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One of my earliest memories is of our family doctor. In my young mind, Doctor Dunn was associated with the parish priest. Both he and Father Brown were larger-than-life figures. If either visited our working-class home, it was a very special occasion.

What sticks in my mind from those visits was the strange way my father acted in the presence of either the doctor or the priest. My dad was a big man who worked all his life making large iron castings at a locomotive plant. At work he was the boss, and he definitely played that role at home. It is not an exaggeration to say that we children were afraid of him. But when Doctor Dunn or Father Brown stepped into the living room, I remember being shocked at how differently he acted. It was as though the doctor or the priest had become the father of the family, and my big tough dad had become one of the children. I didn't know the word, then, for what was going on, but later on I found out that it is paternalism.

If my father became sick enough to call the doctor, it was serious enough to force him to abandon both his working and parenting responsibilities. Then Doctor Dunn took over as boss, giving orders, restricting activity, even requiring that my all-powerful father seek permission to alter any aspect of the prescribed regimen. The doctor definitely played the parent role. He called my dad Jimmy, but my father always referred to him as "Doctor Dunn." (I don't think I ever heard his first name.)

Like my father, Doctor Dunn often expended himself for us children. Many times he came late at night, and everyone remarked how tired he looked. In effect, he did all the things we associated with being a father or a parent. Our Irish Catholic, working-class family may have been slightly more deferential to the doctor than most families, but in those days the doctor was generally a powerful figure. He knew about disease and illness, which were mysteries to everyone else. Associated with his superior knowledge was the power or right to probe the bodies of both young and old, male and female. If disease and illness disrupted life, his role was to restore order and strength.

Doctor Dunn must have been well paid by the standards of our working-class neighborhood. At least he looked affluent, drove a big car, and for us children demonstrated the ultimate in affluence: he gave us quarters instead of pennies or nickles. And yet I never heard any complaints about his bills or charges, and those were days before Blue Cross/Blue Shield. In addition to whatever he charged, he received the enduring respect of those he cared for. He was definitely a parental figure and exercised paternalistic authority.

Enormous opposition has risen to this parental image of the physician and to its associated paternal authority, however. Why? How did such a strong and ancient role recede so quickly? Certainly there were bad doctors who, like bad parents, abused their power and authority. But instances of bad parenting/doctoring alone do not explain the widespread changes. These only fueled strong objections to the paternal power of physicians coming from many sources.

Libertarian critics of modern medicine insist that adults are not children and should never be treated as such. According to this liberal philosophical view, no one can rightfully exercise parental authority over mature persons. No good, according to the liberals, not even the restoration of health, can justify a diminution in the autonomy and self-determination of a mature adult. Being a human person means acting upon one's own interests and wishes, and anything less than the full exercise of autonomy mocks the true image of human being. There is no place, according to these thinkers, for regression to child-like status, not even temporarily for relief and repair. Autonomy is what is human being and therefore is the highest of all human values. Consequently, parental doctors and their parental ways are wrong, and where paternalism lingers it must be removed. Paternalism is referred to as parentalism and is up against the legions of freedom fighters for today's patient population.

Strong images like that of the doctor as parent do not suffer a decline simply because of criticism or opposition. Ordinarily images which are deeply rooted in culture are not seriously threatened by philosophical objections. Because they are concrete and solid, such images have enough of a life of their own not to be extinguished by the fires of academic debate. But when cultural changes occur, on

which the images are based, then real pressure is created agai t tradi-tional ways.

This is just what is happening today in medicine. Once th doctor/patient relationship, the state/citizen relationship, the e ployer/employee relationship, and the church/member relationshi were all patterned on a parental model. Not only was the doctor a p nt, but so, too, was the ruler, the boss, and the pastor. These o r basic cultural arrangements gave support to the parental image in edicine. Once they changed, however, pressure was generated for ange in medicine.

In today's politics, the leader no longer appears as fathe and citizens no longer think of themselves as obedient children. Western Europe and America, at least, elected presidents serve th citizens. They have replaced kings and dictators who thought of th selves as fathers, prescribing what was best for their people.

Religion Less Paternalistic

Under the influence of Protestant reformers, religio too, has become less paternalistic. Pastors are hired by their congr tions, and serve at their pleasure. Parent-like behavior by pastors in n ny Protestant congregations is considered inappropriate. Any atte t to exercise parental authority is likely to be followed by the fo ation of a search committee for a new pastor.

Even in the world of work and economics, the parent model was once dominant. In an older form of capitalism, the fa ory owners provided homes and stores and medical care for wo ers. It was expected that sons would follow their fathers into the m ll, and they were given preference in hiring. Years of loyal service y a worker once were rewarded by paternalistic owners with some f rm of social security, but that is gone almost everywhere. Now the w rker is a free agent who moves from place to place, as he or she is given a better contract. There is little sense of permanence about employment today — no particular loyalty to the company, and neither a filial respect on the part of workers nor much parental concern expressed by employers.

Free association and contracts have replaced the family as a model for relationships in all the basic institutions of our society. Outside the family, father images and parental authority seem inappropriate to many persons. Even within the family, the traditional understanding of what it means to be a parent is under pressure. Children demand shared authority and participation in decisions which affect their lives. How can the doctor continue to be perceived and related to as parent when the parental image has all but disappeared in other parts of our culture? Even the paradigm of father as family authority has been weakened.

The fact that people move every five years or so is another important factor pushing for change in the parental model in medicine. More and more Americans choose a doctor over and over again. As they move, they continuously see new doctors in new clinics in new towns. The doctor for them is an interchangeable commodity and nothing like what Doctor Dunn was for our family. The philosophers, sociologists, and ethicists who criticize paternalism in medicine are not the principal powers pushing for change. Rather, they are articulators and interpreters of changes which are taking place elsewhere.

Doctors themselves can be said to have contributed to the decline of the parental image in medicine. New doctors prefer a contract model for delivering their services. Medicine, like the work place, the church, and the government, has become bureaucratized and specialized. In this new setting, the idea of a doctor being bound by ties of commitment, fidelity, and service to a family, and responding to its needs out of a sense of vocation seems strange and old-fashioned. The new doctor is a specialist, a businessman, perhaps the director of a small firm. Is it any wonder that the authority of the physician, once so much like parental authority, is in decline?

There was a time when young doctors learned to be parental in medical school. Medical education was primarily a series of personal relationships, learning not only from father figures, but being treated in filial ways by medical mentors. Look, for instance, at the responsibilities the young physician felt to his mentor in the Hippocratic tradition. The doctor/teacher was the adoptive father. The old apprenticeship system used the family image. Both the young physician and the patient once looked upon the attending doctor as father or parent. But attending physicians now tend to be hard-driving, ambitious, tough fighters in a highly competitive and meritocratic setting. Young doctors today are not around parental models, and consequently will not be parental themselves. Patients in turn do not give them parental authority and respect.

The institutions in which doctors train also contribute to the disappearance of the paternalism. University medical centers are huge impersonal institutions which manage patients, along with their illness, grief, family, and everything else. Patients are controlled in such settings, but it is a rational/technical rather than a personal/parental control. Patients sense that they are part of a larger system with its rules and routine. Almost nothing about the sick person lies outside established procedures. Patients eat, sleep, visit, make themselves available for mysterious procedures, and do it all according to an institutional routine. Today's patient is subject to an almost total control, but without the personal authority of the fatherly physician. Some unfamiliar doctor says, "We're going to be changing your treatment plan," or "You won't be going home as scheduled because we have to run some more tests before we discharge you."

Big medical centers exercise powerful authority but witho any of the mitigating personal factors of the older paternalism. If patient "gets balky," naked power may show itself. A tough do r may appear on the scene and ask sternly, "What's wrong with y ? Don't you realize we're trying to help you? If you don't do wh we ask, you'll get worse or become a cripple or die." In a total instit on, it is difficult to resist authority.

The new perspective payment system (DRG) will contin nd perhaps intensify this non-parental authoritarianism. In ord to keep their costs down, hospital administrators may have to offe onomic incentives to physicians whose patient care strategies increa hospital profits. Rewards may be offered if physicians can hold a le n of stay in the hospital below some statistical norm. With such a s em, how can the patient continue to trust that doctors will act like g d fathers and do what is in the patient's best interest? If doctors ar oncerned primarily for the hospital, how can they continue to be p ental figures for the patient?

What's to Become of Traditional Image?

Under this new payment system, what will happen the traditional image of the doctor and the traditional ethic th makes the patient's good the doctor's primary obligation? The doct is a professional in the sense that he professes a commitment to the atient. Will the esteem in which the physician is held be further co romised by an erosion of the doctor-patient trust? The new system health care delivery may create serious conflict of interest proble for physicians. Legally, will doctors someday have to disclose in erest adverse to the patient before establishing a doctor-patient relation hip?

All the developments we have described have had an impact on patient attitude toward doctors, which could be understood as a rebellion against parental figures. In West Palm Beach, Florida, for example, with one of the highest doctor-to-population ratios in the country, a People's Medical Society has been formed, committed to pulling the doctor from any place of authority or honor. After only one year this radical anti-paternalistic organization has 35,000 members and is growing by 1,000 a week. The groundswell of opposition to physician privilege focuses on the doctor's treatment of patients and specifically on the cost of medical care. The executive director stated the Society's objectives in simple but direct terms: "No more patronizing attitudes, technical jargon, overtreatment, or disregard for costs. We're only asking doctors the same thing they ask from their Mercedes dealer's service department — up-front costs, prognosis, and 'You can't go ahead and do anything until I give you my full approval.' " People who once treated doctors with the deference due a parent now treat them like automobile dealers.

This same organization is gathering information on doctors all over the country and rating them in light of their data. Patients fill out forms which ask about fees, disclosure of information before tests and treatment, qualifications, length of office wait, etc. Obvious to anyone looking at these categories is a set of assumptions far removed from paternalism, about how doctors should act. These patients treat doctors as merchants rather than parents, and are involved in a mixed consumer/oedipal rebellion. According to their capitalistic image of medicine, what is needed is a strong dose of competition among doctors. What must of necessity disappear, according to these old rebels (they are primarily senior citizens), is the parental deference once paid to doctors.

Despite all this, once patients move into the clinical settings, the parental model which has been battered by all the above-mentioned developments makes something of a comeback. Given half a chance, the parental mode of relationship reappears because acutely ill patients frequently force the doctor into a paternalistic role. At certain times, it simply seems natural even for older people to need a parent and, as my father did on occasion, it seems appropriate to adopt childlike, obedient postures. Freud had an explanation for this.

Very early in his career, Freud discovered that patients developed intense feelings for him. Usually they were positive, loving feelings, associated with deferential attitudes, but not always. After puzzling over these peculiar behaviors for some time, Freud concluded that they originated in intense early attitudes toward parental figures. The child's wish to be loved and cared for by the parent was "transferred" to the doctor. The transference, he concluded, accounts for the tendency of the patient to love the doctor and gave the doctor a special authority. It accounts as well for the often inflated expectations which patients bring to the therapeutic relationship and for their bitter disappointment when something goes wrong.

What Freud discovered about the doctor/patient relationship is not confined to psychiatry. Many instances of contact between doctor and patient involve a transference. This is especially true in cases of serious illness. One objective of both statutory and common law over the last 25 years has been to remedy a perceived inequality in clinical relationships by requiring more patient participation in decision-making and imposing on doctors new obligations to guarantee patient participation. Despite this effort, more often than not, seriously ill patients still treat doctors as parents, asking them to make the decisions and to do what they think is best. Despite all the arguments for autonomy and the effort of liberalism to create equal relations in medicine, paternalism inevitably reemerges in certain situations.

Even mentally healthy patients frequently invite this exercise of paternalistic authority because illness, weakness, vulnerability, and fear of death all combine to cause a normal regression in the service of

the ego. Patients adopt childlike attitudes in order to cop with a threatening situation. Sick people do not want their auton y promoted. They want to be restored to health and, in the pr ess, are anxious to be treated as children by a considerate and c petent physician. Nearly 100 years after Freud discovered transfer ce, and despite all the changes we mentioned above, many patients s l relate to physicians in traditional paternalistic patterns.

But paternalism is more difficult to exercise now, ever hen patients demand it or invite it. With science firmly establis d as the paradigm for medical understanding, and technologies p iferating which aid both in diagnoses and treatment, the physici is much more powerful. Three or four equally effective approach now are often available for promoting the patient's well-being. Wh this happens, who chooses the treatment to be used? The doctor's reference may reflect his own values and interests. It is only reasona that the choice be made by the patient in light of the patient's val and not by the physician doing what he thinks is best. Increasingly ore adult decision-making is required of the patient.

The doctor today continues to be invited to play a ternalistic role, but one which is modified by the new situation in m icine. The above-mentioned factors have brought about change, but t as many as one might think, because there are still doctors wh merit the patient's trust and permit the transference to develop. lature and reasonable people still prefer to hand over to a trusted p ician decisions about what is best for their welfare. Usually, how r, the doctor cannot any longer simply do what he thinks is best fo he patient. Rather he has to learn, through discussion, more about e patient's values in order to help the patient to participate in the d ision about what is best. The transference still creates the basis fo paternalistic behavior, but now it is a modified or soft paternalism.

A Religious Basis for Paternalism

The transference, however, is not the only reason why paternalism persists. The profession of medicine, not unlike the priesthood, claims certain powers and prerogatives. Indeed, like the priest, the doctor is expected to take a reverential stance toward his profession. People still give the doctor and the priest a public and private deference. Libertarian thinkers want this deference eliminated, and yet it persists.

People are eager to give doctors power which they would hesitate to give others because they sense something sacred at work in medicine. Not only does the physician need special ethical endowments to be a good doctor, but the healing which physicians try to foster gives witness to "something more," a realm of mystery. As a participant in this process, the doctor touches what is holy.

Acutely ill patients who find a doctor living out his professed devotion to healing, give him or her a special authority. The priest who devotes himself to the spiritual needs of his people is given a special respect and so, too, is the physician who devotes himself to caring for his patients. It is devotion, even more than learning, which constitutes yet another foundation of deference and paternalistic authority.

Not unlike priesthood, the medical profession requires competence and intellectual accomplishment, but above all, it requires high ethical standards and a certain character formation. More than correct decision-making is required of the good doctor. Physicians, because of the oftentimes unrecognized religious roots of paternalism, are held to much higher standards of ethical conduct than other people. Doctors are expected to be virtuous and specifically to show conscientiousness, industry, temperance, prudence, orderliness, honesty, fairness, but above all, compassion. The good doctor is expected to care for his patients, suffer with them, and struggle to bring them back to health.

Medical practice certainly can be compared with many other professional activities, but few doubt that it also differs from all the rest. Engineers diagnose and fix, but do not work on human beings. The same is true of veterinarians. The latter share with doctors the goal of biologically healthy functioning. But only with human patients is there, in addition to illness, a self-consciousness of illness and a voluntary turning for help to another person. Only the human patient suffers fear, shame, dependency, loss of esteem, and turns to the doctor for help in all these dimensions of ill health. Only human illness is degrading and dehumanizing, and only the human patient is made vulnerable by illness, in body and soul. Only the doctor, by profession, is obliged to address these added dimensions of human illness.

The physician, like a good father, is expected to share the vulnerability of his patient and, above all, never take advantage of a patient's vulnerability. Like fathers, doctors recognize themselves in the sick person, and this recognition provides the basis for moving beyond abstract scientific knowledge of human biology to concern for this particular person's experience of illness. Doctors alone are duty-bound both to technical competence and to helpful speech to bring their patients to health. Physicians, like parents, are ethically bound by professional responsibility to talk to their patients, to engender hope, to provide understanding, to give direction and advice, and to do all this in an atmosphere of respect for the patient. These professional responsibilities are both priestly and paternalistic.

The best defense of paternalism is to keep up a healthy respect for patient autonomy in carrying out one's medical vocation. Paternalism, however, modified and limited by respect for autonomy, is right and good. It is defensible in light of medical theory, theology, and secular beliefs about life. Even in our times, and despite all the changes, a modified or soft paternalism is more than defensible. It is right.