilled at its use. But the fact is, such skills as framing issues, running meetings, and organizing votes may be acquired over a reasonably short time and do not require any specific technical expertise. More importantly, it is a profound error to contend that expert rule automatically confers

better government than mass rule by democracy. The essence of democracy is the making of decisions by those affected, and those affected by a decision have an immediate, nontechnical expertise concerning their needs and values that no expert can share, particularly when one considers the needs and values of an entire population! John Dewey, who wrote eloquently on this point, said it best when he affirmed, "The man who wears the shoe knows best that it pinches and where it pinches, even if the expert shoemaker is the best judge of how the trouble is to be remedied."¹⁴ Expert rule is a poor substitute for democracy because expertise, on close examination, has very little to do with the aggregate knowledge of the population of its own interests. It is practically tautologic to say so, but the best representation of this aggregate knowledge is the stated social preference of the community, rendered through democratic process. The question of the proper sphere for expertise is especially apropos for the patient-physician relationship, and will be discussed at length in the next chapter.

A second, and more substantive, argument against general participation was advanced by Bernard Berelson and others.¹⁵ This argument claims that a democratic process would seize under the clash of diverse perspectives, were every citizen to participate actively. Correspondingly, phenomena that result in voluntary nonparticipation, such as apathy, would in fact be integral to the continued function of democracy. It is certainly plausible that democratic decision making might operate more expeditiously, more easily, with a smaller group than with a larger one, but this is a practical consideration, not one of principle. Theoretically, by improving and adapting the mechanics of decision making, perhaps through technological means, it should be

possible to accommodate the participation of arbitrarily large groups. Indeed, the well established variation of representative democracy operates precisely along these lines (although raising important questions of accountability and fidelity of representation). Further, for reasons made clear above, it is difficult to defend passivity and absenteeism as advancing the integrity of democratic process, since both favor exit over voice and deprive the community of real interests and knowledge that ought to be accommodated.

To summarize, the greater the participation, the more faithfully decisions reached through a process fulfill democracy's aim of decision making by those affected by decisions. Participation cannot legitimately be coerced, but it is sufficiently important that it ought to be encouraged at every turn. Conceivably, to the extent that absenteeism undermines democracy, and the extent that democracy is a foundation of community, participation might be made a criterion of community membership. This approach has some aspects of coercion, but if entered into freely might be acceptable under the value of autonomy. Public spiritedness, or the disposition to participate, is a facilitating value for participation, as is trust for dialog. It is perhaps public spiritedness, rather than participation itself, that ought to be cultivated.

Ultimately, the best incentive for participation is the positive personal benefits of empowerment. Peter Bachrach said, "[human] dignity, and indeed [human] growth and development...is dependent upon an opportunity to participate actively in decisions that significantly affect [one]".¹⁶ In the context of health care, this conception of participation will be important in what follows.

Equality

Equality, the fifth and last value of democracy I will introduce, often seems consigned to status as an impossible and therefore irrelevant ideal. The admittedly important concept of equity, or fairness, often appears as a kind of surrogate. While I would associate equity with democracy, it would be more as an effect and less as a precondition. If a shared decision making process strongly instantiates the values of autonomy, openness, dialog, participation, and equality, equity will result. On the other hand, claims that equity exists are always suspect in nondemocratic contexts, because the standards of fairness, enforced by decision makers, will not necessarily reflect those of the people living under them.

Equality as a value of democracy is not identity of any trait intrinsic to community members. That is, there are no characteristics attributable purely to individuals, as opposed to *individuals with respect to the decision making process*, which will be invariant across the population. For example, the population may vary according to ethnicity, wealth, or education without violating the value of democratic equality. Equality instead demands an *identity of opportunity* to take part in the decision making process and therefore to have one's interests considered by the community.

The implementation of the equal opportunity to participate may be approached both negatively and positively. From the negative side, it may be formally established by deliberately nonexclusive policies. The community may, for example, prohibit the arbitrary exclusion of any particular community member or class of community members from any stage of the decision making process. This approach is straightforward and

protects against fairly transparent, procedural discrimination, but does not address more subtle, functional discrimination arising from underlying differences of access to resources. Protection against these requires a positive approach, guaranteeing not any material equality between members of the community, but rather a minimal standard of material well being deemed necessary for effective participation. The positive approach is a general application of Amy Gutmann's criterion of nondiscrimination,¹⁷ which she defined specifically with respect to educational resources. The positive criteria for equality of opportunity to participate are another means by which democracy constrains the social structure through enforcing material prerequisites, as was noted previously concerning the prerequisites for the value of autonomy. Indeed, the value of autonomy supplies much of the material underpinning of equality, with the latter potentially adding an additional, specific requirement that all citizens be sufficiently educated in political matters to be competent and comfortable participating. Ironically, it is because of autonomy that democratic equality is best framed as equality of *opportunity* to participate, rather than equality of *actual participation*, since autonomous individuals may voluntarily restrict their own level of participation in accord with their interests.

It seems almost paradoxical that the value of equality, as applied to opportunity to participate in the decision making process, should be guarded formally through *de jure* measures aimed at abolishing discrimination in principle, but substantially only through social policies that ameliorate, but do not eliminate, persistent inequality, which is to say discrimination in practice. In the context of autonomy, openness, and dialog, equality of opportunity to participate should guard against undue dominance of the decision making

process by any single group, but it virtually goes without saying that inequalities in resource access may still manifest as differential competence in using the process effectively. It is worth considering what additional constraints may be imposed, either in principle or practice, to mitigate any such effects of persistent material inequality. In *Spheres of Justice*, Michael Walzer advances a model that is the most eloquent statement I have encountered of how democracy must approach inequality.¹⁸ Liberalism is conceived as a set of spheres of influence, such as the economic, cultural, and political spheres. Between the spheres lie conceptual barriers that prevent the automatic conversion of expertise or power in one sphere into corresponding advantage in another. Like the policies against inequality I have described, Walzer's theory does not intend to abolish inequality, even in individual spheres, but rather attempts to prevent it from running amok. How Walzer's walls may be erected in practice is unclear to me, but I believe the construct a necessary one to make equality of opportunity to participate *effectively* a reality. I will return to Walzer's spheres later, in the consideration of the legitimate place of physician expertise in the medical deliberations of the clinical encounter.

There is another important sense in which the value of equality is key to democracy, and one with important bearing on the issue of conflict resolution when divergent interests appear during the deliberation stage of decision making. This is in the sense of *equality of regard*, or the equal consideration by the community of equal interests of its members. In attempting to reach decisions, the community ought to take any one interest of one member as equal in weight to a closely similar interest of any

other member. The interest of one citizen to construct (or not construct) a public radio transmission antenna on her property would, for example, receive equal consideration with the identical interest of another citizen. Conversely, if one citizen sought construction of such an antenna for pecuniary advantage, while her neighbor had reasonable cause to fear the possibility of the antenna's collapse onto her own home, the interest of the second person might justly be regarded as greater and be given correspondingly greater weight in deliberation.

This conception of equality was elaborated by the utilitarian philosopher Peter Singer,¹⁹ and its chief danger in the democratic setting is that of utilitarianism in general: that the majority will become a tyranny, imposing its aims on the minority. The classic example of these excesses is any situation in which multiple citizens could each derive benefit equal to the harm another citizen would experience from the same act. Presumably, by virtue of their greater numbers, the interests of the group would outweigh those of the individual. The values of autonomy and participation, however, establish a principled brake on the potential excesses of utilitarianism. A utilitarian decision that decreased the autonomy of a particular person or group would be questionable on theoretic grounds and would also likely affect that group's participation in decision making. This in turn would run counter to the value of equality of opportunity to participate. Subject to the constraints of the values of democracy, I believe equality of regard is an important principle in guarding the fairness of the democratic process. It also provides a rational basis for the resolution of conflicting interests, though I hasten to add that evaluating the relative importance of interests is no easy task.

The major benefits of the value of equality for democracy are similar to those of autonomy and participation. All three values tend to produce the greatest diversity of perspective in the decision making process. Aside from increasing the legitimacy of same, diversity leads to what Iris Marion Young called practical wisdom. The inclusion of the widest possible range of values "maximizes the social knowledge expressed in discussion, and thus furthers practical wisdom...A public that makes use of all such social knowledge in its differentiated plurality is most likely to make just and wise decisions."²⁰ In addition, accountability is a derived property of any democracy that fully instantiates the five values I have defined. With broad participation in decision making, change will occur as the citizens collectively deem it necessary. Justice is another derived property.

In concluding the discussion of equality, I would revisit the question of how persistent inequality in fact can coexist with any ideal notion of equality. Equality as I have defined it is limited to particular social phenomena only, and thus any paradox results more from verbal sleight of hand than anything else. In particular, equality of opportunity to participate and equality of regard can, in principle, coexist with many gross social inequalities. In so limiting the value of equality, I have attempted to focus on those social phenomena for which democracy absolutely demands equality. Without question, greater equality, particularly in the material sense, is a boon for inclusive decision making. But I suspect complete equality is a dream. The best that can be hoped for is the mitigation of persistent inequality by the leveling effect of carefully chosen contexts in which equality must be enforced for democracy to exist. This is no small challenge, and has great affinity for an inspiring aspect of democratic culture described

by Raymond Williams: "to be *democratic*, to have *democratic* manners or feelings, is to be unconscious of class distinctions, or consciously to disregard or overcome them in everyday behavior: acting *as if* all people were equal, and deserved equal respect, whether this is really so or not. [emphasis in original]"²¹

The values of democracy: conclusion

The five values of autonomy, openness, dialog, participation, and equality are what converts an arbitrary shared decision making process into an authentically democratic process. Without the strong expression of these values in the practice of agenda creation, deliberation, decision, and action, a process of group decision will likely suffer from deficiencies that will detract from, or even abolish, its democratic character. While the five values must be expressed in the setting of decision making for democracy to exist, the social prominence of the values in isolation is a measure of the degree to which democracy is fostered in a given society, and can be thought of as a definition of *democratic culture*. The same analysis may be applied at the subsocial level, to particular institutions and practices, in an effort to determine the strength of democratic culture in these settings. In the following chapter, the setting of interest will be the institution of professionalism in the United States.

Chapter 2 - Democratic Theory of Client-Professional Relationships

Professionalism under democracy

As mentioned previously, democracy as defined is an infectious philosophy, in that it contains no restrictions of scope for its aim of participatory decision making. By extension, the values of that underpin democracy must be similarly general. As a result, while the character of any decision making process may be assessed against the values of democracy, the application of the values does not end with decision process, but extends to decision content as well. Any social policy or institution, whether created by democratic decision making or not, can be assessed for its affinity for or conflict with the values of democracy. To use Amy Gutmann's inspired phrase, democracy implies a *conscious social reproduction* of itself in all aspects of society.¹

Given the simplicity of the theory, any actual pattern of social behavior will likely contain both points of alignment and opposition with each of the proposed democratic values of autonomy, openness, dialog, participation, and equality. To the degree that an institution instantiates and promotes these values in society, it may be said to support and foster democracy, while the contrary conclusion may be made to the extent that an institution abrogates expressions of and generally undermines these values. By balancing the interplay of support for or opposition to the values of democracy, one may perform a kind of "democracy audit" on an institution of interest. In addition, by carefully regarding conflictual aspects between an institution and the values of democracy, specific recommendations may be advanced with the aim of democratizing the institution. This

chapter will be analyze the institution of professionalism in terms of the values of democracy.

Meaning of professionalism

Professionalism is a modern institution that amplifies the role of the entrepreneur by placing it in the context of collegial authority and adding a fiduciary relationship with the client. In addition, all professions have a component of professional sovereignty, or organizational autonomy, that extends to matters within their sphere of expertise, and sometimes matters outside as well.

It is important to emphasize entrepreneurship as a fundamental component of professionalism, because otherwise any analysis becomes distorted through exclusive emphasis on the institution's other components. These components, however critical to the understanding of professionalism, are influenced by the purely economic aspects. The professional is a person of special skills, vetted by the authority of peers, and charged with a responsibility to faithfully serve clients, but she is also a person motivated, at least in part, by the sale of her labor power for financial gain. In the democratic, or in fact any, context, this fact should not be overlooked. The organizational autonomy enjoyed by professionals is justified in part by their deliberate self-definition as distinct from mere commercial agents,² but neglect of the key commercial motivation leads to neglect of key aspects of professional behavior that cannot otherwise be understood.

Having said that, it is certain that the commitment of the professional to service of a special character is a novel feature of client-professional relationships. The

professional's service transcends that of other economic agents. While other agents offer service directly responsive to and generally limited by the client's stated preferences, the professional's service is both interpretive and subject to different motivation. The professional claims authority, in Paul Starr's words, "to judge the experience and needs of clients".³ This authority, *because of the trust relationship enshrined in professional ethical codes*, is in contradistinction to that a salesperson might have in attempting to sell a particular product. The salesperson's authority also involves understanding and attempting to fulfill the needs of a customer, but in a rather limited sphere relating to a particular purchase, and frequently at a less technical level. The salesperson, however, acts in her own interest to make a sale, without any obligation to, or even interest in, thoroughly examining whether the customer's interests are truly served by the purchase under consideration. In contrast, the professional purports to guide the client through a rarefied zone of technical difficulty, at all times keeping the client's interests, *as interpreted by the professional*, in foremost consideration. Moreover, the nature of the professional's recommendations, whether in the field of law or medicine, tends to involve aspects of the client's life that are critically important, more so than those dealt with by the salesperson or other economic actors.⁴ Thus the fiduciary posture adopted by professionals is suited to both the peculiarly subtle judgments of need they offer, and to the intimate implications of these judgments.

The service orientation toward clients also has a more global aspect, that of the general provision of professional services. According to Edmund Pellegrino, profession ontologically involves *professing*, or declaring a willingness to serve those in need.⁵ This

declaration is in principle generalizable, and thus professionalism involves a kind of unbounded disposition to serve, in addition to the fiduciary orientation described above.

Another core feature of professionalism is expertise. The professional claims particular knowledge as much as she claims a willingness to serve those in need. The claim to knowledge is an extraordinarily far reaching one, because it does end at a passive state of simply *having knowledge*, but extends to *claiming authority* over all matters related to that body of knowledge. These claims are not individually, but collectively, mediated, so that the professional's expertise and authority proceeds from her membership in her professional community, which makes these claims on her behalf.⁶ Whether the claim of authority professionals make translates to actual authority accorded them by society at large is, as Paul Starr has said, a function of the legitimacy of this claim as perceived by society. In the 20th century, professionals, and especially physicians, in the US enjoyed increasing acceptance of this claim, a phenomenon Starr attributes to the *legitimate complexity* increasingly conceded to specialized technical matters. In the Jacksonian era, all everyday matters, including health and sickness, were judged within the competence of the average citizen, and professionals were frequently viewed as unnecessary and unduly usurping of individual capabilities. This changed toward the end of the 19th century, as important scientific discoveries made themselves felt in everyday life. Physicians have particularly benefited from medicine's affiliation, which is not to say identity, with science, whose stock as a means of interpreting reality has risen dramatically in the last 100 years.⁷ The legitimacy of professionals increased

with increasing public perception of the areas over which professionals claimed authority as complex beyond the ability of the average person to understand.

The final aspect of professionalism I highlight is that of sovereignty, or organizational autonomy. This form of autonomy is related to that defined earlier for individuals, as prerequisite to democratic decision making, but relates to the collective entity of a professional community. Moreover, in the case of professions, sovereignty implies having *express public sanction to independently exercise power that would otherwise require public support*. Sovereign professionals therefore not only fulfill such functions as regulating the practice of and entrance to their profession, they do so with public enforcement powers at their disposal.⁸ The ideologic basis for this special status is the profession's claim of special expertise in matters related to its professional functions. In effect, a profession collectively parlays the legitimacy of the technical knowledge of its members into a social claim, usually heeded, that it is the only entity capable of regulating its affairs and entitled to do so. This claim is a potentially transcendent one, in which matters not directly germane to the special expertise of a profession may nevertheless be brought under its control. For medicine under democracy, this transcendence of the sphere of technical authority is a dangerous one, as will be seen in what follows.

The implications of democratic theory for professionalism, particularly in the realm of sovereignty, are striking. While all professions to some extent enjoy sovereignty, the degree of sovereignty accorded particular professions varies, and may be regarded as an indicator of a profession's social power. As will be seen in the following

section, strong sovereignty brings manifold benefits to the profession which achieves it successfully. These benefits point to the underlying pragmatic, economic basis for professional sovereignty.

The benefits to professionals of sovereignty

In this section, I explore in greater detail the specific manifestations of sovereignty in professional conduct. While initial consideration will be given the political implications of sovereignty, for the most part I defer examination of professionalism's affinity for and conflicts with democracy to the following two sections.

In one sense, professional sovereignty amounts to a straightforward extension of individual autonomy at the organizational level. In the efforts of professions to set standards for their membership, determine conditions and scope of practice, and so forth, they are in essence acting as aggregates of autonomous individuals, implementing policies in accord with their interests. They may even do so via democratic processes. To the extent that these activities relate primarily to the professionals themselves, they do not significantly threaten democracy, and in fact may even strengthen it.

It is on another level, the level of the legitimate public interests, where the tensions between professional sovereignty and democracy become manifest. Democracy mandates that those affected by decisions be among the decision makers. The frontier at which professional sovereignty begins to affect citizens outside the professional community therefore marks the borderland beyond which broader community participation is necessary to comply with democratic principles. One way this frontier is crossed is with expansion of professional power and influence. For example, a

profession that is socially weak, divided, and with little prestige, as medicine was in the US during prior to the middle of the 19th century,⁹ is unlikely to have a social impact sufficient to permit its professional affairs to significantly impinge on community life. On the contrary, a unified and wealthy profession with a pervasive presence throughout community life, such as lawyers in the US enjoy at present, is quite likely to significantly affect the larger, nonprofessional community through its internal decisions. As a result, the surrounding community would have a strong claim on such a profession that its sovereignty be reduced, perhaps through the incorporation of the community into its decision making.

In contemporary US life, however, such questions are frequently moot because of one aspect of professional sovereignty, namely the support of public agencies for professional activities. The use of public means to serve professional ends, whether democratically arrived at or not, potentially undermines democracy. Without concomitant public participation and oversight, this use is especially troubling to nearly every democratic value previously discussed. To take one example, when quasi-public entities, such as state medical boards, meet in secret for disciplinary proceedings, there is an obvious lack of openness inherent in their operation. The boards' exclusive membership annuls the value of equality, both in its opportunity and interest formulations, since those excluded have zero ability to participate and correspondingly limited ability to have their interests heard. John Dewey once described sovereignty in an international context as "a complete denial of political responsibility".¹⁰ The quasi-governmental status of what are essentially professional bodies represents a carved out

space free from democratic control, in a sense a denial of political responsibility, and one especially troublesome if occurring with the cloak of public agency.

Professional sovereignty is thus democratically suspect, even on principle, when its impacts become significant for the community at large. (This consequentialist perspective also owes credit to the pragmatism of John Dewey.¹¹) I now turn to consideration of the actual effects of sovereignty. How do professions use their organizational autonomy? Though not intending to exclude the potential for consequent public benefit, the answer is substantially for the defense of professional interests. These interests include definition of professional expertise, restriction of the number of professionals, and acquisition and defense of exclusive powers.

Professional expertise is defined through regulation of the course of training through which anyone aspiring to professional membership must pass. The curriculum imposed by institutions of professional learning, customarily with substantial input from professional bodies not directly affiliated with these institutions, represents the body of knowledge deemed sufficient to enter the profession. Through accreditation by professional organizations, the professional corpus is thus enforced. The effect of a profession's ability to define its curriculum amounts to the definition of the profession's practice, potentially to the exclusion of competing definitions that might arise from other social actors. For example, in the case of medicine, the codification of medical training at the start of the 20th century was deliberately carried out to exclude programs not fitting the scientific, university-based model. This was to the detriment of the empiricist/generalist definition, whose practitioners at the time comprised the bulk of US

physicians. Because failure to be accredited by an authoritative professional body often meant the demise of any professional training program, an additional effect of curricular revision was the elimination of many medical schools that could not meet the new requirements.¹² This in turn reduced the number of physicians entering the field, decreasing the supply of professional services, and rendering the services already provided more valuable.

Regulation of the training curriculum restricts not only the definition of a profession, but who can enter a profession. During the aforementioned revision to the US medical curriculum, schools perished as the university model became dominant, closing educational avenues for some. The increasing rigor and duration of medical education also constrained prospective physicians to those classes which could afford the expense, both direct and in opportunity cost, of a longer training, and any prerequisite training.¹³ Curricular control thus imposed an effective class bias on prospective entrants.

The membership of a profession is further restricted by prohibitions on which trained practitioners may receive licenses to practice. State licensing boards that regulate practice to those who meet particular requirements effectively enforce a monopoly on behalf of the sovereign professions that control them.¹⁴ In the case of US medicine in the late 19th century, the genesis of licensing seems to have made common cause between allopaths and their adversaries, the homeopaths and Eclectics, more than it permitted the allopaths to suppress the latter. Nevertheless, licensing seems to have at least hastened the demise of the mentioned alternatives to allopathy through assimilation of their

distinctiveness into the mainstream, and licensing was ultimately used by allopaths against later alternative schools of healing, such as the homeopaths.¹⁵

The final professional benefit of sovereignty I will consider is that of exclusive powers. By exclusive powers I do not refer to restrictions on who may practice a profession, but rather restrictions on what the average citizen may legally do without the services of a professional. For example, historical regulations in the field of law restricted the ability to argue a case before a judge to those with acceptable legal training. In the medical field, the physicians' power of prescription places an effective restriction on public access to medicines. The result of such rules is to increase public dependence on professional services, simply by legal fiat, however arguable the justifications for such fiat might be. Dependence, as I will argue below, is potentially inimical to the democratic value of autonomy.

In the preceding section I have examined some effects of the sovereign character of professions. Not every profession achieves sovereignty to the extent described, but those that do achieve a social significance and institutional support that may impinge negatively on democracy. To the implications of professionalism for democracy I now turn.

Affinity of professionalism for democracy

Professionalism as an institution is complicated in its effects. This section aims to explore the ways in which professionalism fosters and supports particular values of democracy. The analysis is deliberately general. Though eventually I will turn attention to specific aspects of professionalism and how they might be made more democratic, here

I seek no more than a general sense of where professionalism and democracy converge. In what follows, I consider effects grouped by the democratic value for which they have greatest affinity. This grouping is artificial, however, since the various aspects of professionalism each interface with multiple values of democracy. Where appropriate, I therefore discuss multiple values of democracy together.

Autonomy as defined previously involves both the negative proposition of individuals being beholden to no one, and the positive proposition of having enough of one's basic needs met that one can function autonomously. Professionalism's affinity for autonomy is largely through the latter proposition. With professionalism comes a refinement of technical expertise, through development of improved training and advanced knowledge.¹⁶ This new knowledge is not available in less specialized contexts, and therefore professionalism may be said to generate a specialization that promotes autonomy, insofar as the new knowledge is applicable to basic needs and accessible to the community. The new knowledge will typically require professional consultation for its application, so even as autonomy is potentiated by greater flexibility, it is somewhat restrained by greater dependence on professionals, as will be discussed below. The professional function of certification of the quality of new services offered,¹⁷ cited by Max Weber, also somewhat augments autonomy, by providing the community with some basis for the judgment of a practitioner's expertise.

As an example of professionalism's augmentation of autonomy, consider the creation of a new instructional technique by teaching professionals. Prior to the technique's development, education was still possible, but less efficient. With the new

technique, invented through much research and discussion within the professional community of teachers, more people have access to education using the same resources as before. The ability of the average person to obtain education needed increases, fulfilling one basic need for more community members than was previously possible. Because the teaching profession certifies its members as proficient in the new technique, the general community has a some standard for determining whether a teacher is competent to use the new technique. Otherwise, a person inexpert in the field of education might be forced to use their best judgment to determine the competence of a particular instructor, a difficult prospect at best. Professionalism thus benefits democracy by increasing autonomy, in this case by producing and guaranteeing the quality of a new service that meets the basic need of education at a higher level than under the *status quo ante*.

The development of new knowledge through professionalism augments democracy in other ways. To the extent that new knowledge encourages development of novel methods of dissemination, such as printing and computer network technologies, professional innovations in engineering may indirectly result in improved accessibility of information in general, thereby enhancing openness. A culture supporting free exchange of information, the very center of openness, may also be enhanced by the general advancement of knowledge fomented by professionalism. New expertise also provides an additional information input to the process of dialog. This may be useful in cases where particular expertise is applicable, as it broadens the informational content of dialog, potentially increasing the social wisdom of dialog.

The benefits to the quality of dialog from professionalism go beyond the injection of new expert content, however. In a client-professional relationship, the professional's services frequently, though not always, take the form of consultation and advice. There are of course many ways in which consultation and advice may be provided, from the interactive and sensitive to the client's positions, to the unilateral and domineering. To the extent that a style of professional services favoring the former manner becomes conventional, professionalism may enhance the quality of dialog by providing an example forum, with which many members of society have experience, that models respectful, reciprocal interaction. In this way the manner in which dialog is conducted during the decision making process may be improved.

The service orientation of professionalism has, to some extent, commonality with the democratic value of participation. The disposition to participate was previously equated with the facilitating value of public spiritedness. This value implicitly recognizes a motivation toward involvement in community affairs that, while partially stemming from self-interest, in the general case also incorporates an appreciation for community interests and needs. The inclination to serve through participation is parallel to the commitment of the professional to provide aid to those in need. Depending on the visibility of professionalism in a society, and the degree to which professionals publicly discharge their duties, the effect of the mandate to serve in professional codes may become an example that reinforces ideals of service in the culture at large. Similarly, the disposition of professionals to allow significant client participation in their services may also influence community attitudes and expectations toward participation.

Finally, professionalism may potentiate the democratic value of equality, in both the sense of equality of opportunity to participate and equality of consideration. The diffuse availability of professional services may generally increase the autonomy of the members of the community, and in particular cases the political skills for group decision making as well. Both tend to increase equality of opportunity to participate. Equality of consideration may be enhanced by professionalism in various ways. First, in analogy with the argument concerning service and participation, the example of professionals' offering their services to persons based substantially on need may influence the cultural disposition toward equal consideration of persons. If a physician is seen to treat all people in severe pain identically, regardless of their socioeconomic status or other attributes, members of the community may be influenced in their attitude toward each other's needs. Any increased sensitivity to the needs of others can only redound to the advantage of equality of opportunity, as the population becomes more sensitized to subtle discriminations that exist in the modes of participation. Second, in particular cases, professionals may directly enhance the ability of individuals to have their interests considered by the community. This enhancement may offset any prior deficit in equality of consideration. I think particularly here of the legal profession, which specifically advocates in public fora for the interests of its clients, thereby increasing the consideration of the clients' interests.

This section's analysis has aimed at identifying what in democracy is enhanced by professionalism. I have shown that professionalism holds some affinity for each of the values of democracy, notably for autonomy and equality. The actual effects of

professionalism on democratic culture, however, will result from the antagonistic effects of its simultaneous affinity for and conflict with the values of democracy. It is to the conflicts that I now turn.

Conflicts of professionalism with democracy

On examining how professionalism conflicts with the values of democracy, two patterns emerge. First, there are outright conflicts, in which some aspect of professionalism runs counter to one or more democratic values. Second, there are what might be called mirror image conflicts, wherein some aspect of professionalism that has some affinity for democratic values simultaneously undermines them in another guise. This is almost paradoxical, with professionalism enhancing democracy on the one hand, perhaps through providing services that would otherwise not exist, but at the same time undermining it, possibly by limiting services in ways not necessarily intrinsic to professionalism. In either case, the question arises of whether these conflicts may be ameliorated while leaving professionalism essentially intact, or whether a fundamental change in professionalism is necessary for enhancing democracy.

I should say at the outset that where a conflict exists between a particular aspect of professionalism, such as confidentiality, and a value of democracy, such as openness, it is not a foregone conclusion that the aspect in question is an unmitigated ill. As intimated in Chapter 1, societies have other values that compete with those of democracy. It is not necessarily desirable in all circumstances to have the values of democracy trump all others. To say that some aspect of professionalism conflicts with democracy implies

this and nothing more. There may still be good reasons to maintain the aspect in question, even ones related to democracy by way of a different value.

I begin again with autonomy, a key value for both democracy and for standard formulations of bioethics.¹⁸ In the previous section I noted that professions may enhance autonomy through improving citizens' ability to fulfill basic needs prerequisite to autonomous functioning. At the same time, professions may constrain autonomy by increasing dependence on professionals for their services. This may appear paradoxical, but in fact there is a substantive difference between fulfilling one's basic needs through recourse to one's own resources of knowledge, judgment, and skill, and accomplishing the same feat through recourse to another's. In the former case, a general sense of self-sufficiency and competence results. In the latter case, the same needs are fulfilled, but in a manner that may leave one unsure of one's abilities and dependent on the professional for the fulfillment of the involved needs in the future. The former is far more potentiating of the value of autonomy.

In the medical context, Starr elaborates clearly the ways in which dependence may be deliberately fostered by professional actions carried out through sovereignty.¹⁹ In the 20th century, the medical profession repeatedly enhanced its power through specific measures aimed at increasing the dependence of its clients. Innovations such as the power of prescription, reduction in the supply of professionals, and exclusive reimbursement arrangements with health insurers all contributed to this dependence. The prohibition of access to certain medications without a physician's prescription is an example of direct enforcement of dependence, as outlined above with respect to

professional services in general. Reductions in the supply of professionals, described with regard to physicians by Martin Shapiro,²⁰ increases dependence on individual members of the profession through simple economics. Finally, insurance agreements that forbid reimbursement for services rendered by nonapproved professionals tie the use of a valued commodity, health insurance, to a particular profession.

A related problem involving professionalism and autonomy is that of mystification. Professionals frequently use a vocabulary that is unfamiliar to their clients. The professional understanding of a phenomenon may be difficult to convey to one outside the professional community. This reality has been accepted in the US in the 20th century as reflecting the legitimate complexity of the professional corpus, but in the 19th there was great confidence that common sense was a sufficient tool for the understanding of seemingly complicated matters.²¹ At times, it is certain that the professional vocabulary and understanding are necessary to such goods as the precision of intraprofessional communication. But at the same time professionalism risks needlessly obfuscating what could be rendered more simply, and potentially with greater understanding and control by the client, enhancing her autonomy.

A final restriction on autonomy imposed by professionalism relates, again, to the nature of professional services. A chief quality of a profession's pronouncements is authority, or as Starr defines it, the probability that an interpretation will be accepted as true.²² This use of authority, Starr contends, amounts to an abdication of private judgment on the part of the citizen, in the face of the expertise credited to the professional. It may well be that a professional's expertise makes her statements on a

subject within her competence more likely to be true than those of someone outside the profession. This is, after all, the nature of expertise. The difficulty for autonomy lies less with the objective truth or falsehood of a professional's judgment, and more with the tendency of the person hearing it to believe uncritically. Independent minds accustomed to critical reflection are the basis for the collective social wisdom of democracy. To the extent that professional authority encourages overly ready acceptance of professional judgment, the critical faculties of the citizen may atrophy, at least in interactions with professionals. This withering of the disposition to question is akin to a general loss of any sense of self-confidence through consultation with experts. Decreased self-confidence may lead to decreased autonomy.

The democratic value of openness also has sizable conflict with professionalism. As suggested above, the technical language used by professionals may at times unnecessarily obscure the substance of their discussion and judgment. Obscurantism, deliberate or otherwise, hinders openness for obvious reasons. Moreover, the professional uses information as a commodity, producing an economic incentive to its restricted distribution and even concealment. For example, in the medical case it is common for physicians to provide information orally to patients, with little written supplementation, and to maintain control of all or most written material, such as the medical record. It might be argued that general medical information is accessible, at least theoretically, to anyone with the inclination to seek out the appropriate books and journals. This I would concede, but it is noteworthy that a central function of professional expertise is the application of general knowledge to the particular case of the

client. Thus any purported accessibility of general information may miss the critical particulars. And specifically with regard to particulars, the professional doctrine of confidentiality places severe restrictions on their distribution.²³ Confidentiality is framed as being in the patient's interests, and in many cases it is, but its existence also creates impediments to the patient's access to her own information, particularly through her agents, such as in person signature requirements. It is noteworthy, also, that confidentiality is rather more rigorously applied in keeping particular medical information from community members outside the medical profession, than it is in such contexts as medical consultation, medical education, and medical insurance, all these being cases where the medical profession has a financial interest in some degree of dissemination.

In the last section, I observed that professionalism may enhance the instantiation of the democratic value of dialog by various routes, including providing inputs of expert information and permitting the practice of dialog via the consultative model by which professional services are typically shared with clients. Professionalism, however, also presents risks to dialog. Chief among these is a problem of excess authority I would call the cult of expertise. When the authority of a professional is so highly regarded, and individual judgment so willingly suspended, that the weight of a professional's contribution to dialog outweighs that of nonprofessionals, the integrity of dialog suffers. The risk is that nonprofessional voices are heard less than they merit, with professionals' heard correspondingly more.

A reason the cult of expertise may occur, quite apart from the normal authority accorded professionals, is a common confusion concerning professional expertise, and one to which professionals seldom call attention. This confusion is the tendency to attribute authority to professionals on matters that are only peripherally, if at all, related to their technical expertise. For example, imagine the case of a physician discussing various treatment options for leukemia with a patient. The physician reviews the technical aspects of treatment, including such factors as pain, likelihood of cure, and treatment mortality. She then says to the patient, "Of all the treatments, I would choose the one with the highest probability of cure." This statement may well be taken by the patient as an authoritative recommendation *for the patient to choose the indicated treatment*, but of course it is nothing of the sort. The physician has explicitly injected her own value judgments into the presentation of a technical question, whose ultimate resolution depends on the technical considerations *in the context of the patient's values*. She has overstepped the bounds of her authority, which extends only to professional expertise on technical matters, but potentially in a way that may well be unnoticed by the patient. The apparent recommendation may well end the patient-physician dialog with the patient resignedly accepting the physician's "technical" judgment. It is this sort of mistake, intentional or not, that leads patients to make decisions that are poor for the lack of serious consideration of the patient's values. Even if the physician made due regard for the values of the patient, if the patient were sufficiently intimidated by professional authority they might be disinclined to express their own assessment of their needs. The

physician could thus emerge with an unwitting misrepresentation of the patient's needs, in spite of having tried to obtain an accurate one.

The value of participation may be undermined by professionalism's expansive domain of influence. As more problems are moved from the social realm, where all members of the community may address them, into the technical realm of professionals, there is an abrogation of the ability of the community to participate in dealing with them.²⁴ This transfer of problems also has a subtractive, detrimental effect on dialogic content, and consequently on the effectiveness of dialog to ameliorate the reclassified social problems.

Finally, the democratic value of equality may also be threatened by professionalism. Successful professions become competing power centers in the community, ultimately competing against nonprofessional members of the community. With the enhanced prestige, and often income, that professionalism brings, the professional begins to enjoy greater opportunity to participate than nonprofessionals. Further, either because of greater training in advocacy (as is certainly common in the legal profession!), or because of greater respect accorded her, the professional may have her interests considered more carefully than equivalent interests of a nonprofessional. Both these examples might be regarded as violations of Michael Walzer's spheres of justice, in that prowess in the economic or technical sphere is effectively being converted into prowess in the political sphere. In short, professionalism itself can directly enhance inequality.

There is another route by which professionalism undermines equality, and this is uneven distribution of professional services. As argued previously, professional services may intrinsically enhance the ability to participate in the decision making process, for example by improving the health of the individual and hence autonomy. To the extent that these benefits of professionalism are differentially accessible among the community, they may aggravate or create differential opportunities to participate or differential consideration of needs. This is a profound undermining of equality, and is all too likely, given that professionals generally dispense services in exchange for compensation, and that wealth is seldom uniformly distributed, causing professional services to gravitate toward those sectors offering good compensation, which typically enjoy a relative excess of opportunity to begin with.

The objective in describing both professionalism's affinity for and conflict with democratic values has been to provide a general sense of how well professionalism sits with democracy. From the foregoing it seems that while professionalism supports democratic values in certain ways, it undermines them in others. From a reformist standpoint, the question for professionalism becomes how the institution might be altered for greater compatibility with democratic values, and in particular how conflicts between professionalism and democracy might be mitigated or abolished without damaging professionalism's significant affinity for democracy. In preparation for the detailed consideration of the patient-physician relationship in Chapters 3 and 4, I now describe one reconceptualization of the general client-professional relationship that strongly supports the values of democracy as I have defined them.

Democratic client-professional relationships

Prior to describing the meaning of democratic client-professional relationships, I feel I must justify the relevance of such an exercise. The question of why such relationships might be desirable is logically prior to an assessment of their character. Professionals serve a general function, described above, in any society. In a democratic society, why should their function be different?

I believe democracy should deeply influence the form of social institutions for two reasons. The first is simply my own prejudice, influenced by the liberal tradition, that democracy tends to produce a just social order. The second is its general character. Democracy as a philosophy, namely one governing the distribution of decision making power to those affected by decisions, is not intrinsically limited to any particular institution or level of social analysis. Democracy makes an injunction that wherever in society there are decisions, these decisions be made by those who will bear their consequences. My endorsement of democracy as an influence on social institutions is a normative statement on how decisions should be reached, independent of context.

This stand immediately raises the question of how democracy can ever exist, for surely in any society there will be multiple institutions, and among these will be some of greater or lesser democratic character. Rarely will decision making be truly shared among the affected throughout a society. For these reasons I do question whether democracy, or any other abstract principle, can ever exist in pure form in actuality. What can be said about a given society is the relative degree to which decisions are made democratically, and the extent to which institutions and practices generally support the

practice of democracy. *The degree to which democracy is instantiated* in a society is real and comparable. Using this metric, a judgment can be formed as to the democratic character of a society, and moreover recommendations can be made to increase it.

Because hereafter I will be considering democracy in an unusual context, namely that of the client-professional relationship between two people, it is important to precisely define the meaning of democracy in this context. *Dyadic democracy* refers to instantiation of democratic values in the relationship between two people, and particularly with respect to their decision making. Such dyads may actually exist for the sake of decision making, in which case there are clear parallels to decision making in larger groups, but this is not necessary. Most dyadic relationships involve decision making at certain times, and not at others. Based on the degree to which the values of autonomy, openness, dialog, participation, and equality are instantiated, in decision making and in general, any dyad, whether a client-professional relationship, a marriage, or the interaction between strangers, may be assessed for its democratic character.

A legitimate question is whether optimal social functioning results from such an extension of democracy.²⁵ Are there contexts, such as the military, the medical emergency room, or the courtroom, in which nondemocratic forms are superior to democratic forms?²⁶ The answer to this question depends on what constitutes optimal social functioning. If the quantity of participatory decision making is what is to be optimized, it seems almost tautologic that nondemocratic forms would be inferior to democratic ones, and that the proposed extension of democracy to the dyad would be of

benefit. If another basis for optimization were selected, it is possible that nondemocratic forms would be preferable.

One such basis for optimization would be unity of action. Unity of action is desirable under high risk, rapidly evolving situations. Mark Meany wrote that unity of action depends on unity of judgment, which may be realized through either unanimity or authority.²⁷ I recall a conversation with a former Sandinista soldier years ago, who said that on the battlefield, there was no time for a vote on whether to duck when enemy fire was encountered; people simply ducked.²⁸ In this situation unity of action follows from unanimity, but combat situations generally exemplify emergent scenarios where unity of action is imposed by the authority of the commander. While decisions made under extreme urgency admittedly do not lend themselves to democratic process, there are more and less democratic ways to generate decisive authority for such situations. Authority may be appointed by the military hierarchy, for example, or by the soldiers in the field. The latter is likely to be more democratic than the former, and has actually been employed in rare cases, such as in some Republican forces during the Spanish Civil War. While the emergent decision itself may be rendered nondemocratically, then, the process by which a person is empowered to make binding unilateral decisions under conditions of urgency need not be. By removing the application of democracy one step from the actual urgent decisions, the exigencies of an emergent scenario may be met with democratically suboptimal, but still strong, instantiation of democratic values.

The example of the courtroom is distinct and more difficult, in that here the social goal is not so much expediency as it is justice. In certain theories of jurisprudence, one

requirement for the imposition of justice is the insulation of judicial authorities from political influence. From the perspective of democracy, insulation of decision makers from democratic pressures may be dangerous and suboptimal. The decision to authorize someone to act at arm's length from democratic decision making, however, may again itself be rendered democratically, even if the decision itself is somewhat contrary to democratic values. The conflict is simply one of differing goods that may independently motivate action. Depending on how the decision is made as well as its content, such conflicts may be resolved in more or less democratic ways. All are likely suboptimal from the standpoint of pure democratic theory, but not necessarily so from perspectives valuing other social goods.

Before describing democratic client-professional relationships, I should raise one additional issue, and this is the issue of the professional as citizen. It would be inaccurate to portray the professional's role as a kind of foil for the democratic aspirations of the client. As a community member in her own right, the professional has democratic aspirations that are equally significant and not to be neglected. For example, the individual professional's autonomy (as opposed to collective professional sovereignty) ought to be fostered through the client-professional relationship, as well as her participation in dialog and so forth. There are two factors, however, that tend to modulate expression of the professional's own democratic values, and these are at the core of the meaning of professionalism.

First, the professional's expertise engenders a knowledge gap between her and the client. The gap in knowledge is associated with a gap in authority, that may transcend the

professional sphere of expertise (albeit questionably), and a related gap in prestige. From this perspective, the client enters the relationship with relatively diminished status by virtue of the definition of professionalism alone. Moreover, the client enters with an unfulfilled need for which she is consulting the professional, effectively diminishing her status further at the outset, by decreasing her autonomy. The client-professional relationship thus begins with a potential deficit in the client's ability to assert democratic values such as autonomy, participation, and equality. From the standpoint of democratic theory, then, the immediate problem in the client-professional relationship is how to augment the client's expression of the values of democracy, rather than the professional's.

Second, the professional has a fiduciary obligation toward the client that is not reciprocal, as it arises from the code by which the professional has agreed to be bound. This responsibility for the client's interests and well being, if generalized to the democratic context, may include the strengthening of the client's role in the dyad, so that the values of democracy are expressed more vigorously through the relationship. The trust relationship the professional enjoys with the client thus obligates the professional to enhance the client's democratic positioning, rather than her own. An interesting aspect of this is that it suggests entering into a general and asymmetric obligation with another may be in some sense antidemocratic, as it engenders a kind of democratic neglect of one side in favor of the other.

To reiterate, though the professional is a community member analogous to the client, the professional's democratic experience of the relationship is somewhat secondary in immediate importance for the overall democratization of the relationship. This is

because of initial deficits on the client side resulting from differential expertise, and also the professional's disposition to serve in the client's interests. This will confine much of the discussion that follows to consideration of how democratic deficits encountered by the client can be mitigated. It must be repeated, however, that the professional's own exercise of democratic values is not to be neglected entirely. With that, I begin the description of client-professional relationships from the perspective of the values of democracy.

Autonomy, as suggested above, is a constrained value for the client, for reasons both relating to the effects of professional sovereignty and the asymmetry of expertise. One effect of these is to increase client dependence on the professional, and therefore decrease client autonomy. I hasten to add that, as mentioned previously, there is a contrary effect of the client's recourse to specialized expertise, which simultaneously increases her autonomy. The goal in crafting a more democratic professionalism is thus to preserve the existing effects of professionalism that augment client autonomy, while removing or at least mitigating those effects that diminish autonomy.

Earlier I described certain effects of professional sovereignty that tend to increase the power of professionals with respect to clients. These included limitations on the number of professionals, controls on access to professional status, and exclusive powers, such as the physician's power of prescription. These effects are understandable from the perspective of professions as partisan institutions that exist partly for economic gain, and which therefore operate in part to guard their own interests, including economic interests. Some such effects may even be independently justifiable, such as exclusive powers

aimed at safeguarding the interests of clients, as the physician's power of prescription might be. From the standpoint of client autonomy, however, these effects are deleterious, and to this extent they are antidemocratic. What could be done to mitigate these?

With regard to professions' policies and activities aimed at regulating the supply and licensing of professionals, I believe potentiation of client autonomy requires a certain blunt disinterest in overselling a particular professional's, and a particular profession's, virtues. In a situation where access to professionals is constrained by numbers, and in which other practitioners of the same or alternative professions exist, the professional ought to be candid in her suggestions of client recourse to the other practitioners. This will doubtless seem overly demanding of the professional, in effect requiring that they endorse their competitors! The issue is not so much endorsement as it is divulgence of information that could be relevant to the client's interests. From the perspective of potentiating client autonomy, this candor is necessary. Professionals in democratic society are in the position of benefiting from deliberate actions made by the organized body of their professions. Some of these actions might be justified on the basis of a profession's not simply attempting to impede competing professions' access to clients, but attempting to enforce standards of practice believed to be well founded, while eradicating those that are poorly supported by theory or potentially harmful. Others, such as regulating the total number of members of a profession, for example by controlling access to professional education, are of a more purely self-interested character. In either case, autonomy is at least partly circumscribed through professional actions: the client has both fewer alternatives to the profession in question and fewer practitioners of that

profession as potential consultants. For this reason, professionals ought to counteract the antidemocratic actions that reinforced their professional dominance by being aware of available alternative practitioners and, in the context of the client-professional relationship, by discussing them with their clients.

Exclusive professional powers are a far greater infringement on client autonomy than efforts to regulate the number of professionals. While the effects of licensing and professional education policies may limit a client's access to alternative practitioners, the client still, at her option, may seek out other professional consultants, albeit with greater difficulty. Exclusive powers leave the client no choice in the matter: if the client wishes to obtain the service in question, she is strictly required to turn to a professional. Exclusive powers thus impose a monopolistic condition, with the constraints on autonomy that monopoly produces. This is a condition of strong dependence of the client on the professional.

Redressing client autonomy lost through exclusive powers is challenging. In the context of the client-professional relationship, it is difficult for the professional to in any sense transfer an exclusive power even temporarily to the client. For one thing, the client would still be beholden to the professional for the indulgence, making any gain in autonomy negligible. For another, there are typically professional sanctions for any such transfer of power. Professional and often legal restrictions complicate the professional's surrendering exclusive authority, even if she were inclined to do so.

Exclusive powers are exceedingly difficult to defend from the standpoint of democracy. Aside from fundamentally constraining autonomy, they threaten values of

participation and equality as well. Even if the delegation of exclusive authority to a profession for some particular task is rendered democratically, it is still problematic for the foregoing reasons. Constraints of this magnitude may be justified if imposed democratically and in accord with a compelling community interest; if rendered primarily for the benefit of a profession, they are unduly restrictive. If this analysis is correct, professionals ought to act politically in opposition to their being granted exclusive powers. This would be contrary to their economic interests as professionals, but in the absence of compelling community interests justifying exclusive powers, it would be a more democratic course than complacency with those powers.

Beyond the constraints on client autonomy imposed by professional design, there is a fundamental one stemming from the nature of the client-professional relationship itself. This constraint is the product of the gap in expertise between client and professional, the essential reason for the client's recourse to the professional in the first place. As such, it cannot be abolished without abolishing one of the bases of the relationship, and so must be palliated instead. Two hopes for its palliation lie in appreciating the limited scope of professional expertise and disseminating that expertise to clients, with the goal of empowering them to fulfill their own needs.

Expertise is a paramount source of professional prestige. In a culture where technical capability is valued as a method of control over complexity, those who wield that capability are correspondingly valued. The valuation may extend beyond the immediate sphere of expertise to more general attributes of competence, and even to worthiness as a person. By extension, those who lack the capability are denigrated to the

extent that they lack knowledge to assert control over the conditions of their lives, a key aspect of autonomy and implicitly of democracy. This denigration may not even originate primarily in others, but in the person's own psyche. The sense of inferiority and lack of control may be aggravated by the client's confronting the professional's expertise in the course of their relationship. The arbitrary attribution of qualities independent of expertise to a person based solely on her technical knowledge I have called the cult of expertise. If a professional is to reinforce the democratic value of autonomy in the course of her work, she must counteract the effects of this cult, which subsume the potentially disempowering aspects of her own expertise.

One method of counteraction is the acknowledgment of limits on specialized knowledge. These appear in at least three forms: epistemologic, personal, and applicational. The epistemologic limitation is that all knowledge is fundamentally incomplete and imperfect, even on its own terms. This applies as much to the entire corpus of a profession as to any other body of knowledge. Even in professions with a theoretically finite corpus of underlying information, such as the law, there is derived metainformation that is theoretically infinite and hence not masterable. In the field of law, an example of such metainformation is the body of legal commentary, which is never complete in the sense of having fully assimilated and accounted for the myriad possible arguments based on underlying statutory and case law. Within any field there will always be questions that are unanswerable in any definitive form, particularly those regarding complex metainformation, such as the choice of an optimal legal strategy. Even those questions that are theoretically answerable may not be answerable with

absolute certainty. It was once speculated that perhaps the fundamental insight of the expert is the appreciation of knowledge as inherently probabilistic and therefore uncertain.²⁹ These epistemologic issues are thus intrinsic limits on expertise, whatever its nature.

Apart from epistemologic limits, there are personal limits related to the individual professional's inability to perfectly master the corpus of even her own profession. Modern professions are the repositories of a voluminous, evolving history of practice, and only a portion may be assimilated and applied by any one individual. The professional, as regards technical expertise within the bounds of her profession, is thus always an imperfect representative of said profession. This is essentially a human failing, uncorrectable by any alteration of the corpus.

Finally, what I have called applicational limits on expertise arise from the fact that specialized knowledge is, by definition, knowledge limited in applicability to a particular, and usually small, sphere. This is true even in the hypothetical case of an area of the professional's field where perfect certainty existed, both for the individual professional and the profession as a whole. In a highly interdependent industrialized society, the technical province of decision making is itself heterogeneous. The lawyer, for example, may have command over the legal arena, but she routinely requires an array of experts skilled in other fields as part of her everyday life: teachers to school her children, physicians to facilitate her health, and even experts outside the traditional understanding of professionalism, such as mechanics, to repair devices important to her expectations of normal life. The old saw that the specialist knows progressively more about

progressively less, until she knows everything about nothing, is of course an exaggeration, but there is truth to the adage inasmuch as the expertise of one field is limited in scope to that field, and it is impossible to be expert in every field ordinarily encountered in modern life.

There is a deeper, and more personal, aspect to the applicational limits of expertise, and this relates to decision making outside the technical sphere, or more precisely, outside *any* technical sphere. There are many informational components to a good decision, and the technical is merely one of these. Others include cultural norms, community decisions, and perhaps most importantly in private matters, the values and expectations of the client herself. The presumptive extension of a professional's technical expertise into the realm of personal value judgments is a conceit on the part of professionals and an error on the part of clients. One reason this may result is the overvaluation of the technical in US culture, an aspect of what I earlier called the cult of expertise. In any case, there is no reason to presume the professional to have expertise outside her own field, and especially in so extraordinarily value-laden a sphere as that of individual, personal judgments. In fact, in the area of the client's personal judgment, the client's expertise far outweighs the professional's! The fact that this personal expertise is usually not considered as such is, perhaps, a reflection of a deliberate definition of what constitutes expertise, so that knowledge outside a professional corpus is inherently inexpert.³⁰

In the client-professional encounter, there is thus a need for the professional to be forthright in unambiguously circumscribing the bounds of her professional expertise.

Regarding the profession's knowledge, there is a need for any individual practitioner to inform the client about the limits of understanding, and the corresponding limits of certainty. Regarding the professional's knowledge, there is a need for the practitioner to freely admit to points of uncertainty that may, however, be resolvable on further consultation of the professional corpus, or through consultation with another practitioner. Finally, and most importantly, the professional must regularly affirm the paramount importance of the client's personal inspection of information provided, through the lens of the client's own perspective and values, and assume the role of consultant rather than decider. These disclosures, aside from being true and reinforcing the democratic value of openness, encourage a reasonable appraisal of the capabilities of the professional. Because unrealistic expectations of expertise amount to false beliefs, their correction potentiates the client's autonomy. Moreover, placing the professional's expertise in perspective aids in demystifying professional knowledge and affirming the client as an autonomous actor in her own life.

So far I have argued for a strengthening of the client's autonomy through the professional's explicitly arguing against the cult of expertise. Another path to the same destination is for the professional to train the client, where possible and reasonable, to fulfill the client's needs independently of the professional. Education is in many ways a secondary effect of professional services, in that the client approaches the professional as a person in need, seeking expert consultation. There is education as an unintended consequence of professional consultation, however, and education as a deliberate effort on the part of professionals. To offset the reduction in client autonomy that occurs with

dependence on the professional, the practitioner might reasonably teach the client the basic knowledge needed to perform tasks the professional might otherwise perform on their behalf. This effort on the part of the professional to, in essence, obviate their role in certain contexts is unambiguously contrary to their economic interest in maintaining client dependence on, and demand for, their services. It is congruent, however, to the democratic social interest in facilitating the autonomy of individuals, and might under democracy be regarded as consistent with the professional's fiduciary pledge to serve the client's interests. At a minimum, the professional might enhance client autonomy by teaching how to distinguish situations demanding professional consultation from those that do not. This at the very least offers the client a role in her own life as judge of her dependence on the professional, and would act against professional economic interests to a lesser extent than the more radical proposal above.

It should not be overlooked that modern professionalism may also unduly constrain the professional's autonomy, as well as the client's. I refer here not to the existence of a professional code, which is a consensual restriction on autonomy accepted on accession to professional status, but external constraints that may restrict the professional's ability to act independently in the interests of clients. For example, the professional who is an employee of a corporate entity is placed in a conflictual position, with allegiance owed both the client and the employer. In making a fiduciary pledge to clients, professionals in effect commit to redirect a portion of their personal autonomy on behalf of their clients. If the professional's autonomy is already partially surrendered to an third party, the effectiveness of the fiduciary pledge to clients is compromised. For

this reason, it is important that the professional not only act to potentiate the autonomy of the client, but also guard carefully her own autonomy as an element in the integrity of her profession. I shall have more to say on this matter when I discuss problems of democracy in the patient-physician relationship in Chapter 3.

Instantiating the democratic value of openness also places restrictions on the character of the client-professional relationship under democracy. Some of the preceding arguments in favor of amplifying autonomy also would instantiate openness. It goes without saying that the professional, based on her professional responsibility to the client alone, ought to disclose to the client any technical information she believes necessary to the resolution of the latter's needs. I have defined openness as a democratic value related to the availability of any information relevant to decision, however, and this suggests a broader requirement of disclosure. The client is the ultimate arbiter of what information is needed, as her autonomous, global definition of her need, including not merely technical but other factors, is paramount. The professional's role is primarily that of counselor regarding which *technical* information is relevant. The client's interests and values thus shape the boundaries of professional disclosure required by democracy. As mentioned in Chapter 1, the value of openness requires a disposition to disclosure and away from secrecy, and this amounts to an injunction on the professional to readily disclose conflicts of interest, cultural barriers, and any values that might have a bearing on the relationship with the client. Such disclosure is critical even when the client does not explicitly request it, as it may well have a bearing on the light in which the client considers professional recommendations. What are the limits to such disclosures, when

the client does not request the corresponding information? A "reasonable person" standard would suffice: information the client requests as relevant should be disclosed, as well as any information the client does not request that a hypothetical reasonable person would probably consider relevant.

The value of openness has a corollary effect on professional disclosure, in that mere availability of information is insufficient if the information is not also understandable by the client. Not only what information is disclosed, but what makes information useful, is of importance.³¹ The language and manner of disclosure must be sensitive to the client's abilities to understand, which may be assessed either based on preferences directly stated by the client or via the professional's efforts to confirm the client's understanding of information already conveyed. This mandatory sensitivity may justify delays in disclosure until such time as the client is, for example, mentally capable of understanding, but any delay is on its face a possible violation of openness and hence should only occur subject to the assessments proposed above, and not exclusively on the beliefs of the professional.

The accessibility of professional expertise is itself a function of its cost relative to the means of potential clients. To the extent that professional expertise is relevant information for community decisions, from a democratic perspective such expertise must be within the financial reach of community members as a collective. Moreover, to the extent that professional expertise has a bearing on the equal opportunity of citizens in general to participate in community decisions, it could be argued that democracy requires it to be within the financial reach of *all* community members individually.

Instantiating openness is not only a matter for the professional, though I believe her role is primary. The client must also practice disclosure of information both technically relevant to the relationship and personally relevant *to the professional*. Both of these happen under guidance of the professional, but the first is subject to professional judgments and is necessary to the rendering of professional services, while the latter is necessary for potentiation of the professional's own autonomy. Even as questions of conflict of interest are relevant to the client, the same is true of client aims for the professional. The professional is a member of the community as well as the client, and has legitimate claims for autonomy in dealing with clients, albeit claims potentially attenuated by the professional duty to serve faithfully.

To take an example from the legal field, in the last several decades the social conception of the lawyer's professional duty to clients has changed. Originally considered to require nothing more than efforts within the law to fulfill any *legal* aim of the client, the lawyer's duties are now modulated by the need to consider the *moral* aims of the client as well, even if these aims are entirely legal.³² Though this conception amounts to a social redefinition of the professional's role, it requires the autonomous judgment of the lawyer as a member of society, based on information that, in some conceptions of the relationship, would be outside the bounds of professional inquiry. I raise this point prominently because I believe it is a model for the operation of the professional's personal values as well. Where professional duty does not enjoin service, the autonomous professional may refuse a client. This may be for various reasons, but moral judgments based on the client's aims may be among them.

It is impossible to leave the implications of openness for the client-professional relationship without discussing its implications for confidentiality. Confidentiality is an aspect of the professional's trust relationship with the client. Its justifications are many, and include liberal ideals of privacy and freedom from unjust discrimination. Confidentiality, with its commitment to keep secret, seems diametrically opposed to a disposition to disclose. In a strongly democratic society, with robust instantiation of the five democratic values I have described, the importance of confidentiality might well be less than it is in actual US society. This is because under strong democracy the ability of community members to counteract the possibly harmful consequences of nonconfidentiality would be amplified. The fact remains, however, that in the imperfectly democratic society of the US, there are sound reasons to defend confidentiality as a protection of the individual.

What, then, for confidentiality under democracy? I believe it would be conditional but still substantial. The continued substance of confidentiality would result from openness as I have defined it being limited to information *material to a given decision*. This explicit restraint prevents the value of openness from becoming a universal injunction to disclose everything, abolishing the line between public and private. The conditionality of confidentiality would arise in those situations where, for the community at large or even for another individual, information deemed confidential became relevant for decision, and potentially subject to disclosure. However, even here disclosure would not be a foregone conclusion. The decision whether to disclose or not would, under democracy, necessarily involve those affected, certainly including the

person whose information was solicited, the professional who was its custodian, and the person soliciting the information. There would thus be involvement of affected individuals, subject to the constraint of the other values of democracy, including equality, in the guise of equal consideration of equal interests. Openness and democracy, as I have characterized them, therefore do not abrogate, but certainly redefine, the professional ideal of confidentiality into one in which the potential for disclosure is created, but disclosure is still not guaranteed.

As a last note to openness, it is worthwhile to reflect on the meaning of the professional as the custodian of the client's information. In some ways, the information of the client is guarded by the professional on behalf of the client. It is privileged by the professional value of confidentiality, and will typically be stored in a format useful to the client in obtaining professional services. From the standpoint of professional economic interests, however, the client's information is a commodity that ties the client to the professional. For both openness and autonomy, then, it is critical that the client enjoy free access to information the professional has compiled in the course of their association. Otherwise the existing knowledge gap between client and professional is aggravated by the professional's amassing information relevant to the client to which the client is not privy. This has the effect of increasing client dependence on the professional, which undermines autonomy.

The democratic values of dialog and participation are best considered together with respect to their implications for general client-professional relations. In my application of democratic theory to the dyad, it is with participation that the analysis

appears perhaps most degenerate, since without both parties' involvement there is no relationship! Participation is therefore a somewhat obviously relevant value, and to the extent that it is molded toward an ideal of active involvement and not merely presence, it becomes a value overlapping with dialog.

For the client, possibly facing a professional history that discourages extensive client involvement, it is important to assert a desire to participate fully in the relationship and all attendant decision making processes. Because of such traditions and their potentially antidemocratic effects on client expectations, however, the burden for encouraging client participation rests with the professional. As discussed previously, participation is not compulsive under democracy, but it is sufficiently important that any inclination not to participate should be discussed, in the hope of understanding and perhaps alleviating it, if it is based on false premises, for example. The professional's democratic responsibility for client participation includes creating space in the encounter for the client to speak freely and exercise her autonomous choice. This extends to a willingness to become actively engaged in understanding the client as citizen, in an effort to understand the full context of the her need, and to assist in shaping the relationship in accord with that need. The values of participation and dialog, perhaps more than any other, demand the professional assume a chameleon-like identity, respectful of the professional's personal autonomy, but also compliant with the needs, expectations, and goals the client autonomously brings to the encounter.

Dialog serves as a vehicle to facilitate the understanding necessary for the professional to fulfill this role. There is a great need for open and fully bidirectional

communication between client and professional, so that the professional's understanding may be developed and corrected in conversation with the client. I advanced reciprocal communication as a key aspect of dialog, and thus the bidirectionality of communication should not end at the professional's soliciting information and the client's providing it. It must extend to the converse as well, particularly in cases where the client brings questions about any aspect of the relationship, or where the professional has concerns over her ability, either technically or ethically, to fully serve the client. As I have said previously, the professional's own autonomous choice, outside the constraints of professional and democratic duty, is an important consideration, and must be expressed through the client-professional dialog, particularly once the professional has confirmed her understanding of the client's needs with the client and can begin to intelligently respond to them. The reciprocal aspect of dialog should also be employed in reaching any individual decision made in the course of the encounter, because while general considerations may affect the relationship as a whole, additional, particular ones will influence individual exchanges of more limited subject. Through dialog, both professional and client exchange views at multiple levels of the encounter.

The other use of dialog, to achieve harmony and synthesis between contrasting or opposing views, is also critically important in the democratic client-professional relationship, especially as a mechanism to resolve disagreement. It is inevitable that in the clash of different values, or client expectations and professional recommendations, or even client demands and professional capabilities, to name just three possibilities, there will arise disharmony in the relationship. The value of dialog enjoins that the people

involves commit to, at minimum, an understanding of each other, and more comprehensively, a rapprochement. Such an accord, if achieved, will resolve the conflict not strictly in accord with the individual desires of either client or professional, but in a manner that, considering the constellation of needs and values in the dyad, both parties are able to support. Even if accord is not reached, the client and professional will at least part with an understanding of each other's perspective, an important basis of any decision to continue or terminate the relationship.

The democratic value of equality is the last to be considered for its impact on the client-professional relationship. I defined this value as having two aspects: equal opportunity to participate in decisions, and equal consideration of interests in those decisions. The participatory aspect carries an implication for the global conduct of professionals in democratic society. Professionals, as noted previously, frequently enjoy high social status, to say nothing of economic compensation. Because of the social spectrum of these variables and their likely correlation with the opportunity to participate in decision making processes, professionals as a whole may enjoy greater such opportunity than many or most of their clients. This disparity is another potentially corrosive effect of professionalism on democracy, though it likely has more to do with wealth and its uneven distribution than with professionalism itself. What it suggests is that, in order to support the democratic value of equality, professionals ought to act at the social level to redress the disparity. One route to accomplish this would be to reduce the power associated with professional sovereignty, in particular the existence of exclusive powers, which I have argued are inherently at odds with democratic values. It is

undoubtedly a difficult prospect to entreat professionals to undermine the power of their profession, secured through effective use of professional sovereignty. There are, of course, other routes, including efforts to free democratic participation of its association with wealth and other indicators of social status. Whatever the course, the value of equality commands efforts to redress imbalances in the opportunity to participate at a social level between clients and professionals.

The equality of opportunity to participate also relates directly to participation in the client-professional relationship. How both client and professional participate is intimately related to the definition of their roles, which in turn is determined by the definition of the relationship as a whole. William May has described three potential bases for the client-professional relationship³³: code, contract, and covenant. Under code, the profession unilaterally and without consultation with other social actors enjoins its members to adhere to a body of general rules and standards. Typically, these standards also make general injunctions on clients who enter into relationships with professionals. Clients have little choice but to accept these standards, which define the relationship. In contrast, contract is a far more mutual model. Under contract, the specific responsibilities of both client and professional are enumerated and disclosed, according to agreement between the two. The provisions of contract are highly precise and limited in scope, and a difficulty of contract from the professional standpoint is the lack of more general expression of fiduciary obligation, supported as it is by the self-interest of both parties. Finally, covenant is in some respects a hybrid form. Like code, covenant is relatively general in character. Like contract, it arises from mutual agreement between

client and professional, but on the broad, rather than specific, parameters of the relationship. Unlike either, however, covenant contains an element of dedication unconstrained by time or place. Covenant also involves an acknowledgment of indebtedness by one party, the client, to the other, the professional, meriting general standards of conduct in return. Covenant is a robust, mutual pledge between client and professional, though like code and contract, its provisions may be asymmetric.

I take pains to describe May's distinct conceptions because while I believe all may be bases for the client-professional relationship, they are not all equal with respect to the democratic value of equality. In particular, it is clear that code is the most unequal basis, essentially excluding the client from participation in the definition of her relationship with the professional. Contract is the most equal, being explicitly consented to and defined by the two parties in consultation. It also has the greatest affinity for the democratic value of openness, in that its provisions are highly specific. Covenant is mutual in that its terms are mutually recognized, but is somewhat troubling from the standpoint of equality in that the inequality between the parties is implicitly accepted and *advanced as the basis for indebtedness of one to the other*. It is surprising that May endorses covenant, given that he correctly acknowledges that professionals (in his case, physicians) owe a great deal to the community for their training and opportunity to practice, even as their clients owe them for their service. This makes the asymmetry of covenant questionable, at the very least.

These arguments suggest contract to be the basis for the client-professional relationship most congruent to the democratic value of equality. Contract does suffer an

inherent lack of flexibility because of its specificity, which may be problematic in certain contexts, such as cases where action by the professional is indicated in the absence of both provision in contract and client availability or ability to participate. It additionally sits poorly with the trust relationship between client and patient. Covenant would perhaps better express the fiduciary nature of the relationship, but its emphasis on asymmetric indebtedness and responsibility rankles egalitarian sentiments. From the democratic and professional perspectives, it may be that the optimal basis for the client-professional relationship is itself a hybrid, with the full mutuality of contract, and the generality and fiduciary aspects of covenant.

Finally, the discussion of equality should be concluded with a mention of the equal consideration of equal interests. I advanced this utilitarian principle as a means for resolving disputes in the democratic polity. It may serve this function in client-professional disputes as well. As stated in the material on client-professional dialog, disputes will occur. If both parties are committed to dialog and an honest assessment of the conflicting interests, it is likely that any dispute can be resolved in a manner acceptable to each. This should indeed be the model throughout society, for when it fails there is risk of community fracturing and failure of the entire democratic process.

I conclude this chapter by affirming that professionalism is by no means incompatible with democracy. In many respects, professionalism strengthens democratic values, while in others it undermines them. The goal for the democratic reform of professionalism is to reform the institution so that those respects in which it is antagonistic to democracy are abolished or at least mitigated. This final section has been

an examination at the level of principle as to how that might be accomplished. In the next and subsequent chapters, I apply the principles developed here, respectively, to understanding the problems of democracy in the patient-physician relationship and how these may be alleviated.

Chapter 3 - Problems of Democracy in the Patient-Physician Relationship

Introduction

In the first chapter, I advanced a basic definition of democracy as shared decision making among those affected by a decision, along with five core democratic values necessary to fully instantiate democracy. In the second chapter, I explored the idea of democratic professionalism, and particularly of the democratic client-professional relationship, in terms of the mentioned values of democracy. In this chapter, the focus becomes the democratic problems of the patient-physician relationship, as a particular form of the client-professional relationship. As before, when I refer to democratic problems in this relationship, I intend those aspects of conventional practice which compromise the standard of shared decision making or its underpinning values of autonomy, openness, dialog, participation, and equality.

Democracy is particularly vulnerable in the patient-physician relationship because of intrinsic features of the patient role. The word "patient" is derived from the Latin verb "to suffer".¹ A patient is thus a client of a peculiar sort. The person who becomes a patient has needs, as does any client, but needs of a potentially profound and existential kind relating to her state of illness. Edmund Pellegrino has beautifully described the effects of illness on the patient's being, saying that it:

...opens up all the old anxieties and imposes new ones--often including the real threat of death or drastic alterations in life-style. This ontological assault is aggravated by the loss of most of the freedoms we identify as peculiarly human. The patient is no longer free to make rational choices among

alternatives. He lacks the knowledge and the skills necessary to cure himself or gain relief of pain and suffering. In many instances, the patient is not even free to reject medicine, as in severe trauma or other overwhelming acute emergencies. Voluntarily or not, the patient is forced to place himself under the power of another person, the health professional, who has the knowledge and the skills which can heal--but also harm.²

In Pellegrino's description, illness is a fundamental threat to personhood. The client who is also a patient is in an exceptional state of dependence on the health professional, mediated by the depth of their need and the compromising effects physical need has on their usual capabilities. The tendency of illness to produce disability and dependence may be aggravated because it is nearly always unanticipated and frequently unplanned. This represents a problem of democracy because the state of dependence, fear, and imbalance that characterizes illness is inimical to the exercise of autonomy or the other values of democracy. Because of the nature of the patient as a client threatened by illness, the patient-physician relationship is at the outset beset by a condition intrinsic to its nature that threatens to compromise its democratic character.

The role of the physician as a professional of unusual sort also imposes initial obstacles to the exercise of democracy in the patient-physician relationship. Like other professionals, the physician offers expert services to her clients. Unlike other professionals, the physician's services involve a level of personal and, at times, physical intimacy likely, if anything, to impede effective expression of the values of democracy in the relationship. Moreover, these services are offered in the context of illness. And as described above, this context is one substantially unfavorable to the patient's autonomy and participation in the encounter.

There is another aspect to the physician's role that may further compromise participatory decision making. This is the physician's professional authority. Like all professionals, the physician pledges expertise. Unlike other professionals, however, the physician's expertise relates to personally threatening phenomena with two critical properties. First, they are frequently incompletely understood by the client, shrouded in arcane language and mystery. Second, they occasionally result in severe disability or death. Because of the fact of illness and its existential portents, the physician's expertise implies an authority qualitatively different from that of other professionals'. William May has described this authority as greater and yet more unstable than that of any other professional's: greater in its implicit command of death, yet more unstable in its ultimately unavoidable failure.³ To the living patient, however, the instability is less evident than the greatness. In addition to the ordinary gap of expertise that separates client and professional, the physician and patient are separated by an almost mythologic aura of power over death. As might be expected, this mythology does nothing to enhance egalitarian, collaborative decision making, particularly in the setting of a patient's illness.

From the standpoint of democratic theory, then, the patient-physician relationship is handicapped to a level perhaps greater than that of any other client-professional relationship, by the existential threat of illness, the intimacy of the physician's services, and the quasi-magical authority with which the certainty of mortality imbues the physician. The suggestions made in the previous chapter for constructing a more democratic client-professional relationship will be relevant, but they are unlikely to suffice. The peculiar nature of the patient-physician relationship calls for stronger

defense of democracy. What commonly transpires, however, is an interaction that not only fails to redress the imbalances described above, but in fact reinforces them. In the words of Roy Menninger:

The fact is that medicine, as many of us practice it, encourages a patient's dependency. It does not encourage a more desirable goal, namely the establishment of a kind of parity in the relationship that promotes a greater responsibility by the patient for his own treatment...Physicians generally do not give enough attention to the need for enabling, encouraging, promoting patients to establish a greater sense of individual control, a sense of mastery, through a kind of therapeutic alliance rather than a therapeutic autocracy that is psychologically and economically gratifying to the physician.⁴

For democracy to flourish in the patient-physician relationship, the physician, especially, must actively seek to redress the problems of democracy in that relationship. These problems are the subject of this chapter.

The hijacking of autonomy

Patient autonomy has been enshrined as a central value, and perhaps *the* central value, in biomedical ethics. It receives substantial treatment in standard texts on this subject, such as Beauchamp and Childress's *Principles of Biomedical Ethics*.⁵ The supposed preeminence of autonomy, to the point of requiring the physician accede to patient desires that appear mistaken, has been described by Atul Gawande as the "current medical orthodoxy".⁶ On cursory examination of the literature, it would appear that autonomy is well protected in the contemporary medical relationship, if not overly so.

Why, then, should I begin by discussing impediments to the effective expression of autonomy? Autonomy may be theoretically well supported in the patient-physician relationship, but I am skeptical that it is practiced clinically so well as it is preached

academically. In my own experiences as a hospital interpreter, I saw the patient's autonomy controlled and constrained by the physician in various ways that robbed it of its authentic, independent character. Sociologist Charles Bosk alluded to this vulnerability of autonomy when he referred to its "manipulation...by physicians as a sword to compel some decisions and as a shield to avoid responsibility for others".⁷ The authentic expression of patient autonomy depends to a high degree not only on protection from such manipulation, but on the encouragement of the physician, as the historically, technically, and materially dominant member of the patient-physician dyad. This encouragement is all too seldom offered. Patient autonomy also suffers from outright nullification by the physician's authority to prescribe, a power so exclusive it may be unprecedented in the history of professionalism in the United States. Finally, the problems of autonomy in the patient-physician relationship are not merely those of the patient's autonomy, but of the physician's as well. Physician autonomy has itself become constrained by the intrusion of external factors, such as health insurance corporations.

As argued previously, to the extent that dependence inhibits the exercise of autonomy, it is in conflict with democracy. Dependence, however, is strongly and involuntarily reinforced by the fact of illness and the historic dominance of the patient-physician relationship by the physician. Jay Katz coined an apt phrase to describe this dominance when he referred to the "feudal practices"⁸ of medicine. From the ancient Hippocratic codes that enjoin patient obedience to only slightly more nuanced modern concerns over compliance, the history of medicine is replete with images of the physician as feudal power, offering protection in the form of medical care to those patients who, in

return, offer a serf-like fealty to the physician's authority. Like a knight or noble from medieval times, the physician bears a title, "doctor", that sets her apart from the patient in training, authority, and prestige. From the standpoint of autonomy, let alone the other values of democracy I have described, this feudal relationship is incompatible with the patient's free choice. The patient operates under a prior constraint on her ability to exercise full autonomy, her illness. This state of constrained autonomy is itself a problem of democracy, but one intrinsic to the state of being a patient, and therefore one that cannot be eliminated. To skew the relationship further by setting the physician in authority over *the patient*, as opposed to over the technical matters relating to the patient's illness, only compounds the patient's compromised autonomy, and indeed runs the risk of exploiting it for the physician's own ends. Why a physician might wish to do this will be discussed when problems of participation are considered.

It is worth raising here a point of linguistic usage. I have already described the patient as a client of a special kind because of the peculiar physicality and intimacy of their need for professional services. Many physicians believe the patient to be a special form of client in another sense as well, in that the level of fiduciary responsibility the patient should evoke from the physician is greater than the level to be expected for any other professional. With the consumer rights movement in the United States, it became common in some circles to refer deliberately to patients as "clients", in an effort to reclaim verbally some of the autonomy a person loses in becoming a patient. Some physicians object to this usage, arguing it runs the risk of robbing the patient-physician relationship of its special character, in effect reducing it to the status of any client-

professional relationship, or even to that of an ordinary business transaction. The use of "client" to mean "patient" does, I believe, neglect certain relevant distinctions of dependence between the general class and the particular case. By the same token, however, this practice asserts an independence commonly enjoyed more by clients in general than by patients in particular, and in doing so it does at least verbally redress some of the constrained autonomy of the patient, lost in illness.

Whether the physician arrogates authority over patients or not, there are other ways in which the patient's autonomy may be compromised. A central one is the knowledge disparity between patient and physician in medical matters. This aspect of the relationship is also intrinsic, in that the physician's special expertise in disease and therapy is, after all, the reason for the patient's seeking her counsel. The immediate problem for patient autonomy is almost paradoxical, in that the expertise sought by the patient, which presumably potentiates autonomy by restoring health, simultaneously undermines it by creating a context, albeit a limited one, in which the patient cannot exercise autonomous judgment to evaluate the quality of the physician's advice. This situation amounts to a constraint on the patient's ability to effectively identify and articulate her own interests. Because democracy depends on equal consideration of interests through a process of dialog, the physician's expertise threatens democratic decision making by engendering a context in which the patient cannot effectively evaluate the truth or falsehood of certain matters related to herself. The knowledge disparity, necessary for the client-professional relationship, thus becomes, in a certain limited sphere, a power disparity, and a disparity of autonomy. This problem and the

need for its mitigation were noted by William May, who observed, "...the physician's knowledge so exceeds that of his patient that the patient's knowledgeability alone is not a satisfactory constraint on the physician's behavior."⁹

There is another way in which the disparity of expertise constrains patient autonomy. Martin Shapiro eloquently described this as follows:

...the people who provide health services are not regarded as fellow citizens whose labour power just happens to be invested in such activities, and who come to know, as a result, a little more about the function and dysfunction of the body than the patient does. Instead of being treated as consultants, there to help the patients arrive at the best decisions for themselves, doctors are accorded special powers and titles. In these circumstances, patients are likely to lose sight of their own capacities for healing themselves, and can easily overestimate the influence of therapists on the course of their diseases.¹⁰

The dependence engendered by the patient-physician relationship can erode the patient's confidence that her health is understandable and subject to her own authority. The knowledge of the physician is not regarded as merely different in amount, but different in kind. Moreover, it is construed not as a distillation of a particular theory of the body and its healing, and an imperfect one at that, but rather as an arcane mystery that endows its bearer with abilities unavailable to the patient. These abilities extend beyond the power to heal, to embrace the ability to understand and interpret biologic phenomena.

To some, the conception of medicine as mystery and the physician as sorceress is integral to medicine's efficacy. Even Jay Katz, for example, argues that in the prescientific era, before any rational basis of therapy existed, the patient's blind faith in the physician's powers was necessary.¹¹ Howard Brody invented the character of the Chief of Medicine, who asserts that for the vast majority of patients, magic is precisely

what they want from their physician.¹² Whether the healing power of medicine depends at all on faith in miracles, from the standpoint of democratic theory, shrouding medical knowledge in obscurity, or encouraging its perception as mystery, makes it more inaccessible to the patient. The gap in expertise tends to make this mystification easier. If not addressed and mitigated in the relationship, the knowledge gap between patient and physician may therefore alienate the patient from the experience of her own body, and from any sense of independent control over it. This increases the dependence of the patient on the physician, further eroding the patient's autonomy.

Illness and its consequent dependence, sometimes reinforced by physician conduct, is only one of the constraints on patient autonomy. Patient autonomy requires the ability to make judgments of the impact of medical information, provided by the physician, on the patient's *personal* life. The physician enjoys a significant edge in expertise concerning medical theory, and even on interpreting the patient's health in light of medical theory. In the distinct sphere of the patient's personal life, however, it is the patient who enjoys the greater expertise. This sphere consists of all that informs the patient's perception of their identity and needs, including immediate preferences, values, past experiences, and long term aims. Portions of these may be shared with the physician, even as the physician may share medical knowledge with the patient, but since any exchange of information will nearly always fall short of the full complement of the expert's knowledge, the patient has an effectively permanent excess of knowledge in this realm over that held by the physician.

Ironically, in spite of the personal expertise enjoyed by the patient, the physicians

frequently conflates her own expertise in medicine with an expertise in the patient's personal life. To borrow an idea from Michael Walzer's work *Spheres of Justice*, in a democratic interaction there should be no automatic conversion of authority in one sphere to authority in another. Rather, there ought to be recognized barriers that effectively limit authority to the particular sphere in which it has a basis in expertise. For the physician to presume authority in the patient's personal sphere is a violation of the integrity of the latter, one I call *invasion of the sphere of personal judgment*. This might not be so problematic for democracy were it always detected and rebuffed, but in fact this may rarely be the case. The physician enjoys special prestige in society, and in a dependent patient this prestige may breed too ready and uncritical an acceptance of physician judgments, an example of the mystification of medical knowledge mentioned above. Beauchamp and Childress observed that, "Although recommendations are informational, they are also normative". What the physician says, through her prestige and authority, may be taken as more than merely informational by the patient. It may suggest an absolute right course of action, as opposed to one among several options. This normative attribution by the patient is especially troubling outside the physician's limited area of expertise. When the patient accepts the physician's judgment on an issue personal to the patient as authoritative, the patient has, probably inadvertently, allowed the physician's authority in the medical sphere to invade the patient's personal sphere.

Physicians make incursions into the patient's sphere of personal judgment as a matter of course. It would already be questionable for the patient herself to ask questions that essentially compromise her autonomous judgment by inviting a sphere violation,

such as, "If you were me, what would you do?" This question truly has no answer that is demonstrably accurate, since its answering would require an impossible premise: identity between physician and patient. On epistemologic grounds alone, the physician can never know what it is to be the patient, and hence can never truthfully answer the question. Far more serious, however, is when the physician deliberately projects her medical expertise into the patient's personal decision making.

In the hospital, I once witnessed an emergency physician attempt to convince a patient that she ought to have an expensive imaging study performed before being discharged. The patient had been involved in an automobile accident and was suffering from mild abdominal pain. The emergency physician argued that the patient's abdominal pain could be caused by internal bleeding from the accident, and that if the patient went home without having her abdomen imaged, she could simply bleed to death with no outward sign. The patient was both reluctant to stay in the emergency room and concerned over her ability to pay for the proposed test. The patient's husband was present in the room, and the physician said to him, "If it were my wife, I would have her get the test done." The patient acceded to the physician's wishes, at her husband's urging.

Where the physician severely compromised the patient's autonomy was not only in the questionable appeal to her husband, rather than to the patient herself, but in the nature of that appeal. The physician, by referring to a false situation, "If it were my wife", made a statement that could not be demonstrated as true. While it may have been related to the physician's medical judgment, it also assumed an identity of the physician's values with those of the patient's husband, a questionable assumption at best. The

physician's advice may have been accepted by the patient because it was confused with authentically medical judgments, such as those relating to risks of internal bleeding, or perhaps the patient acquiesced with full knowledge of the personal and value-laden nature of the advice. In either case, however, the patient had no reason to believe the physician to be authoritative in this personal realm. By accepting his judgment, the patient effectively ceded her autonomous and expert judgment in the personal sphere. Such violations of the sphere of personal judgment recall arguments I made in Chapter 1 concerning tactics of persuasion that are unacceptable in democratic decision making. Because these violations tend to prey on patient anxieties (or those of the patient's family members, as in this case), they are dialogically illegitimate, besides being logically invalid.

Patient autonomy is also procedurally constrained by the frequently inadequate time allocated for consideration of new information or the statement of patient preferences. In the US, the doctrine of informed consent was ostensibly introduced to guard patient self-determination,¹³ which I would consider identical to patient autonomy. Though I consider informed consent an important institutionalized protection, and perhaps the only one, for patient autonomy, it has not lived up to the lofty standard of its proclamation. (Jodi Halpern once referred to informed consent as the "bureaucratic dregs of autonomy".¹⁴) One reason for this failure is that there is no standard for how long a patient may take to render their decision. Informed consent is supposedly obtained by having the patient sign a form that expresses such critical details as the nature of the procedure to which they are consenting and the risks involved. However, in practice the

conditions under which the form is offered and signed vary dramatically.

In my own experience, I have seen allegedly informed consents run the gamut from a gruff surgeon shoving the page at a patient and demanding a signature, to an anesthesiologist who explained at length the risks and benefits of a particular intervention, and concluded by encouraging the patient to take all the time they needed, including up to the next day! Obviously, the time a person has to assimilate and reflect on information is a critical variable in determining the quality of any preference they state. There is likely considerable variation in the time required among different people, and also a point of diminishing returns in terms of time spent. It seems very likely, however, that within an upper bound of time that substantially exceeds that customarily offered, less time correlates with poorer decisions. Robert Dahl once wrote that, "Each citizen ought to have adequate and equal opportunities for discovering and validating (within the time permitted by the need for a decision) the choice on the matter to be decided that would best serve the citizen's interests."¹⁵ In the patient-physician relationship, "the time permitted by the need for a decision" is typically set by the physician, and frequently set so that the patient's opportunities to determine their best choice are limited. Furthermore, the urgency implicit in medical settings is frequently overstated, and often exists for reasons of efficiency of health care workers and not medical reasons.

In the discussion to this point, I have argued that various aspects of the patient-physician relationship unduly constrain the patient's autonomy. Few such aspects, either those intrinsic to the relationship or those determined purely by physician caprice,

completely abnegate autonomy. One that does, however, is the physician's power of prescription. There may be no other examples in client-professional relations of a power so exclusively held, save the ability to practice a profession itself, secured through general prohibition of unlicensed practitioners. For example, in the field of law, there is a strong tradition of the right to represent oneself in legal proceedings. Again, this right does not extend to representing *others*, but it still essentially prevents anyone from being *forced* to consult a lawyer in order to initiate or respond to legal action. This is not the case with federally restricted medications in the US, which are only accessible subject to the prescription of a physician. Note that there is no general prohibition against using prescription medications or other treatments on oneself (save, perhaps, for suicidal purposes), but *access to* the medications is strictly controlled. In comparing the legal and medical situations, Sanford Kadish once said, "If a person is free to harm his life, liberty and property so far as legal proceedings are involved, why is he not free to harm himself by taking any medicine he chooses?"¹⁶

The physician power of prescription is on its face an abrogation of patient autonomy. To obtain access to certain medications, the patient has no option but to consult a physician and obtain a prescription. Consulting a physician implies certain actions, such as making an appointment, keeping the appointment, and paying the requisite professional fees. The dependence is even greater than this would suggest, however, since the patient has no guarantee that a visit to a physician will produce the desired prescription. The patient must convince the physician, one way or another, that she medically requires the medication of interest. This is perhaps least difficult if the

patient's claim is deemed medically legitimate by conventional standards, but even here there may exist differences of opinion that will lead one physician to accede to the request and one to refuse it. In any case, the patient is almost entirely subject to the physician's judgment, beliefs, or whims when it comes to securing prescription drugs.

The nullification of patient autonomy represented by the power of prescription is substantial, given the importance of medicinal therapy in modern medical practice, and the sheer number of agents subject to prescription control. In the United States, however, the power of prescription is federally sanctioned and enforced. Presuming the federal government to act democratically in accord with the will of the people, is prescription control a problem of democracy? That is to say, is the loss of autonomy for the individual patient in some way compensated for by the fact that the loss, at least in theory, is collectively sanctioned by the autonomous wishes of members of the society? I believe that in spite of government sanction, the power of prescription remains both a threat to autonomy and a problem of democracy. Earlier I made the distinction between a decision *democratically made* and one that is *democratic in effect*. Even allowing the imposition of prescription laws to have been democratically made, because of the effective enforcement of patient dependence on physicians and the corresponding loss of autonomy, this policy is of questionable democratic effect. To justify it in terms of autonomy would require an argument that in society as a whole, a net increase in autonomy occurs as a result. Moreover, it is uncertain whether the policy was in fact democratically made. First, it is questionable whether my own definition of democracy is compatible with representative democracy of the type that, optimally, exists in the United

States. Second, given the gigantic economic interests of physicians in maintaining control over prescriptions, it is plausible that any decision regarding prescription policy was tainted by a disproportionate physician influence, in violation of the value of equality of opportunity to participate.

Thus far my consideration has been limited to patient autonomy. In fact, physician autonomy is also integral to the patient-physician relationship, and is also constrained. The autonomy of the physician is important because of the physician's professing expertise and fiduciary responsibility to the patient. This pledge must be made autonomously to have integrity. If the physician makes her profession under coercion, it is unlikely she will be able to fulfill it by serving the best interests of the patient. More plausibly, if the physician makes her profession autonomously but later enters into external entanglements that constrain her autonomy, her ability to fulfill her profession may become compromised.

What external entanglements could compromise a physician's autonomy and thereby her profession? There are a variety of such entanglements in contemporary medical practice. Physicians are increasingly employees of corporations, such as health management organizations. These corporations place constraints on physicians aimed at controlling costs, and the public has begun to question the extent to which physician decision making is skewed toward the best interests of the corporation, as opposed to the patient.¹⁷ Physicians also may enter into relationships with pharmaceutical firms, agreeing to enroll patients in drug trials in exchange for compensation. In either case, the existence of commitments by the physician that are both external to the relationship with

the patient and affect this relationship may compromise physician autonomy, and thereby damage both the professional and democratic integrity of the relationship.

In this section, I have examined problems with autonomy in the patient-physician relationship. Autonomy is critical for authentic expression of preferences by the patient and the integrity of the physician's profession. I have argued that autonomy is impaired by patient dependence on the physician, both for reasons intrinsic to the state of being a patient and for reasons relating to contemporary practice, such as the power of prescription. Autonomy is also constrained by the patient's intimidation by physician expertise, and its potential effects of alienation from the patient's own body and suspension of autonomous judgment when the physician projects her expertise into the nonmedical sphere. External constraints, such as time limitations and outstanding obligations of the physician to entities other than the patient, may also impair autonomy, in the latter case, particularly the physician's. Autonomy must be protected against these malignant influences by nurturing, respect for boundaries of expertise, and a minimization of external entanglements. Ways to increase the autonomy of the patient-physician relationship will be discussed in Chapter 4. I now turn, however, to problems of democracy with respect to a different value, that of openness.

The triumph of secrecy over openness

Like all decisions, medical decisions require information as an input to the decision process. In some ways, all factors that enter into decision may be ultimately considered informational, in that they are all ultimately processed by human minds. When I consider information, however, I emphasize those facts relating to external

matters that are relevant to an individual's decisions regarding a particular question. These may include issues of resource availability, the interests of others, and even arguments regarding the desirability of particular courses of action. Lack of information introduces a risk of ineffective or inaccurate decision in any context. In the democratic context, access to information is especially important in fostering the authentic expression of preferences. A preference in a particular situation cannot be accurately formulated, let alone expressed, without the availability of information relevant to decision. This is why openness, or accessibility of information, is a fundamental value of democracy.

The question of what makes information relevant to a given decision is important, particularly in the medical context. It is certain that technical information derived from the physician's medical expertise is relevant, and this includes information regarding different medical interventions available, disease prognosis, and risks associated with taking action or not acting at all. There are many additional types of information, however, that may be materially relevant to a medical decision. From the perspective of the physician's contribution to decision making, patient values and preferences are relevant quantities that may influence, for example, which options or risks receive special emphasis. Perhaps more importantly, because of the patient's role as the ultimate arbiter of at least what will *not* be done to her body, is what the patient considers or would consider relevant. Therefore the ambit of information that should be disclosed in the patient-physician relationship, in support of the value of openness, is potentially wide and

transcendent of the usual bounds of medical discourse, depending on the concerns and interests of a particular physician and, especially, patient.

In practice, however, the patient-physician relationship is one in which substantial nondisclosure, if not outright secrecy, is the norm. Much terrain controlled by the physician goes substantially or entirely unexplored, terrain whose geography might be of considerable relevance to decision making. This territory includes such tracts as the medical dimensions of decision, costs of treatment, and the medical chart. In addition, for various reasons the patient may be reluctant to voice information she holds that could have a bearing on the interaction with the physician, information such as her past medical history or risk factors for particular diseases. Finally, there is a larger social context to the medical encounter, one that impinges on the roles of both patient and physician, and about which both have information. To the extent that open access to information is impeded by either party, the democratic character of the patient-physician relationship suffers.

The bounds of disclosure in the medical sphere alone have been slowly widening over the past half century, with the development of the legal doctrine of informed consent. However, I have already alluded to the gap, identified by Katz, between theory and practice, or even between judicial proclamation and actual remedy. Early 20th century legal opinions propounding informed consent trumpet patient self-determination in their preamble, but in their substance this rhetorical grandeur is replaced by considerably less stirring exhortations. The seminal *Pratt* and *Scholendorf* decisions, for example, admonish physicians for violating norms of good custody, not for violating

patient liberty. The offenses in these cases were particularly egregious ones in which physicians either failed to even mention surgical interventions they intended to perform, or else expressly contravened the patient's wishes.¹⁸ It is certain that far less severe but, one should hope, more common physician lapses also substantially constrain patient autonomy by omitting crucial information.

Informed consent's legal articulation was clarified at a less rhetorical and more practical level as the century continued. Katz quotes judicial opinion in the 1957 case *Salgo v. Leland Stanford Jr. University Board of Trustees*, saying, "A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."¹⁹ This doctrine introduced the idea, similar to that in my definition of the democratic value of openness, that the facts of import are those needed for intelligent decision making. The scope of disclosability was further specified, and its wide nature made explicit, in the 1972 case *Canterbury v. Spence*: "...the test for determining whether a particular peril must be divulged is its materiality to the patient's decision: all risks potentially affecting the decision must be unmasked."²⁰

In spite of the ambitious level of disclosure mandated in these important opinions, the actual practice of informed consent, even in a single hospital, suffers from a considerable spectrum of quality. In my limited experience, allegedly informed consents that were little more than formalities were the rule rather than the exception. Few were so egregious as a thrust paper and a demand for a signature, but at best a minority involved any substantial disclosure of medical information to the patient, and none

embraced the level of dialog necessary for an honest appraisal of what information the patient deemed relevant to decision. Typically, informed consent involved identifying the name of the procedure to be performed, the name of the person performing the procedure, and a virtually standardized list of possible adverse outcomes.

Perhaps problems such as these arise, in part, from a misguided attempt to standardize informed consent into a bureaucratic process that robs of it all but the "dregs", to use Jodi Halpern's word, resulting in a deprecatory attitude toward the practice by caregivers, and a corresponding lack of effort to make informed consent meaningful. In fact, however, the problems for openness which the failure of informed consent engenders are not limited only to problems of the quality or quantity of information provided. The very notion that a decision process can be standardized *as to content* is itself a problem of democracy, because of the imperative of access to information *relevant* to decision, and the dependence of relevance on the individual's judgment. Even a procedural standardization of informed consent will fail the test of respect for individual values and judgments, if it does not contain steps to solicit the patient perspective on what constitutes relevant information. Within the medical sphere, then, there is a variable level of disclosure that is typically inadequate in its own right to informed decision making. Moreover, efforts to repair this problem have erred in focusing more on content than process, resulting in a procrustean tendency to overlook patient notions of what constitutes disclosable information, and compromising openness.

Outside the limited but important sphere of the technically medical, there is a considerable range of issues that might well be judged to have "materiality to the patient's

decision", but which are not routinely disclosed. Among these are the costs of medical services. Professionals hold themselves apart from those occupations with purely commercial interests, and while this distinction has a real basis in service and expertise, it may become disingenuous if it fosters any sense that professionals lack pecuniary interests. Perhaps because of this self-differentiation, some professionals, and it would seem especially physicians, are reluctant to address costs, and patients, perhaps sensing this reluctance, are themselves reluctant to ask. (In contrast, it is routine in the legal profession to discuss fees among the first items in a client-lawyer encounter.²¹) The exclusion of medical costs from the ordinary discourse between patient and physician seems normal, I think, chiefly because it is customary. Juxtaposed with the practice of other entrepreneurs, it becomes astonishing.

Imagine yourself going to the grocery store and approaching the checkout lane with your purchases. There, you are told there is no need to pay up front. Instead, you are sent on your merry way, with the information that you will receive a bill in a short time. You proceed home, and over the next week or two you consume everything you picked up at the store. You wonder at the cost of what you took, and a few weeks later your curiosity is answered with a sizable bill, greatly in excess of your expectations. You are inclined to protest, but you recognize that bargaining would be difficult at this point, your having already made short work of your purchases. Had the cost of your purchases been known to you at the time of your visit to the grocery store, your purchasing decisions might well have been otherwise, but of course you lacked this salient information when it could have made a difference in your behavior.

The previous scenario is entirely analogous to that faced by patients every day in their dealings with physicians. In the case of patients with ample health insurance benefits, cost may not be of great interest. Considerations of cost may also not be of immediate concern to physicians, particularly today as more are employees of larger organizations; indeed, it is quite common for physicians to have at best a vague idea, if any at all, of the costs of the tests or procedures they recommend. Costs are, however, certainly germane to patients who lack medical insurance, and they are likely to become increasingly so to insured patients as well, in this era of erosion of traditionally generous health insurance benefits. Particularly for patients who are uninsured, the costs of their medical care may be the paramount information in their medical decisions. The exclusion of costs from medical discourse amounts to obscuring profoundly material information, and thereby severely compromises the value of openness and the patient's decision making.

Another aspect of the patient-physician relationship that compromises the democratic value of openness is the concealment of the medical profession's own knowledge and decision making processes. Earlier I discussed the professional disinclination to admit to limitations of knowledge, either those relating to the professional corpus as a whole, or those of the individual professional. Katz has described this behavior in the context of medicine as follows: "Modern medicine remains caught between science and intuition. This is not necessarily bad; indeed medicine may have to be ruled by both science and intuition for a long time to come. What is disturbing, though, is that physicians are so reluctant to acknowledge to themselves and

their patients which of their opinions and recommendations are based on science and which on intuition."²² It is questionable whether physicians are even aware, for a particular recommendation, how well grounded their claim is in clinical research versus the empirical traditions of the profession. Uncertainties are inherent to any medical matter, but particularly to those in which solid clinical research is either unavailable or equivocal. Because the patient may take the recommendations of the physician as fact, the failure to disclose uncertainties can deprive the patient of salient information.

The physician's decision making process is also potentially of interest to the patient for its nonmedical content. A physician's medical recommendations may be shaped by presumptions concerning important patient values and goals. If these presumptions are inaccurate and not openly disclosed by the physician, a patient may unwittingly accept a recommendation based, in actuality, on nothing other than physician prejudice, as if it were sound medical judgment, to be disregarded at the risk of life or health.

I once witnessed a glaring example of this in the hospital. A man in his 40s was brought to the emergency room. A gardener, he had suffered an accident at work, in which one of his fingers was severed by a wood chipper. A hand surgeon told the patient that two options were available. First, the severed finger could be reattached, but with uncertain success and a long period of rehabilitation to reacquire effective use of the finger. Second, the amputation could simply be completed surgically. The surgeon affirmed it was the patient's decision, and said he would be willing to reattach the finger, but repeated that the rehabilitation would be long and difficult. The patient, who had said

little, agreed to a surgical amputation. The surgeon later said in private that the patient's choice made the most sense, given the patient's work as a manual laborer and his corresponding need to maintain a "power grip", which was best fulfilled by amputation, and not by reattachment.

The surgeon in this story made a presumption, deriving the patient's presumed life goals from his present occupation. Did this presumption shape the information the surgeon shared with the patient? Although the surgeon offered two options and affirmed the decision to be the patient's, it seems the option of reattachment was implicitly deprecated by an emphasis on the difficult rehabilitation. By comparison, the fact that amputation would also have carried extensive, and guaranteed, implications for the patient's life was left unsaid. The danger in the physician's words was less in their possibly slanted content than in how the patient was likely to interpret them. To the patient, amputation might have appeared the better *medical* option, based on the physician's recommendation, while in fact any special prominence this choice may have had resulted from a hidden prejudice the physician held, perhaps without conscience awareness or malice, concerning the patient's goals.

Openness is the issue at hand because if the physician had voiced his assumption of the patient's preference for a medical intervention compatible with hard physical labor, the patient would have been aware of it, and could have either agreed or disagreed. As it was, the patient was deprived of this information that might have supplied critical context for the physician's potentially partisan words. Katz summarizes these issues perfectly when he writes, "...treatment decisions involve a combination of medical, emotional,

aesthetic, religious, philosophical, social, interpersonal, and personal value judgments. Just as patients bring different values to bear on their ultimate choice, so do physicians, although doctors' value judgments are often obscured by their homogenizing all values under the single rubric of medical judgment."²³ Openness requires that physicians honestly disclose the basis for their judgments, whether it be medical or otherwise. While the physician's medical judgment is likely to be far superior to the patient's, in other spheres the physician is likely to be considerably less expert than the patient.

Disclosable details of the medical decision making process go beyond the epistemologic limits of medical knowledge and the internal presumptions of the physician's mind. Physicians frequently make medical judgments not in isolation, but in consultation with various external resources, including medical literature and other physicians. In my experience, these consultations are often unstated, effectively obscuring or even concealing them from the patient. The physician will make some excuse to leave the exam room, consult *Harrison's Principles of Internal Medicine*, and return to dispense the knowledge only just gained as if it were all part of her own personal store. Alternatively, the physician will talk with other physicians concerning a difficult case, with the consensus of such a discussion then presented to the patient as the physician's independent conclusion, or perhaps as the outcome of a discussion with unspecified other physicians.

There is nothing unprofessional or wrong in these consultations. What is suspect is that they are not disclosed openly to the patient, let alone carried out in the patient's presence. To obscure their nature is to feed cultural expectations of physician

omniscience, which disempower the patient as well as provoking an unrealistic appraisal of physician skills, in both the particular and general cases. Failure to disclose consultations may also understate the physician's level of concern for the patient's problem, by obscuring efforts to recruit resources outside the patient's knowledge. The patient may have a false sense of security from the idea that her problem is sufficiently simple to require the attention of only one practitioner, or she may be angry if she later discovers that other physicians were consulted without her knowledge. These matters are material to the patient's decision making inasmuch as they reflect the physician's knowledge base, ability, and need to marshal alternate resources, any of which may affect patient judgments of physician competence and commitment to serve.

Physician competence is another area in which openness between patient and physician is not the norm. The patient, perhaps fearing even to contemplate the issue, or fearing that by doing so she will anger the physician, is unlikely to inquire about the physician's background or skill in carrying out any particular type of care. The existence of professional credentialing does offer a basic guarantee of expertise, but clearly even among physicians trained in a particular area there will exist a spectrum of skill and experience. The physician's familiarity with a particular type of illness, diagnostic procedure, or therapy is transparently material to a patient's decision of whether to consult with that physician for the service in question. This is especially true for physicians still formally in training, such as interns, residents, and, especially, medical students. And yet in health care settings the caregivers often appear generic in dress and accouterments, blending into one homogenous mass of medical authority, and leaving the

patients unclear as to even who *is* a physician, let alone at what stage of training a particular physician may be. This collapsing of the spectrum of competence, from the nearly incompetent neophyte medical student, to the supremely competent physician of many years experience, into a single, amorphous standard is deceptive. It is often justified as protecting patients from information that might be upsetting or threatening, when in fact it should be condemned as deliberately withholding information that might otherwise prompt patients to seek care from another health professional.

Questions of physician training and competence are not isolated in being omitted from the patient-physician discourse. Howard Waitzkin has written extensively on the exclusion of the social context of the medical encounter from consideration within that encounter.²⁴ This exclusion is a bit less deliberate than that of questions of training, being enforced more by conventions concerning, as Waitzkin says, "what medicine *is* in our society. [emphasis in original]"²⁵ On reflection, it seems that in very few interactions, professional or otherwise, are the social forces and experiences that shape and constrain the roles of the participants brought under consideration. The reason such consideration might be especially relevant in medicine is the interaction between social context and health. The Declaration of Alma Ata defined health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity".²⁶ While medicine concerns itself greatly with physical health, and considerably with mental health as well, social well being is seldom included as part of the legitimate sphere of discussion. And yet, as the Declaration of Alma-Ata suggests, the social matrix exerts a significant impact on individual health, and perhaps ought to on

the tactics employed to secure health. Howard Waitzkin wrote that, "When occupational toxins, stress or job insecurity produces symptoms, for instance, labor organizing is the preferred therapy, in addition to whatever physical treatment may prove appropriate."²⁷ The practical exclusion of such social factors from the patient-physician interaction may limit both the patient's and the physician's ability to fully consider the entire range of potential interventions, to the detriment of decision making.

Moreover, social context exerts an effect not only on health, but on the conduct of the patient-physician relationship itself. The class and cultural differences between patient and physician, for example, have a significant influence on the perspectives each brings to the medical encounter. These differences should have their place in discourse, in order that a full appreciation of the influences on both patient and physician can be made each to the other. I recently was involved in the denial of services to a patient at a free clinic. The patient and physician never actually met; I acted as messenger between the waiting room and the clinic proper. The patient requested that the treating physician examine her, to provide medical clearance for her to be enrolled in a partial hospitalization program for the treatment of depression. Because of the limited facilities at the free clinic, the physician denied service, believing (correctly) that a traditional medical clearance would be impossible without space to perform a physical exam and a lab for clinical testing. The patient, however, was truly not seeking such exhaustive evaluation, nor did I have the impression that the treatment program in question required such. I cannot help but consider that an airing of the physician's logic, the patient's needs as a homeless person seeking care, and the services offered by the treatment program she

had selected might have led to some appreciation of the relation between social milieu and the expectations of both physician and patient, possibly with some rapprochement that would have enabled the patient to obtain what she needed. Omission of the underlying social reasons for people's perspectives and motives robs the patient-physician relationship of potentially valuable information, to the detriment of the democratic value of openness. I shall have more to say concerning the social context of the medical encounter in what is to come.

The problem of compromised openness in the patient-physician relationship is not purely one of obscuring information external to the relationship. It extends to concealment of information generated and recorded in the context of the relationship, in the form of the patient's medical record. By convention, this record is deemed the property of the physician or her employer. The information contained within, however, is information concerning the patient's medical problems and treatments. While a case could well be made that the patient is the rightful proprietor of this record for legal purposes, it is at least certain that the contents of the medical chart are critical resources for the patient in her encounters with health care professionals. To the extent that this information is rendered inaccessible to the patient, or even accessible subject to constraints of time, place, and cost, the patient's autonomy is compromised by her inability to easily transport this information between different settings, both purely medical and those extramedical ones nevertheless requiring medical information, such as are encountered in life insurance and education. While the restriction of the patient's access to her own chart is fundamentally a restriction on autonomy, the fact that this

crucial information, germane to decisions both inside and outside the purely medical, is not freely accessible reflects a conflict with the value of openness.

Finally, the topic of openness should not be left without mentioning restrictions on free access to information that are imposed by the patient herself. I have asserted that medical decisions are like any other in requiring information, but of course the generation of what Edmund Pellegrino calls "a right and good healing action"²⁸ for a particular patient depends critically on information concerning the patient herself, information that generally must be disclosed to the physician in the context of the medical encounter. Openness in the patient-physician relationship may thus be compromised by the patient's reluctance to introduce specific information into the discourse. To be sure, given the fact of illness the patient may have good reason to be incapable of full disclosure. Past adverse experiences with physicians may also make a person reluctant to divulge information they consider shameful or compromising. These understandable barriers to patient disclosure can be mitigated by actions of the physician aimed at encouraging the patient to share difficult material. Nevertheless, it is important to acknowledge that whatever the power inequalities in the patient-physician relationship, the patient, too, has responsibilities for instantiating the values of democracy. In the case of openness, this responsibility extends to disclosing all information that may be relevant to medical decision making.

Because the patient-physician relationship is fraught with decision making, openness is a particularly important value. Whether a decision is technical, such as one involving a treatment decision that may be influenced by a patient's allergies to

medication, or personal, such as one requiring a balancing of the risks and benefits of different therapies with the values of the patient, there is a need for liberal access to relevant information. Regrettably, any democratic character the relationship might have is frequently eroded by violations of the value of openness, over which secrecy frequently triumphs.

Constraining dialog by convention

The conversation between patient and physician is one of mutual construction but largely unilateral design. The medical encounter is heavily structured by longstanding conventions used by the medical profession. Students in medical school are instructed to use a medically standardized format for the information they report about patients, and this format in turn shapes the interaction by which that information is gathered. This scripting of the encounter creates two fundamental problems of democracy in the patient-physician relationship, one of physician dominance and the other of circumscription of content. In addition, time constraints impose their own restrictions on effective dialog. As a result of these constraints, the conversation between patient and physician often does not fulfill the democratic value of dialog.

Physician dominance of the conversation is reflected in an information flow that, while bidirectional, is both stereotyped by medical convention and substantially controlled by the physician. The essentials of the medical model of conversation are simple. The physician solicits information from the patient that she believes fits into the medical rubric of diagnosis and treatment. By default, patient participation is limited to responding to questions. The physician also provides information to the patient, in the

form of medical data such as diagnoses, risks, and treatment options. Again by default, the information received by the patient is based on the physician's judgment of what is medically relevant. It is apparent that this conversational model promotes physician over the encounter, at the expense of the patient's.

An objection may be made that the foregoing description is itself exceedingly stereotyped. For example, surely along with the conversational operations described, the physician would routinely solicit feedback from the patient regarding her preferences, or whether she understood the information provided. These seem rather elementary dialogic maneuvers, and I do not mean to imply that they never occur. And yet, they may well be less common than one might think. In a recent study by Clarence Braddock and colleagues,²⁹ the conversational behavior of some 100 physicians, both generalists and surgeons, was evaluated through review of more than 1000 patient interactions in which a medical decision, ranging from simple to complex, was made. In only 21% of cases were the patient's preferences explored, and in an astonishingly low 1.5% did the physician attempt to check the patient's understanding of the information provided! My admittedly simple description of the typical patient-physician interaction is thus, at least so far as decision making in the Braddock study is concerned, surprisingly faithful to reality, and one might say alarmingly so.

The prevailing model of patient-physician interaction, however consonant it may be with prevailing medical practice, poses substantial problems for democracy because of its neglect of the reciprocal character of dialog. In dialog both parties share control of the interaction, as is necessary for each to voice goals, interests, and objections, and also for

each to respond to material introduced by the other. Without joint control of the flow of conversation, dialog is impossible, and dialog's implicit goals of mutual education, conflict resolution, refinement of ideas, and decision may become unreachable. The information necessary to these goals' fulfillment is unlikely to be introduced. John Dewey wrote, "Logic in its fulfillment recurs to the primitive sense of the word: dialogue. Ideas which are not communicated, shared, and reborn in expression are but soliloquy, and soliloquy is but broken and imperfect thought."³⁰ As was seen in the example of the woman seeking medical clearance in the free clinic, lack of dialog may have prevented a resolution that would have respected the interests of both physician - in preserving the integrity of the medical clearance process - and patient - in obtaining treatment, rather than effectively imposing the interests of the physician. In general, if openness is the value mandating disclosure of relevant information from both patient and physician, dialog is the mechanism of its disclosure.

The particular role of dialog in bringing to light new information, including in settings where there is no apparent conflict, is important. Jay Katz wrote:

Affirmative responses deserve study in their own right. Doctors' acceptance of a mere 'yes' response is often meaningless because they have no idea what it means to the patient. In addition, an all too ready acceptance of a 'yes' response can constitute what Edmond Cahn has called an 'engineering of consent by exploiting the condition of necessitous men.' Cahn identified a most troublesome flaw in physician-patient conversation: the witting and unwitting manipulation of disclosure and, in turn, of choice by trading on the ignorance and fears of scared patients.³¹

There are two issues here that relate to dialog. First is the importance of actively seeking understanding and motive. The example of the hand surgeon and gardener demonstrates the pitfalls of a physician's uncritical acceptance of patient consent, Katz's "'yes'

response". In the absence of authentic dialog, the physician may, with good intentions, convince the patient of a course of action, and never know that her medical recommendation was based on a mistaken assumption of the patient's interests, or that the patient was convinced on the mistaken assumption that the physician's recommendation was purely medical! The absence of dialog leads easily into a morass of missed communication and, potentially, error.

The second point Katz makes concerns acceptable tactics of persuasion in dialog. The physician exploitation, intentional or not, of patient fears as a vehicle for persuasion unfairly preys on the patient's compromised state of autonomy. It recalls Charles Bosk's image of patient autonomy as a sword wielded by physicians to compel certain decisions. This is a particularly important point in a situation of conflict, where the patient is leaning away from the course of action chosen by the physician. As was seen in the example of the emergency physician and the woman with abdominal pain, the physician may resort to logically invalid and frankly inappropriate rhetorical methods, where dialog might have offered both patient and physician a better sense of the concerns of each and hope for accord satisfactory to both. Dialog, again, does not promise final accord, but it is always at least a vehicle for mutual understanding. Physician dominance of the medical conversation, and in particular the use of questionable tactics of persuasion, impede the full expression of dialog.

Lack of dialog constrains the content of the medical conversation in various ways. The physician, as the dominant partner, may steer the discussion away from some areas and toward others. More generally, however, lack of dialog tends to freeze in place

social or cultural definitions of the encounter that otherwise might be subject to challenge and modification by either the patient or physician. The definition of the scope of the medical conversation deems certain items appropriate to discussion, while others are excluded. Social context, as discussed in the section on openness, is such an excluded topic. I have already made reference to a portion of the following quote by Howard Waitzkin, which I now cite in its entirety: "The exclusion of social context from critical attention is a fundamental feature of medical language, a feature that is linked with ideology and social control. Inattention to social issues, especially when these issues lie behind patients' personal troubles, can never be just a matter of professional inadequacy, or the inadequacy of professional training. Instead, this *lack* is a basic part of what medicine *is* in our society. [emphasis in original]"³² This effect is akin to agenda control of a particularly thoroughgoing type. I do not mean to imply that lack of dialog itself produces a definition of medicine that excludes social context, but that lack of dialog reinforces such a definition. Dialog enables the discussants to raise issues of import, potentially novel issues that have previously passed unconsidered, or would likely be unconsidered in the traditional rubric. Without dialog, these issues may remain unconsidered.

The objection may be made that the structure of conversation in the patient-physician relationship is optimized for the efficient use of the physician as a medical resource. The physician is, after all, being consulted by the patient for her professional expertise, so it is only natural that the patient should respond to questions deemed medically relevant by the physician, and should in turn be told the physician's medical

pronouncements. Why should the patient have any greater control over the flow of conversation, and why should matters so apparently exogenous to medicine as the social context be legitimate topics for discussion?

I have already outlined the conflicts of standard practice with the democratic value of dialog, but I believe the conventional model also conflicts substantially with the ostensible goal of the patient-physician relationship, that of restoration and maintenance of health. From my examples, it is apparent that the quality of medical care may suffer in the absence of dialog. Even considering only error correction and prevention, dialog stands to benefit medicine by engaging patients in their own care, and using patient knowledge as a check on physician actions and recommendations. In addition, dialog furnishes the patient a greater sense of control over her health and life, a sense that some say is positively correlated to health itself. Finally, there are clearly other determinants of health besides medicine. Some of these lie in the social realm of adequate food, shelter, and safety. If the physician dedicates herself to the health of her patients and not merely to medicine, these social factors become relevant, and dialog is one route to their consideration.

I conclude the problems of dialog in the patient-physician relationship with consideration of time. Even as insufficient time constrains patient autonomy, it also hobbles dialog. Oscar Wilde once said that "socialism would take far too many evenings", and Michael Walzer has intimated the same might be true for democracy.³³ It is certain that dialog as I have defined it takes time, often a scarce commodity in the contemporary patient-physician relationship. Wendy Levinson and colleagues have

argued that, in the long run, time invested in longer conversation between patient and physician may be recovered through fewer problems in the relationship, such as patient dissatisfaction.³⁴ But even if on balance time spent is conserved, or even reduced, there would still be a need for an expansion of the time spent in a given patient visit. This seems unlikely to happen in an environment where corporate paymasters demand visits be limited to 10 minutes or less, or where low government reimbursement rates on public health insurance encourage physicians to pack indigent patients tightly into a schedule to earn a living. Without a commitment by physicians and patients to spend the time required for a thorough and wide ranging discussion, the promise of dialog will remain unrealized.

Dialog is, with participation, the fundamental active value of democratic decision. Dialog enables exchange of information, discussion of the meaning of information, and dispute resolution. With a sincere effort at dialog, both patient and physician may discover what they need in order to either advise or reflect effectively. With dialog constrained by conventions concerning information flow, content, and time spent, a democratic patient-physician relationship will remain a distant dream.

The expropriation of participation

The idea that patients should participate in medical decisions affecting them is a fairly recent one in US jurisprudence, and an even more recent one in US medicine. The very novelty of patient participation as a principle of the patient-physician relationship speaks to the historic reality of the democratic problem of patient *non*participation. For hundreds of years physicians have, in various ways and for various reasons, expropriated

patient's participatory role in the medical encounter. This was not regarded as expropriative or even problematic by the medical profession because of the arrogation to itself of the role of patient advocate. Physicians claimed with complete confidence that, in the absence of open and thorough dialog, they could nevertheless effectively represent their patients. Sometimes the absence of dialog was paternalistically justified as itself serving a therapeutic interest in protecting the patient from painful thoughts. This is an ironic presumption since, while medical professionalism demands the doctors act in their patients' best interests, the ability to *determine* those interests unilaterally at best strains credibility, and at worst appears tautologic. Jay Katz wrote that, "The idea that physicians' and patients' interests are one and the same allows a doctor to speak for the patient. That idea has been the bedrock of physician-patient relations since the beginning of time...The question that begs for an answer is: Can a new medicine be built on a foundation dedicated to the idea that patients also have a right to make decisions?"³⁵ This question is a critical one for democracy and the patient-physician relationship, because what Robert Dahl said in a political context applies in the medical one as well: "To deny any citizen adequate opportunities for effective participation means that because their preferences are unknown or incorrectly perceived, they cannot be taken into account."³⁶

Even without the wholehearted efforts of the medical profession, patient participation in the medical encounter may well have been naturally limited from the beginning. As described previously, the fact of illness imposes certain deficits on the person seeking care. She is not in full independence and may even be in a profound state of need. Similarly, her ability to effectively participate in decision making is likely to

suffer, how much depending on her degree of illness, and potentially to the point where no meaningful participation is possible. Even allowing for the effects of illness, however, there is much in medical practice that further discourages patient participation. While informed consent has mandated the involvement of patients in a variety of situations, many medical decisions are routinely made without consulting the patient affected. These include decisions of what diagnostic tests should be performed, which treatments to offer, and whether to disclose medical mistakes. Many of these, even when discussed with the patient, are presented less as options to be considered and more as *faits accomplis* of which the patient is simply being informed. I have seen such things happen many times in the hospital, where it might be more justifiable than in routine clinic visits, though I am skeptical that even here it can be generally supported using the basis of patients' grave illness and corresponding inability to effectively participate. Such complete exclusion is really a primary constraint on patient autonomy, in that it effectively forces someone to do something, if not against their will then certainly without assessing their will. But the negative impact on participation is apparent.

Direct exclusion of patients from participation in decisions related to their care, whether conscious or simply following from routine practice, is only the most extreme method by which patient participation is restricted. Technical medical language imposes a barrier to patient understanding, and hence to patient ability to respond to what is said and done. Physician efforts to limit dialog, in content or duration, clearly constrain what a patient can learn and advocate, with attendant effects on openness and autonomy. Interventions that impair patients' ability to think or communicate, such as breathing

devices that prevent the patient from speaking through her mouth, and various forms of sedation, also hamper participation. Lastly, lack of active encouragement from physicians, coupled with patients' unfamiliarity with taking part in medical decisions, is itself an obstacle to participation. Clarence Braddock wrote, "The need for this new element [discussion of the patient's role in decisions] arises because many patients may be unclear about their role in decision making and hence, adopt a passive or nonparticipatory style. Consequently, in certain decisions, particularly complex ones, the patient may need an explicit invitation to participate in the decision-making process."³⁷

Why should there be so many obstacles actively placed in the way of patient participation by the medical profession? A key reason may simply be time. As observed in the section on dialog, even if more dialog actually saves time in the long run, the fact that it consumes more time in the short is likely to lead to the perception that it consumes more time on the whole. Jay Katz observed, "Authority seems to make doctors' lives easier."³⁸ Authority, in the sense of the ability to elicit certain behaviors from others with minimal effort, certainly does enhance efficiency for the health care provider. This is one reason the physician may prefer relatively restricted patient autonomy to its fully engaged, expressive counterpart. The cost, of course, is damage to the democratic character of the patient-physician relationship, and the deleterious effects I have argued this loss works on the quality of health care itself. Martin Shapiro has considered other reasons for the expropriation of patient participation in decision making by physicians and other health care workers.³⁹ In addition to being more efficient, Shapiro argues that use of authority may reflect the authoritarian culture of medicine, including the power

relations between different classes of health care workers. Medical organizations are frequently hierarchical structures, with physicians, at least until their recent displacement by corporate bureaucrats, occupying the highest tier, and patients, ironically, the lowest. In this explanation, constraints on patient participation are simply an aspect of the dominance component of the medical environment, with each layer of the pyramid effectively restricting participation of the layers below.

Another reason Shapiro offers for the expropriation of patient participation is the dehumanization of patients. I suspect this is both a cause and an effect. The greater the extent another's humanity is acknowledged, the more difficult it becomes to avoid treating them with the respect due another human, and conversely. This respect includes participating with them in dialog. For many reasons, including the impersonal character of health care delivery settings, the coping needs of health care workers, and the status gulf between physicians and patients, dehumanization is an effect of receiving care. Especially in the hospital, patients are literally stripped of their own clothes and clad in uniform, exposing gowns, housed in identical rooms, and fed the same distasteful food. This is a ripe setting for dehumanization, and inviting the participation of someone in health care decisions is likely to become a very low priority once dehumanization has occurred. But as I suggested, the expropriation of participation is itself dehumanizing, and thus a vicious circle is formed, to the detriment of both the values of participation and humanity.

Shapiro also explores the various justifications offered for the restrictions imposed on patient participation. In general, they do not withstand scrutiny through the

lens of the values of democracy. Patients are sometimes excluded on the basis of a presumed inability to understand medical language. As I have argued, most people can understand the portions of a medical decision relevant to their life situation and values, the latter of which are the major determinants of a decision. In addition, knowledge gaps between patient and physician that are sufficient to impair communication may be redressed by physician efforts to educate patients, and should not be accepted as fixed and immutable. Another justification offered is the need to protect patients from distressing thoughts. There is a longstanding tradition in medicine of "therapeutic privilege", permitting physicians to paternalistically withhold information deemed harmful to the patient, but its basis has been considerably eroded with the advent of informed consent doctrines. From the standpoint of democratic theory, the withholding of information clearly restricts the patient's ability to meaningfully participate in her health care, and can be rejected on these grounds. Finally, Shapiro suggests that physicians justify limiting patient participation to preempt the patient's expression of her desires, presumably because these desires would otherwise flood the health care system, and the physician's work, with inefficiency. If this justification is seriously advanced by physicians, they ought to be commended for the confession, but the deliberate suppression of patient desires through limiting participation cannot be seriously considered as valid in light of the values of democracy.

In Chapter 1, I claimed participation is fostered by public spiritedness, or the disposition to participate. In the context of democracy and the patient-physician relationship, participation is required of both physician and patient. Because of historic

inequities in the relationship, the greatest dearth of participation would likely be relieved by increasing patient involvement, but in truth both patient and physician must be willing to work together to resolve decisions. A patient's disposition to participate may be squelched by the various barriers I have described, particularly the absence of encouragement toward participation. Whether a physician, accustomed to a model of medical care skewed away from patient involvement, would be interested in participating on other terms that involve the patient more, is uncertain.

For a last time I would like to visit the topic of the social context of the medical encounter. Participation increases diversity and thereby amplifies varying perspectives on what may legitimately be included in the patient-physician discourse. Poor participation in the patient-physician relationship, like poor openness and poor dialog, tends to exclude subjects from consideration and reinforce existing criteria of inclusion. Because it is in the nature of medicine, as Howard Waitzkin has stated, to exclude consideration of the nonmedical, even when relevant to health, I contend that lack of patient participation tends to reinforce this exclusion. Ironically, however, social impacts on health may be excluded *as such* from medical conversations, rather than being excluded entirely. Abram DeSwaan and Howard Waitzkin argue that when health effects of the social context do enter into discussion, they do not tend to be reckoned as socially originating and socially correctable, but rather are "medicalized" into the health problems of an individual patient apart from the problems of society.^{40,41} What I heretofore described as the exclusion of social context from patient-physician interaction, is thus more accurately characterized as a combination of exclusion and *desocialization* or

medicalization of social context. I argue that limitations on patient participation tend to reinforce this. What are the ramifications?

To a certain extent, the medicalization of socially originated problems might be viewed as augmenting patient power. As DeSwaan and Waitzkin argue, the medical model, when applied to the effects of economic, labor, and other structures, is reductionist in character. Phenomena that originate in these structures, such as occupational illness, are reduced to health problems of the patient and treated medically. Reform of the social structure, the obvious alternative approach, is a task of considerably greater difficulty than the treatment of a medical problem, even a serious one. Medicalization thus could be argued to potentiate patient autonomy by furnishing an action that can mitigate the larger social problems' personal manifestations, if not abolish them entirely. Perhaps, for a given person, this would be a more desirable approach than opening a discussion of the underlying, structural reasons for their problems. The other side to medicalization, however, is one that may be more disempowering to the patient and physician in the long term. Waitzkin argues that relegating what are essentially social problems to the medical realm in effect removes them from potential social action. The patient may thus gain a measure of control and autonomy through medical relegation of social problems, but lose some control by the impoverishment of the dialog in the larger social realm. With medicalization, participation in ameliorating the personal effects of social problems may expand in the patient-physician relationship, while participation in addressing the roots of social problems may contract in the larger democratic society.

I do not know whether on balance the exclusion and recasting of social factors amplifies or restricts the democratic value of participation. Because individual "solutions" to social problems are unlikely to ever abolish the social precursors, I would argue that the positive gain of medicalization is at least somewhat less than the loss, and this would argue in favor of the inclusion of social context as such in medical discussions. In any case, however, decreased patient participation in the medical relationship likely impedes the patient from expressing her preferences on how such matters should be approached, in medical or social terms. In terms of the relationship, lack of participation therefore remains a problem in its own right, whatever the effects of greater participation on the processing of social problems might be.

In this section I have argued that the patient-physician relationship suffers from insufficient participation. Because participation is a value related to effective dialog, openness, and autonomy, its limitation has profound and negative effects on the democratic character of the medical encounter. Its restriction has its roots deep in medical traditions and culture, and this suggests that the problem is not merely one of lack of participation, but lack of physician alacrity in encouraging it. Without improvement in patient participation, the relationship is likely to remain an unequal one in the physician's favor.

Inequalities of opportunity and interests

At this point, the assertion that the patient and physician enjoy unequal opportunities to participate in their relationship should scarcely need defense. Factors both intrinsic and extrinsic to medicine's nature make this so. The fact of illness and the

technical knowledge disparity tend to amplify the physician's role at the expense of the patient's, and these factors, if not their exact manifestations, are immutable features of the medical landscape. They may also reinforce practices that could be eliminated, such as physician dominance of dialog. Taken together, they determine a medical relationship in which the patient's opportunities to participate effectively are restricted, through both physician imposition and lack of invitation to do otherwise. Even were the patient to assert an interest in participating, it might well be for naught without physician support.

It is especially troublesome that the expansion of the patient's opportunity to participate should rely on the encouragement of the physician. Earlier, I described reasons that patient participation is limited, and perhaps deliberately, in the physician's interest. It thus appears a conflict of interest for the physician to be in the best position to equalize opportunities to participate, since she would likely lose in authority what the patient gained. This seems particularly true in light of what William May has described as the covenantal ethics that exist between physicians, in comparison to the code-based ethics that exist between physicians and their patients.⁴² In May's view, covenant acknowledges mutual indebtedness and obligation, and thus binds more tightly than code, which is unilaterally proffered by the physician, without input from the patient. To the extent that broadening of patient opportunities to participate can be regarded as eroding not merely the authority of the individual physician, but of the profession as a whole, the covenantal basis of intraprofessional medical ethics may give physicians pause.

This attitude, however, would run counter to the physician's pledge of fiduciary responsibility for the patient, to say nothing of the values of democracy. The professional

goals of the physician are to serve the patient with expert medical knowledge, not exercise authority over the patient, though such exercise may have benefits to the physician. The imperative that the physician expand the patient's opportunity to participate actually takes on greater power in light of professionalism, because of the importance of patient participation for quality health care. Robert Dahl wrote in a different context that, "Throughout the process of making binding decisions, citizens ought to have an adequate opportunity, and an equal opportunity, for expressing their preferences as to the final outcome. They must have adequate and equal opportunities for placing questions on the agenda and for expressing reasons for endorsing one outcome rather than another."⁴³ Dahl's words echo the operational justifications I have made for greater democracy in the patient-physician relationship: the outcomes for a more democratic relationship are better for the patient, because they are reflective of a shared decision making process in which the patient expresses her own interests, and arrives at a resolution between them and the physician's. The need for equal participatory opportunity in the medical encounter is thus supported both by medical professionalism and the values-based theory of democracy.

The other aspect of the democratic value of equality, that of equal consideration of equal interests, also fares poorly in the contemporary patient-physician relationship. At the outset, it must be admitted that the interests the patient and physician bring to the relationship are, if anything, highly unequal. Both share interests in the successful medical treatment of the patient's health problems, but of course the intensity of these interests is likely to be very different. The patient stands to bear the most immediate and

direct effects of any success or failure of therapy. The physician is, to be sure, affected by the patient's outcomes and her own internal response to these outcomes, but these might be considered second order interests in comparison to the patient's. The physician also brings to the relationship a variety of other interests, such as an interest in the enjoyment of her work and in earning a living through that work, and an interest in the excellence of her profession. How do these interests balance out?

Simplistically, the patient may be said to have a generally greater stake in the encounter, and therefore to carry more weight in democratic deliberations pertaining thereto, because of the fact that her body is in jeopardy, and because of the relatively greater weight given this interest. However, the significant interests of the physician should not be dismissed lightly, and should be carefully evaluated in relation to the patient's. For example, imagine a context in which the patient's interests in her own health involve relatively minor concerns that are non-life threatening, such as a cold. The patient demands the physician prescribe unreasonably strong pain relievers that are controlled substances. While I have argued that the power of prescription infringes substantially on patient autonomy, the physician in this case has interests that may be more significant than those of the patient, and that may bring dialogic judgment down on the physician side. The physician, in acceding to the patient's wishes, would be compromising the excellence of her profession by providing medical care inconsistent with the situation. Further, she may be exposing herself to legal sanction and risking her ability to practice, and livelihood, by inappropriately prescribing controlled substances as pain relievers. In this case, the physician's entirely personal interest might be regarded as

outweighing the patient's, and also as not conflicting with the physician's fiduciary pledge to the patient.

The reason, however, I would assert that equal consideration of similar interests fares poorly in the patient-physician relationship is that cases such as this are probably relatively rare. It is inherently difficult to judge the reasonableness of a patient's request for pain relievers, there being no objective standard of pain. In general, there is always a measure of uncertainty in any treatment decision, so cases where it is unambiguously contraindicated are outnumbered by cases of relative or uncertain contraindication. Moreover, in all but rare cases such as the foregoing, the physician will not be exposing herself to professional sanction by well-intentioned, though uncertain, actions. Therefore I assert that, generally speaking, the physician will be bound by the values of democracy and her own profession to generally support the patient's wishes, countervailing interests not being greater. In accord with the values of participation and dialog, the physician is of course free to discuss disputes with the patient and attempt to advise her of any medically questionable perspectives. Once this has been done, however, and a discussion of the interests involved has found in the patient's favor, the physician has strong reason to accede to the patient's wishes.

I believe the case of the patient who was refused medical clearance to enter psychiatric treatment exemplified this. The physician had reasonable interests in guarding the integrity of her evaluation of patients' medical fitness for psychotherapy. She was reluctant to simply "sign off" on the patient's clearance form, and moreover she did not believe she could do so with reasonable integrity of profession, given the

primitive facilities available. The patient's interests, however, were of a different timbre. The patient, as a homeless person attempting to obtain treatment for a psychiatric condition, had a need likely greater and more immediately threatening than the physician's. Moreover, the physician is additionally bound by an obligation to serve the patient's best interests. It is very questionable that the physician's refusal to examine the patient as well as possible, with an eye to possibly clearing her medically, was made with adequate consideration of the disparate interests involved. If anything, the patient's greater interests should have carried the day. I do not consider the conduct of the physician described reprehensible or even grossly unreasonable. I do believe, however, that the physician's decision was based on inadequate consideration of the interests involved, and was therefore fundamentally inconsistent with the democratic value of equality.

The danger in unequal opportunities to participate between patient and physician is that they will lead to unequal consideration of similar interests, generally in the physician's favor. Iris Marion Young observed that dominant interests tend to, even if unintentionally, promote their own interests to the exclusion of others not represented.⁴⁴ Opportunities to participate in dialog being the raw material of representation in a democratic relationship, the compromise of the value of equality has dire consequences for the interests of the patient.

Conclusion

A component of my argument is that no shared decision making is possible without expression of democratic values. For a decision reached by two parties interested

in the outcome to be genuinely shared, it must be informed by the autonomy, openness, dialog, participation, and equality of the parties. Without these values' full realization on both sides, the decision will be vulnerable to perturbations of power that will tend to bias it in favor of one party or the other.

The patient-physician relationship is a dyad marked by disparities of technical knowledge, prestige, power, and health. These disparities tend to manifest as basic inequalities or impediments in the five democratic values cited. Because of the compromised status of these values, the medical relationship suffers from a lack of democracy. The physician, as the dominant member of the dyad, regularly trumps the patient on the strength of her dominance.

This is a profound problem for the democracy of the relationship, but is it unreasonable from the perspective of medicine? That is, might the physician's dominance of the interaction be salutary in some sense, producing outcomes superior for the patient's health than some more democratic alternative? Sometimes restrictions of the values of democracy, such as openness or participation, are justified in therapeutic terms. I have tried to argue that these justifications are flimsy, not only on the basis of democratic theory, but even in terms of the goals of medicine itself. My assertion is that a more democratic patient-physician relationship is of benefit to both democracy and medicine, and this assertion will be advanced in the final chapter.

Chapter 4 - A Democratic Patient-Physician Relationship

Why a democratic relationship

The previous chapter explored many ways in which the contemporary patient-physician relationship in the United States deviates from democratic ideals. There are severe conflicts between the relationship and each of the five democratic values. Since I have defined a democratic dyad as one in which decisions are shared, and in which each of the five values are strongly supported, I conclude that the patient-physician relationship as currently practiced is substantially undemocratic. In this final chapter, I will describe a different patient-physician relationship, one in which the interaction itself expresses the values of democracy, rather than contravening them. The present chapter attempts to answer the questions of what a democratic patient-physician relationship looks like, and how it might be achieved.

A manifesto for the democratic medical dyad comes from Jay Katz's *The Silent World of Doctor and Patient*. He writes:

The experiment of fashioning a new ideology of professionalism that is more firmly grounded in a commitment to mutual equality, in a trusting recognition of common dependence, is worth the effort. This new ideology asserts that both physicians and patients 'profess.' Only after physicians have professed their esoteric professional knowledge and patients their esoteric personal knowledge, and both have confessed (another meaning of profess) to what they can do and what they expect, can a mutually satisfactory recommendation emerge.¹

The relationship Katz describes strongly resembles what I have called a democratic dyad. Present are a sharing of information relevant to decision, a dialog in which the capabilities and interests of both persons are exchanged, and a setting of equality.

Implicitly, the interaction is participatory for both patient and physician. The only value not evidently present is that of autonomy, and yet the goal of the interaction, a "mutually satisfactory recommendation", suggests that autonomy, too, is part of this conception of the patient-physician relationship. Aside from outlining a democratic relationship, in this passage Katz addresses the question of why such a relationship is desirable. He suggests that dyadic democracy is, in fact, the only route to decisions that are acceptable to both patient and physician. Given what I have argued previously, this claim is not so surprising as it otherwise might be. Democracy is grounded in the making of decisions by those affected by the results of said decisions, in a spirit of equality and collaboration. Though democratic decision making techniques do not guarantee a decisive result, when this can be achieved it is virtually by definition an outcome acceptable to all parties, though not necessary the optimal outcome for any given party. Other methods of decision making, including authoritarian ones, are far less likely to produce this result, generally because not all affected parties are able to assert their interests as to outcome.

The ability of a democratic patient-physician relationship to regularly produce results to which both patient and physician are amenable is one of its great strengths. There are other reasons for which this model of the patient-physician relationship is desirable, notably its affinity for the established model of bioethics.² Because democratic relationships are consensual ones, based on autonomous decisions to participate by the involved parties, the democratic medical relationship strongly expresses the established bioethical value of autonomy. In addition, the bioethical principles of beneficence and nonmaleficence are implicitly present in the collaborative discourse between parties,

which includes dialog aimed at resolution of disputes through respect for, and not domination of, the various interests involved, and also openness regarding information material to a decision, instead of secrecy. It is worth noting that some of the aims of beneficence and nonmaleficence may also be fulfilled in a democratic patient-physician relationship through self-guardianship. Because the democratic dyad provides for the expression and defense of interests, the importance of beneficence and nonmaleficence is somewhat less than it otherwise might be. Of course, in those cases in which the patient is truly incapable of expressing preferences, beneficence and nonmaleficence again come to the fore. Finally, the bioethical value of justice is implicitly satisfied in the democratic dyad, through the participation of those affected by decisions in the decision making process, and their ability to promote their interests alongside those of others.

It is important that any new theory of the patient-physician relationship be substantially consistent with established principles of bioethics. Otherwise, a new theory, such as that advanced here, would at the outset face a struggle to validate its opposition to very well founded prior theories. Ideally, however, any new theory should offer something more than that provided by its predecessors. If there is a novel benefit of the democratic patient-physician relationship, it is likely in its mirroring of established sociopolitical values at the microscopic level of the dyad. By implementing the values of democratic society in the setting of a client-professional relationship, the experience of democracy is brought into a new context, in which citizens will be exposed to its techniques and virtues. This is likely to have an effect of strengthening democratic practice in the society at large, through what Amy Goodman called conscious social

reproduction. At the conclusion of this chapter, I shall have more to say on the benefits of a democratic patient-physician relationship for democracy in the larger society.

In what follows of this chapter, a description of the democratic patient-physician relationship is proposed, organized by the five core values I have defined. Afterward, I advance several ideas aimed in general at realizing the relationship described, involving both actions to be taken in the context of the relationship and outside, in the larger society. Finally, the benefits both to medicine and to democracy at large of a more democratic patient-physician relationship are defined.

Defining the relationship by prescription

In this section, I describe in itemized fashion the aspects of a democratic patient-physician relationship. It is important to emphasize that this description is not unique. There are likely various possible implementations of patient-physician relationships, each strongly supportive of the five core values of democracy and emblematic of shared decision making. The description I propose undoubtedly stems from my own culturally influenced sense of the purpose of medicine and how it works. Other conceptualizations of the basic relationship between a healer and the person seeking healing could well yield correspondingly different descriptions of a democratic version of the relationship.

I must reiterate a disclaimer made in Chapter 2, this time concerning what follows. A significant task in democratizing the patient-physician relationship is enhancing patient decision making capacities. This is not because the physician's decision making is democratically unimportant, but rather because of the historic predominance the physician has enjoyed in the relationship. This predominance focuses

the democratic agenda on redressing existing imbalances of power in favor of the patient. And again, because of this predominance, the physician is the agent in the best position to redress the imbalances. My primary focus on the physician as potentiator of the patient's exercising of democratic values is thus in part a pragmatic one. Is it realistic to hope or expect that the physician would so act on the patient's behalf, and conceivably at the expense of her own power? There are two reasons that impel the physician to do exactly this. First is the physician's role as professional, bound by trust to act on the patient's best interests. I have suggested, and will argue further below, that the problems of democracy in medicine are, simultaneously, problems from the standpoint of medicine alone. If this is correct, the physician is compelled by professional code to act to strengthen the patient's democratic participation. Second, the physician has a distinct role as a citizen in a democratic society. This implies some adherence to the democratic values described repeatedly in this work, that should motivate the physician to achieve a democratic interaction with the patient as a fellow citizen with whom the physician must engage. Finally, my emphasis on the physician also stems from my own interest as a medical student in identifying those actions I may take in relationships with patients to realize their democratic participation.

I have either stated or implied a great deal about the substance of a democratic patient-physician relationship, both in the description of democratic client-professional relationships in Chapter 2, and in the description of democratic problems in the patient-physician relationship in Chapter 3. I have chosen, rather than further exposition of these ideas, a tabular format, organized by the values of democracy, and containing suggested

actions both physician and patient would perform in a democratic patient-physician relationship. In all cases the goal is the enhancement of the overall democratic character of the relationship, particularly focusing on augmenting patient decision making capacities, whether by ameliorating barriers intrinsic to being a patient, or by eliminating barriers imposed by the physician. The results of this description appear in Table 1 below.

Table 1. Actions of a Democratic Patient-Physician Relationship

<i>Values of democracy</i>	<i>Actions for the physician</i>	<i>Actions for the patient</i>
Potentiating autonomy	<p>Redress the deficit in autonomy the patient faces from illness and institutional practice.</p> <p>Allow adequate time for patient consideration of issues and alternatives.</p> <p>Be forthcoming with referrals to other health professionals, both inside and outside medicine.</p> <p>Minimize the imbalance created by the power of prescription by giving to the patient the benefit of any medical doubt, unless greater interests contravene.</p> <p>Educate the patient for greater independence from the medical profession in making health decisions.</p> <p>Charge accessible fees for access to health care services.</p> <p>Undermine the cult of expertise.</p> <p>Admit the limitations of professional expertise.</p> <p>Demystify expertise through explanation and demonstration.</p> <p>Assume the role of a health consultant.</p> <p>Proclaim the patient's own expertise in the personal sphere of her life, and respect this sphere.</p> <p>Maintain integrity of profession.</p> <p>Avoid binding obligations to outside agencies that exert an influence on medical care.</p>	<p>Assert autonomy, in spite of illness.</p> <p>Be willing to develop skills in independently handling health problems.</p> <p>Defend the sphere of personal values from incursions.</p>

Table 1 (continued). Actions of a Democratic Patient-Physician Relationship

<i>Values of democracy</i>	<i>Actions for the physician</i>	<i>Actions for the patient</i>
Practicing openness	<p>Make information useful to the patient.</p> <p>Conform information provided to your sense of the patient's ability to understand.</p> <p>Confirm the patient's understanding by regularly asking the patient to restate the information provided in her own terms.</p> <p>Provide the patient with full and free access to her medical record, including the ability to remove it from the premises.</p> <p>Be willing to disclose.</p> <p>Provide the information the patient requests and deems relevant to a decision.</p> <p>Contextualize the bounds of disclosability to the patient's individual assessment of relevance as stated in conversation. Provide information within these bounds whether the patient directly requests it or not.</p> <p>Apply a "reasonable person" standard to guide disclosure of information the patient neither requests nor seems to consider relevant, but which appears relevant to decision.</p> <p>If a patient request for information would violate confidentiality and yet is relevant, enter a dialog with the affected persons to find a resolution.</p> <p>Do not arbitrarily restrict what you will disclose to exclude your training and competence, fees and costs, presumptions, and the social context that influences you.</p> <p>Demonstrate the manner in which you make decisions, including the use of resources and references.</p> <p>Do not assert therapeutic privilege, deliberately withholding information, without a stated patient preference to this effect.</p> <p>Encourage patient disclosure.</p> <p>Create a space safe for disclosure by being nonjudgmental and explicitly widening the bounds of legitimate patient disclosure to include any item of concern to her.</p>	<p>Attempt to understand, and state when you do not.</p> <p>State the information you believe you need to make informed decisions.</p> <p>Disclose information deemed relevant by the physician, including your aims in seeking healing or information.</p>

Table 1 (continued). Actions of a Democratic Patient-Physician Relationship

<i>Values of democracy</i>	<i>Actions for the physician</i>	<i>Actions for the patient</i>
<i>Enabling dialog</i>	<p>Amplify the goals of dialog.</p> <p>Make explicit the goal of having a reciprocal conversation aimed at understanding and decision.</p> <p>Aim for articulation of interests and resolution of difficulties and disputes.</p> <p>Attempt to negotiate a solution satisfactory to both you and the patient.</p> <p>Be flexible about the conversational model used.</p> <p>Effectively engage the patient.</p> <p>Take time for dialog.</p> <p>Proclaim the importance of what the patient brings to dialog.</p> <p>Continuously inquire as to patient preferences, the accuracy of your sense of things, patient refusals, and patient assents.</p> <p>Solicit the patient's questions and ideas.</p> <p>Preserve the aim of aiding the patient.</p> <p>Encourage the patient to decide things that are hers to decide.</p> <p>Acknowledge but do not exploit the patient's worries and fears.</p> <p>Let the patient define and introduce novel topics, including social context.</p>	<p>Be willing to engage the physician in dialog.</p> <p>State preferences and expectations clearly.</p>
<i>Encouraging participation</i>	<p>Affirm the patient's right as a person to participate in all decisions.</p> <p>Tactfully question a patient's refusal to participate.</p> <p>Discuss all decisions.</p> <p>Undermine the authoritarian culture of medicine by generally encouraging participation of other health professionals in decisions.</p>	<p>Assert your desire to participate in decisions.</p>

Table 1 (continued). Actions of a Democratic Patient-Physician Relationship

<i>Values of democracy</i>	<i>Actions for the physician</i>	<i>Actions for the patient</i>
<i>Negotiating equality</i>	<p>Encourage equal participation by offering a contractual basis for the relationship, without abandoning fiduciary responsibility to the patient.</p> <p>Carefully and openly discuss conflicting interests when conflict occurs.</p> <p>Weigh interests carefully, considering equal interests equally.</p> <p>Defer to the preferences of the person with the stronger interests, within the bounds of fiduciary responsibility to the patient.</p>	<p>Assert your expectation to participate equally in the relationship.</p> <p>Weigh interests carefully, considering equal interests equally.</p>

Routes to achieving the relationship

At the risk of repetition, I observe the irony, in an investigation of democracy's implications for client-professional relationships, of Table 1's description of the relationship containing so many actions to be taken by the professional and so few by the client. Egalitarianism, one might expect or even hope, would demand equal participation by both the patient and physician. As stated earlier, however, we are beginning from a valley of patient power and authority, and climbing our way toward a plateau at the which the patient's power equals that of the physician. Table 1 is not meant to imply paternalistically that the patient, incapable of progress on her own, must passively rely on the physician to pull her through every inch ascended on this journey. There are other ways parity of participation might be achieved, and I have merely chosen one by which I suspect progress would be fastest. Indeed, my model is less one of the patient climbing the mountains of power from an isolated valley, and more of the physician descending from a remote pinnacle. If the physician creates a space for the exercise of democratic

decision making in the relationship, and the patient is willing to step into it, perhaps even asserting her desire for it, the greatest progress may be made most quickly.

Table 1, prescriptive as it is, begs certain questions of why these steps would lead to greater democracy in the relationship, and how they might be achieved. In this section I will discuss at greater length these issues. To some extent, great strides toward a more egalitarian medical relationship can be made by direct reform from within, through the actions of the patient and, especially, the physician. Even so, there is abundant need for reform of the outside society, and this will also be considered.

Many of the physician's actions in Table 1 fall into the broad category of creating space in which the patient may exercise autonomy and participate. There is a presumption that if the space is opened, the patient will occupy it, but how realistic is this? It is certainly true that illness may compromise both a patient's ability and enthusiasm for sharing in medical decisions. And yet, my own experience in the hospital suggests that the vast majority of persons requiring even acute care are quite willing and able to participate, if encouraged to do so. The problem is not only lack of encouragement, but lack of proclamation that decisions exist, and that the patient has a right to be party to them. Simple, empowering statements along these lines can completely transform a patient's appraisal of their role in the clinical environment. Without such statements, the hospital or clinic frequently become incomprehensible, threatening, "surrender-prone medical settings"³ that induce withdrawal, not assertion or participation.

I have already mentioned the wide spectrum of quality I witnessed for informed consents while working as a Spanish-English interpreter in a US teaching hospital. What is of interest is that the patient's behavior changed markedly based on the packaging of the consent procedure. Typically, a patient at whom a consent form was thrust with minimal explanation would simply sign and not bother reading. Even if the process were explained at some length, the patient would usually sign without reading. But if any statement, to the effect that the patient *had a right to read whatever she wished of the form prior to signing*, were introduced, patients almost uniformly read the entire form. This hardly represents a controlled study, but reflection on the behavior of humans in any institutional session suggests that encouragement to exercise one's rights is an important mediating influence on the actual exercise of one's rights. Unfortunately, the converse is equally true! For this reason a tremendous gain could be made in the expression of patient autonomy through participation, merely by encouraging the patient's natural inclination to participate, rather than squelching it through such routine acts as failure to proclaim decisions exist and that the patient is among the principal decision makers, if not *the* principal decision maker. Clarence Braddock spoke to this point when he wrote, "Physicians may assume that patients will speak up if they disagree with a decision, but patients often need to be asked for their opinion. It should be clear to the patient that it is appropriate to disagree or ask for more time."⁴ Ideally, a patient should know their participation is valued and feel comfortable in this role, but because this normative statement is so at odds with medical culture, it is imperative that they be encouraged to participate.

The importance of the patient's assertion of her autonomous preferences is so great it bears repeating. John Dewey, writing in a different context that nevertheless has a bearing in the patient-physician relationship, said, "No government by experts in which the masses do not have the chance to inform the experts as to their needs can be anything but an oligarchy managed in the interests of the few. And the enlightenment must proceed in ways which force the administrative specialists to take account of the needs. The world has suffered more from leaders and authorities than from the masses."⁵ Autonomy is critical to medicine because in most medical situations there is no "obvious objective way to maximize a person's well-being", to use Jodi Halpern's words. Medical decisions are no more decidable objectively than decisions of work, marriage, or any other deeply personal matter.⁶ Thus the physician, as expert, requires the patient's autonomous statement of her needs, and further must act on it in order to avoid worsening the patient's suffering by wittingly or unwittingly managing the relationship in her own interests. Moreover, as Dewey suggests in his reference to "administrative specialists", medical institutions and not merely physicians must be equipped to solicit and respond to patient needs.

In highly ranking patient autonomy among the values of the democratic patient-physician relationship, it is important to address the concern that support for autonomy leads to the patient's isolation and abandonment by the physician. Atul Gawande, addressing Jay Katz's work, once asked whether it might even be cruel to expect a person to make their own decisions.⁷ These concerns are less pertinent than they might seem, in consideration of the fact in the democratic patient-physician relationship, patient

autonomy is promoted in the context of a mutual and participatory relationship. By encouraging patient autonomy, the physician does not so much place the burden of decision on the patient, as she supports the patient in assuming some (but not all) of the burden, and a portion necessary to secure the patient's best interests. In the democratic dyad, a decision that is "the patient's" is not truly the patient's alone. Rather, it is a joint decision of physician and patient, in which, through dialog, the patient's interests have been identified as greater than the physician's or the community's, and the physician awaits the patient's judgment with the intent of supporting it, in effect "voting" the same way as the patient. Katz has also cited the importance of conversation in placing individual autonomy in the supportive community of the dyad, without which there is a real risk of abandonment.⁸ To support someone in their autonomous decisions is to support their values, and in fact Katz has identified the refusal to allow a patient's autonomous participation as itself a form of abandonment.⁹ The democratic endorsement of patient autonomy is based on a mutual process in which patient and physician work toward one among their common goals, the patient's healing and health.

The proclamation of the existence of decisions, and the patient's right to participate in their resolution, is one mechanism by which the democratic patient-physician relationship may be achieved. Another is a recasting of the formal basis of the relationship as a contract rather than a code or covenant. Timothy Quill has advanced a contractual model of the patient-physician relationship, emphasizing the distinct responsibilities of patient and physician, the consensual nature of the relationship, negotiation as a means for formulating plans and solving disputes, and the need for both

patient and physician to derive benefit from the relationship.¹⁰ My formulation in terms of the five values of democracy has considerable affinity for Quill's approach. By making the parameters of the relationship explicit and subject to scrutiny by both patient and physician, Quill in effect permits democratic decision making to be applied to the fabric of the relationship itself. This greatly enhances the equality of opportunity to participate of patient and physician, and at a very fundamental level.

The contractual model is sufficiently distinct from contemporary practice that it represents a route by which the democracy of the patient-physician relationship could be greatly amplified. By its nature, contract tends to bring critical matters into the open and clearly delineate expectations concerning them. Katz has written that, "Without a sharing of such vital information, physicians and patients become estranged from one another; recommendations become orders and advice becomes command."¹¹ A contractual relationship thus addresses many actions required for a democratic patient-physician relationship, and mitigates some of the problems of the current relationship. The needs of both patient and physician are considered, allowing each to perceive and respond to the others' interests, and encouraging the expression of information that normally remains unsaid. Iris Marion Young wrote, "If we consider just democratic decision making as a politics of need interpretation, as I have already suggested, then democratic institutions should facilitate the public expression of the needs of those who tend to be socially marginalized or silenced by cultural imperialism."¹² Contractual negotiations serve to let the historically marginalized and silenced patient participate in need interpretation, through a democratically revised patient-physician relationship. In addition, contract

allows both parties to be fully participant at the outset of the relationship, leveling the tendency of physician authority to dominate. And finally, a map of the relationship is established through dialog, which can serve as a reference over time and a basis for future behavior and development.

One objection William May has made against contract is that it excludes the dimensions of indebtedness and obligation in the patient-physician relationship.¹³ This charge, if born out, would be a serious blow to my endorsement of contract, particularly in that I have made frequent recourse to the physician's fiduciary relationship with the patient to justify physician-initiated efforts to expand the patient role. I do not believe, however, that the dimensions May believes are excluded must necessarily be so. While both May and Quill suggest that contract has a precision at least somewhat incompatible with statements of indebtedness or general obligation, I claim that these could be made contractual provisions as readily as any other commitment in the relationship. They would be provisions of different character, and would be more difficult to assay for compliance than would be more specific provisions. From the perspective of democratic openness, however, I cannot view it as anything but salutary that these more diffuse obligations be brought into the open during the process of contract formulation. They are certainly relevant to decision making and are rarely made explicit in the patient-physician relationship. Even if it were logically impossible to enshrine such aspects of the relationship in contract, there is no reason these principles could not continue to influence the conduct of patient-physician interactions, as Quill himself suggests they could. Holding major determinants of the relationship outside a contract purporting to define the

relationship would greatly weaken the utility of contract, but not irreparably so. The alternative, after all, would be the continued obscuring of patient and physician expectations; at the very least, a contract would bring some of these to the light of day.

Thus far I have advanced the making explicit of decisions, duties, and expectations, the latter two via contract, as routes to achieve a more democratic patient-physician relationship. As a final technique that might be employed, I offer a potential enhancement to patient-physician dialog invented by Brazilian educator Paolo Freire. Freire's educational methods promoted the idea of everyone as a learner, or student-teacher, rather than segregated roles of expertise (teacher) and ignorance (student). He believed that each person brought distinct knowledge to the learning encounter based on their personal experience, and that learning could be directed to social betterment by engaging the learners, in their diversity of knowledge, on issues of social import.¹⁴

One technique Freire used was called a *code*. It used representations of social realities, such as stories and pictures, as the starting point for a facilitated discussion concerning an issue related to the material portrayed through the representations. For example, a discussion concerning housing as a human need might have begun with an array of pictures, each depicting a different dwelling, ranging in character from impoverished, to humble, to opulent. The participants might have been asked to select the picture representing the house most like their own, or that showing a house in which they would prefer to live. Afterward, the discussion may have concerned why people live in the houses they do, or how people could go about securing the house they wished.

For several reasons, I introduce Freire's technique as another path to a more democratic patient-physician relationship. One is to illustrate a radically different, and more open ended, interaction, to contrast it with the often stereotyped interaction between patient and physician. I have encouraged physicians to be open minded about the conversational model they use with patients, with the implication that allowing the patient a greater role might take the discourse in new directions. How different? Potentially, in so different a direction the physician would have as little sense of what was expected as the patient often faces in the typical medical interaction. This sense must become acceptable to the physician if the patient is to share equivalent control in shaping the interaction.

A second reason for my recourse to Freire regards my claim that the unilateral structuring of this interaction by the medical profession tends to exclude certain content from discussion, such as the social context in which patient and physician operate. Freirian codes are intended to expose matters such as this. While the Freirian code is in stark contrast to the typical medical encounter (though in some specialties it might seem very familiar, such as psychiatry), I advance it because of the lack of techniques in medicine for exposing social context and the presumptions both patient and physician may have concerning it. In addition, Freire's methods tend to fulfill one function of decision making counsel identified by Amy Gutmann, namely helping the client "understand and develop [her] own values".¹⁵ By eliciting people's reactions to social situations, and asking them questions such as how they would respond personally to such situations, both the questioner and the answerer may learn something about what

motivates, preoccupies, or concerns the answerer. Finally, Freire's methods are another vehicle by which reflection between persons may be carried out. Jay Katz highlighted the importance of this in decision making: "In my view, the right to self-determination about ultimate choices cannot be properly exercised without first attending to the processes of self-reflection and reflection with others."¹⁶

I have advanced three methods by which the internal terrain of the medical encounter might be made more hospitable to democratic decision making. There are substantial outside constraints to this process, however, that make the route to democratic reform dependent on more than changes in the patient-physician relationship. These abundant constraints include economic pressures that limit the time patients spend with physicians, the limited supply of health professionals, the power of prescription, restrictions on patient access to medical records, and the existence of physician obligations to outside entities such as pharmaceutical and insurance businesses. Howard Waitzkin wrote, "...it is foolish to think that changing the doctor-patient relationship in itself would lead to wider social change...Modification of doctor-patient relationships needs to accompany change in the larger contextual conditions that impede a decent and humane health-care system."¹⁷ Therefore the democratization of the patient-physician relationship relies on social action in addition to individual action.

It will be recognized that the social constraints listed above are all factors which rebound to the material benefit of physicians. The only possible exception is that of insurance, which has turned against physicians as the corporations' power in the health care system has eclipsed that of physicians. It is certain, however, that physicians retain

considerable political and even moral authority in society. The realization of a democratic patient-physician relationship through social reform will rely heavily on physician organization in favor of this reform, until such time as patients themselves, or the people in general, are sufficiently organized to effect change on their own.

How could physicians' be motivated to act against a system that is materially to their benefit? Every human has multiple motivations for her actions, materialism being only one. The physicians have a particular motivation related to their pledge to care for the sick. As I argue below, the current lack of democracy in the patient-physician relationship is itself detrimental to the efficacy of this pledge. Physicians therefore might be motivated to organize against the external constraints on the medical relationship on the basis of the integrity of their profession to patients. The constraints mentioned are fundamentally corrupting of the patient-physician relationship because they place physicians' material interests in conflict with those of their patients. This is a reality against which every physician should rebel. And indeed, physicians should work as well toward redressing the imbalance in authority between client and professional at the social level. At this stage it is likely that only a unified opposition of physicians and patients will be able to reverse the features of the US healthcare system that externally impede the democratization of the patient-physician relationship.

Why the democratic relationship is good for medicine

Of all the benefits to medicine itself from a more democratic patient-physician relationship, none is greater than the potential for improving the health of patients. Some evidence suggests, perhaps surprisingly, that this may occur through direct, positive

effects of participatory decision making. Earlier I referred to Peter Bachrach's thesis that human fulfillment is dependent in part on the ability to participate in decisions affecting oneself.¹⁸ This idea has intuitive appeal, based purely on the unpleasant experiences any of us have had of feeling out of control and powerless to obtain relief for ourselves. And yet, Leon Eisenberg, citing a study by Kaplan and others, reported that in medical encounters, "better health outcomes resulted when the patient had greater control over his or her own care, expressed more affect, and sought and received more medical information during the interview."¹⁹ It is as if the sense of control that accompanies meaningful participation is itself therapeutic. Placing the finding in the context of the current work, it appears that in the medical setting a more democratic patient-physician relationship may itself be therapeutic.

Without doubt, however, a democratic patient-physician relationship improves medical care through secondary effects as well. These effects are ameliorative ones that remedy problems in medicine that interfere with its mission of health. For example, in the wake of a recent report by the Institute of Medicine, great attention has been turned to the problem of errors in US medicine. It is estimated in this report that as many as 90,000 people may be killed through medical accident annually!²⁰ I have argued above that improved patient participation serves as a check on errors by medical personal, and indeed, Amy Gutmann and Dennis Thompson have identified error correction as one of the functions of deliberative democracy.²¹ Among the others are encouragement of mutually respectful dialog and legitimation of group decisions. Both these functions would also be of benefit to medicine. Respectful dialog could relieve the sometimes

strained relations between patient and physician, particularly at times of conflict. Legitimacy of decisions refers, in the case of the dyad, to the belief by both members that decisions already made reflect compromises by both, and are therefore to be accepted. The oft cited problem in medicine of patient compliance could become moot if the patient supported medical decisions as, in part, of her own making. In addition, the resentment that at times breeds malpractice complaints would likely be lessened if both patient and physician were committed, at all stages of the relationship, to cooperative decision.

A final strength of the democratic patient-physician relationship in improving medicine is that it operates while involving both the patient and physician. Democratic theory embraces a family of communication strategies the purpose of which is, in the words of Wendy Levinson, "not to convince the patient to do what the physician desires, but rather to understand the patient's concerns and make decisions that are *acceptable to the patient and physician*. [emphasis added]"²² While there are other possible changes that could mitigate some of medicine's problems, or that could directly improve patient health, application of the ideals of democracy to the patient-physician relationship offers the opportunity to realize these gains while simultaneously enhancing the participation of the two most immediately affected by medical decisions - the person seeking healing and the healer.

Why the democratic relationship is good for democracy

I have outlined in brief certain general benefits that the democratization of the medical encounter might offer medicine. These are against the backdrop of my prior arguments concerning the particular improvements democratic decision making might

allow. Throughout this work, the focus has been on the client-professional relationship, and especially on the patient-physician relationship as a particular case. In this final section, I consider the implications for democracy as a whole of a democratic patient-physician relationship.

In Chapter 1 I asserted that democracy relies on particular values for the fruition of its promise of shared decision making. Among these values, autonomy is noteworthy for the material preconditions it imposes on the larger society, and among autonomy's preconditions is health. Medicine, in US society, is one among multiple mediators of health, perhaps a key one. By the preceding logic, medicine thus becomes effectively a prerequisite for democracy.

Earlier I distinguished between decisions made democratically and decisions that are democratic in effect. While a decision making process can be characterized as democratic based on the presence of shared decision making supported by the five key values, the characterization of a society as democratic relies on the predominance of shared decision making among all decisions made, and on the robustness with which the five values are exemplified in the society at large. Decisions that are antidemocratic in effect are those which circumscribe the sphere of shared decision making, or which undermine the core values of democracy. The more numerous and significant such antidemocratic decisions are, the less democratic the society as a whole becomes.

Medicine in US society exists, undoubtedly through both accident and design, in substantial conflict with the values of democracy. As a resource, it is extremely nonuniformly shared, with at last count some 42 million citizens uninsured and facing

corresponding impediments to their access to health care.²³ Because of the strength of the physicians as a profession and the cultural definition of professionalism itself, there is little public authority over its operation. Much of its practices and tools are shrouded in obscurity, by rules of confidentiality, by patents, and by deliberate obscurantism. Interprofessional relations are organized as a hierarchy of power, with multiple tiers beneath the physicians. Finally, medicine's hallmark, the relationship between patient and physician, is characterized by a tradition of unilateral decision making that effectively limits the role of the patient in her own care. Medicine's general antagonism for democracy itself detracts from the democracy of US society as a whole. Both as a prerequisite for democracy through the importance of health to autonomy, and as a significant social institution in its own right, medicine threatens democracy by its sheer lack of it.

To democratize the patient-physician relationship is, of course, not to democratize medicine as a whole. As seen above, medicine is far more than the dyad between client and professional, even if the latter is its center. Nevertheless, creating a more democratic patient-physician relationship could be a first step in the larger struggle to democratize medicine. In its own right, a democratic patient-physician relationship would enhance the democratic character of medicine, and there is reason to believe the effects of this change would not end there.

Imagine, for example, a patient who enjoys an democratic relationship, as I have defined it, with her physician. She considers her physician not as a heroine, goddess, or sorceress, but as a health consultant with particular expertise relating to medical care.

She is accustomed to exercising a major role in all decisions, and in fact to have the same opportunities to participate as her doctor. She expects to engage the physician in dialog, and to have access to information needed for decisions. When disputes arise, the patient is accustomed to openly considering the conflicting interests, and to reach a settlement by careful reflection on these interests, with similar interests being reckoned as having equal weight.

Now imagine the same patient in her interactions with staff members in the physician's office, or with other health professionals such as nurses, or with her health insurance company. Will she be any more willing to cede active status in decisions involving these people than she would be with her physician? Perhaps, for matters she does not consider of particular note, she will have no expectation of a fully democratic relationship. It is likely, though, that her experience with her physician will influence her expectations of how she will participate in any decision of importance. The experience of democratic interaction in one thoroughly important context may be seminal for the rest of her experience with the health care system. As my personal experience working in a hospital bears out, people in need of medical assistance may well not assert their rights on their own, but if given encouragement they often vigorously exercise them. Imagine what the health care system would be if people did not wait for such encouragement, but routinely asserted their autonomy! Democracy is an infectious philosophy in more than one sense.

Howard Waitzkin wrote, "A vision of progressive medical discourse must include a conception of how professional-client relationships either reinforce current social

conditions or contribute to change in those conditions."²⁴ I would conclude with consideration of how a democratic patient-physician relationship might contribute to changing social conditions in the United States. The experience of medicine in the life of the hypothetical patient above might well be no more confined to medicine than it was to her experience of the patient-physician relationship. Medicine is only one context of many encountered by people in their daily lives. Arguably, it is far less important, based on frequency and duration of contact alone, than institutions such as the workplace, the church, the school, or the home. Nevertheless, the experience of democracy in the patient-physician relationship could shape the patient's expectations for conduct in other settings. Gutmann and Thompson asserted that, in the area of disputes alone, "Democracies cannot avoid disagreement, but citizens, professionals, and public officials can deliberate about their disagreements in a way that contributes to the health of a democratic society."²⁵ In a similar way, the conduct of medical encounters may contribute to the health of democratic society, through the degree to which those encounters express values of autonomy, openness, dialog, participation, and equality.

In *On Revolution*, Hannah Arendt describes one peculiarity of the founding of the republic of the United States. Jefferson, along among the founders, seems to have appreciated that in creating a representative, constitutional form of government, at a level far higher than the town hall meetings that had given birth to the revolt against Britain, the founders had essentially nullified the one authentically democratic context the people had known. No space had been left for the average person to exercise her public duties as citizen. Later in his life, Jefferson focused on the possibility of a system of government

based on wards, or subdivisions of the counties, as a means of putting democracy back within reach of the people.²⁶ Jefferson's fears have been realized: democracy has become something exercised infrequently, through secret ballot, and little more. The promise of the democratization of the patient-physician relationship, and in general of the application of democratic theory to everyday experience, is that it opens a new frontier for the exercise of democracy in the interactions we have with each other, one whose borders may expand by the will of the people.

Conclusion

This work had its genesis years ago, in an idle remark made to a group of friends that medicine would be a fit subject to which to apply democratic theory. At the time, I was considering the gulf between the democratic ideals of the United States and the frequently nondemocratic, or even antidemocratic, experience of its citizens. It seemed medicine, with its richness of social manifestation, its importance, and its myriad injustices, was ripe for a democratic critique. But of course there were many such targets, and I was undoubtedly drawn to medicine because of my interest in studying it and becoming a physician. The thought that what I would eventually do as a physician, talking to people, and trying to help them toward a healing action that was right for them, had something to do with my ideals, including political ideals, motivated this study.

This document, as the result of that long ago beginning, satisfies my expectations in some respects and surprises me in others. I embarked with a conviction that democracy meant more than population based, formal processes of electing officials, and in particular that democracy held implications for the deep structures of society. In the research I conducted concerning democratic theory, I found considerable support for this conviction. The fact that I turned to describing the meaning of democracy for relationships of only two people was something I did not originally anticipate, but in the attempt I have learned a great deal about what democracy is and just how deeply in human experience its ideals may be extended. The interface between democracy and client-professional relationships, and in particular between it and the patient-physician relationship, has been a challenging proving ground for my own sense of the everyday

democracy that can occur in very small groups. There is a tension between democratic ideals and the dependency inherent to client-professional relationships that I have not resolved, but only identified and placed in the context of a value-based democratic theory. In doing so, I have fulfilled one aim of this research, namely that of giving myself some intellectual guidance on how the physician (or medical student) may both infringe on and cultivate the democratic aspirations of the patient, in the course of facilitating their health. And perhaps the greatest surprise to me, which in retrospect should have been no surprise at all, was the fact that democracy in the patient-physician relationship does not simply imply an unlimited space in which the patient can exercise her autonomy, with the physician satisfying her every desire. The fact of the patient-physician relationship as a dyad, an interaction between two people, embedded in myriad other social interactions, made me appreciate the need to include the physician, her autonomy, and her aims in any treatment of this subject, as well as some consideration of the society at large. Writing this thesis has taught me a great deal about democracy, patients, and physicians.

In a real sense, the material on the democratic patient-physician relationship is merely a recasting, in a democratic framework, of the seminal work on egalitarian communication in the medical encounter by Jay Katz. His work, *The Silent World of Doctor and Patient*, more eloquently articulates the need for a new ethics of communication in the patient-physician relationship than any other I have read. One point at which Katz's words resonate especially strongly with my thesis is in a historic reference, where he writes, "Pioneer America distrusted specialists. Its confidence in

common sense of citizens extended to the management of illness, which it believed should be left to citizens' individual judgment. The idea of a profession with special prerogatives was repugnant to a rising American democracy. To prescribe high qualifications for, and to limit access to, a profession seemed undemocratic and un-American."¹ When I began considering this topic, I wondered if, indeed, professionalism were simply antidemocratic, and if I would end by advocating a return to Jacksonian ideals of self sufficiency, the complexities of modern medicine notwithstanding. But the relationship between professionals, as highly trained specialists, and democratic society is far more complicated. In some ways, such as its sequestration of control of important social resources within the clique of professionals themselves, professionalism is antagonistic to democracy. In others, such as the making available of expertise that enhances people's ability to live their lives autonomously, professionalism is a profound asset to democracy. If there is a return to the ideals of Andrew Jackson's day that I endorse, it is that democracy should inhere in the client-professional relationships of democratic society, not in the sense of obviating or eliminating professionals, but in leveling the power disparities that have arisen between client and professional, to the detriment of both, and to democracy as well. And as Katz wrote, "Challenging the long-standing tradition...requires nothing less than uprooting the prevailing authoritarian value and belief systems and replacing them with more egalitarian ones."²

I mentioned above that the patient-physician relationship was not my original focus. Through the wisdom of my advisers, my initial area of application for democratic theory was reduced from medicine as a whole to the interaction between client and

professional. This reduction was entirely reasonable and fruitful, but there does remain the larger project of democratizing medicine, of which democratizing the patient-physician relationship is only one part, albeit an important one. Medicine is beset by colossal distributive injustice, affecting not only access to medical care but to health insurance and pharmaceutical treatments, both on a national and international scale. The idea of health, and therefore medicine, as a prerequisite for autonomy and, indeed, democracy is probably even more powerful in this context. Without democratic control of the distribution of medical resources, a democratic patient-physician relationship may be like an egalitarian island amid a stormy, unjust sea. Extending the gains of democracy in the medical encounter to these frontiers will require ambitious organization and agitation, by physicians, non-physician health professionals, and patients. This process is itself one of great import for democracy, for it relates to the issue of the actors mentioned, not as separate constituencies, but as different sectors of a single constituency, sectors with fundamentally similar interests in obtaining the best care possible for all. Organization here leads to questions of a public voice in medicine, and in particular a public voice in the professional affairs that in part shape medicine. Katz writes that for professionals, "the cause for freedom from lay control loses much of its force in a democratic society that in principle is opposed to granting unnecessary authority to any group, particularly when such authority impinges on citizens' rights to make decisions that are most intimate and personal in nature."³ The beginnings of democracy in medicine, in the interaction between patient and physician, are bound to eventually encompass contentious questions such as these. While their resolution will be difficult, if

it is sought and carried out with a commitment to shared decision making, in a setting of autonomy, openness, dialog, participation, and equality, the results will be to the benefit of all.

The democratization of medicine, beginning with the patient-physician relationship, can both amplify democracy in the society at large and improve medicine on its own terms. Katz propounded, "What is therapeutic for citizens turns out to be equally therapeutic for patients."⁴ This is my conclusion, that in any interaction, whether as physicians or patients, students or teachers, husbands or wives, people are served by what democracy offers: "...to be trusted and to trust themselves, to be allowed to stand on their own feet and not to have their dependence exploited, to be talked to and listened to, to be treated as equals and not to be ruled, to have their life style treated with respect, and to be allowed to live life in their own self-willed ways."⁵ There is healing in the narrow sense of medicine's use, and healing in a broader sense as well, a social sense, of which medicine can also be a part.

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Conclusion

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