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Book Reviews

A Guide for the Perplexed

THE HEALER'S POWER. BY HOWARD BRODY.[1] NEW HAVEN: YALE UNIVERSITY PRESS, 1992. 311 pp.

Reviewed by
Joseph J. Fins, M.D.†

A 31 YEAR OLD merchant is admitted to the hospital with alcohol withdrawal seizures. She is an up and coming executive at a local department store and this is the first time her alcoholism has caused her to seek medical attention. In the midst of her alcoholic detoxification, she insists that she must leave the hospital and return to the management of her store. Her doctor, worried that she might have a recurrent seizure if discharged prematurely, tires to convince her to stay a few more days. The patient refuses. When she remains firm in her desire to leave the hospital, the concern which guided the physician's earlier actions is replaced by caution.

The physician's response to the patient's intransigence is to carefully inform her of all the conceivable risks she might face if she left the hospital and terminated her treatment. The patient senses that the empathy that marked her physician's earlier warning about a recurrent seizure is absent from his subsequent recitation of the dangers she might face if she left the hospital. Although the physician believes that she understands these risks and can assume the responsibility of making this decision, he informs her that he has asked a psychiatrist to see her "to see if she is competent." As expected the psychiatric assessment confirms that the patient has the decision-making capacity to refuse potentially beneficial treatment. The patient's final moments with her physician are spent signing a

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release which states that she has signed out "against medical advice."

This unhappy and all too familiar outcome thus concludes with a patient in great need failing to receive the care that she needs and with the disruption of the doctor-patient relationship. The standard ethical analysis of such a case helps us reconcile ourselves to our disappointment. We are told that the primary good that should be fostered in the clinical encounter is the preservation of the patient's autonomy. If the psychiatrist adequately assessed the patient's understanding of the therapeutic choices presented to her and found that she had decision-making capacity, then she is free to leave the hospital prematurely. Although the theoretical reasons for this outcome are compelling, one is left to ponder the curious question of how physicians came to satisfy their patient's need for autonomy over their need for healing.

Howard Brody has helped us answer this central paradox of current medical practice in his engaging and provocative new book *The Healer's Power*. Brody, professor of family practice, medical humanities, and philosophy, and director of the Center for Ethics and Humanities in the Life Sciences at Michigan State University, has made an important contribution to medical ethics by introducing the question of power into the field. Brody's explication of the importance of the healer's power and his prescription for its judicious use helps us understand medical practice in a new light.

Although trained as a philosopher, Brody wrote this book as a physician who had discovered an unspoken incongruity between medical ethics and medical practice. Brody contends that this divide between theory and practice stems from a failure to recognize the important power dynamics of the doctor-patient encounter. This critical omission is further compounded by a theory of medical ethics, which Brody calls the "new medical ethics," that strives to protect patients from the very power they seek to benefit from when consulting a physician. Brody learned at the bedside that the physician's true function was as a purveyor of healing and not as a protector of rights.

Brody contends that the medical ethics' failure to incorporate a consideration of the healer's power has gone unrecognized because "the existing vocabulary, which constitutes the standard view of modern medical ethics, seems to be all-inclusive, offering a label for almost every imaginable dilemma." Bringing together the perspective of physician and philosopher, Brody came to appreciate that the labels offered by the existing paradigm confused physicians

about their true role. By excluding from its analysis of the clinical encounter something as basic as the healer's use of power, Brody argues that the "new medical ethics" avoided a central theme understood intuitively by all who have either sought healing or who have tried to heal. Indeed, one leaves Brody's book wondering whether the rights language which so predominates medical ethics is but a *proxy* for an explicit discussion of the power dynamics between patient and physician and within the physician him/herself.

Brody has used an ample dose of fiction and literary allusions to illustrate this heretofore unrecognized but glaring omission of power. In fact he begins this work of nonfiction with a powerful story entitled, "*The Chief of Medicine*." This short story, like all the literary sources used in *The Healer's Power*, allows the lay reader to see for him/herself the centrality of power through the use of fiction. Just as the life stories of his patients helped Brody learn of the importance of power, fictional characters allow the reader to come to the same realization. As story-teller, literary critic, and physician, Brody makes a compelling argument for the inclusion of power considerations into medical ethics.

Brody defines the elements of the healer's power as either Aesculapian, charismatic or social. Aesculapian power is the practitioner's knowledge of his/her craft and is "transferable" from one practitioner to the next. Charismatic power is highly personal and dependent upon the physician's personality. Social power stems from the ability conferred by society upon a physician to define "what counts as medical knowledge and medical truth" as well as the socioeconomic status now accorded to physicians. Recognizing that healing can not occur without the use of power, Brody discards the unhelpful appellation of any use of physician power as paternalistic. Instead he offers a guide for what counts as the ethical and responsible use of power in the clinical encounter. He suggests that the proper use of the healer's power is "when that power can be described as *owned power, shared power, and aimed power.*" Brody argues that when power is used properly it is ultimately shared between physician and patient. This partnership requires that physicians own or disclose the power possessed and have a goal at which the power is applied or aimed with the help of the patient. When these criteria are met, the healer is allowed to use his/her power to promote healing, for the patient, through enfranchisement, is protected from the potential abuse of that power. To illustrate the responsible and indeed "judicious" use of power, let us return to the case with which we started with Brody's guidelines in

mind. At the onset we are at an advantage—at once able to recognize that we are facing a power struggle between an ill and vulnerable patient and a physician who seems to hold all the cards. By acknowledging his power, the physician could share it with his patient and preempt the need for her to seek refuge in her right to leave the hospital against medial advice. When the patient refuses continued hospitalization, the physician could explore what is motivating this decision and perhaps confess that he could call a psychiatrist to see if "you can make this decision for yourself," and then quickly add that "I'm not going to do this because we both know he'll find that you can leave if you want to." With this admission, the physician informs the patient that he understands the limits of his power and that he is more interested in taking care of her than in taking advantage of her vulnerability. This acknowledgement of owned power is powerful reassurance that the physician is willing to consider the goals of the patient's hospitalization in collaboration with the patient.

Brody argues that the patient's life goals should be the focus of aimed power. This important realization, so often lost in the standard ethical analysis of cases like this one, is that one of the patient's life-goals is not to sign out of the hospital against medical advice. The goal, at least at some level, is to get well. If the physician seeks to discern what is motivating the patient's refusal of treatment, he can help the patient achieve these life goals. Instead of admonishing the patient by pointing out that a premature hospital discharge might result in a seizure, death, or even the loss of insurance reimbursement, the physician can more productively seek out what the patient herself wants out of her hospitalization. A brief yet compassionate remark by the physician will cement the doctor-patient relationship just as quickly as a litany of recited risks will fracture it. Aimed power has the physician suggesting to the patient that the "real reason you came to the hospital was that you wanted to get over your drinking problem so that you can take care of your little girl who has just started kindergarten." He might suggest he has "little doubt that you want to continue working at your store and keep rising up the corporate ladder" and that "I don't think you want to be an alcoholic."

Although some might see this approach as paternalistic because it is so active and seemingly over-involved, the active intervention suggested by the Brody guidelines actually protects the patient from paternalism, which never involves the sharing of authority. It is

clear that Brody's model is not the return of old-fashioned paternalism in new clothes.

Brody contends that, unlike the paternalist, a physician who is able to establish such a human connection with a patient has come to understand the power s/he possesses and accept the vulnerability which comes with its full expression. This concerted use of physician power is compassion, not paternalism. He writes that:

> Surely, being with the sufferer and helping him find his own story to attach meaning to his experience is a prime example of shared power. Few things that the physician can do have the capacity to empower the patient to a similar degree.

Liberated from simplistic formulations of patient autonomy and physician paternalism, Brody is able legitimately to understand autonomy as a end constraint of power directed toward the ultimate pursuit of physician compassion which is described as "the embodiment of shared power." Brody argues for a virtue ethics that promotes compassion through the development of empathic curiosity.

The intersection of rights language and Brody's theory of power is most significantly seen in the question of informed consent. The two chapters dedicated to this topic should prove especially interesting and provocative to lawyers who read this journal. Brody contends that the ethical use of power allows the physician some discretion about the disclosure of risks. Motivated by the importance of sharing power, Brody argues that physicians should adopt a conversation model of informed consent rather than the one which evolved out of negligence law.

His model seeks to establish informed consent as a "natural component of a physician-patient relationship that respects patient autonomy" and not as a "legal intrusion" into the field. This is an important corrective because physicians, as Brody rightly notes, "see informed consent as a legal practice, not as part of doing medicine; and they fail to see any basic link between jumping through the perceived legal hoops and doing anything valuable for the patient or for patient self-determination." By making informed consent more of an organic component of medical practice Brody hopes that it will become a substantive as well as procedural endeavor which serves patients and promotes healing.

Brody offers his conversation model in light of empiric data which suggests that the current model, while "theoretically satisfying", fails to be implemented adequately. He is critical of the legalistic model which uses tort law to mandate physician compliance and which retrospectively evaluates the "adequacy of the disclosure

(of risks) in light of later events, especially in cases of adverse outcome." This way of evaluating the informed consent process, Brody maintains, will lead physicians to feel compelled to explicitly disclose even the remotest of risks. Although this strategy might provide protection in future litigation, this approach may lead to a situation in which the physician absents him/herself from a counselling role by presenting the patient with all potential risks without evaluating their relative importance.

In Brody's conversation model, the physician plays a more active role using his/her technical ability to differentiate the seriousness of one risk versus another. This is critical because:

> In a reasonable and realistic medical conversation, we can not disclose this remote risk without at the same time conveying additional messages that are both unintended and confusing.

In contrast to the legalistic model which might encourage *iatrogenic* levels of disclosure, the conversation model encourages "a sort of conversation between physician and patient designed to involve the patient in medical decisions in an informed way to the extent that the patient wishes." This participation is predicated upon physicians actively laying the "groundwork" for this exchange.

Using his/her Aesculapian power to first evaluate the probabilistic nature of medical risk, the physician would then help the patient understand what risks were relevant by limiting disclosure to those dangers which met the transparency standard of informed consent. The transparency standard safeguards the informed consent process from physician paternalism by operationalizing the physician's owned, aimed, and shared power. Transparency protects the patient and promotes healing by requiring that the physician "think out loud" about "precisely those risks that the physician weighed seriously before deciding what intervention to recommend." Informed of these deliberations, the patient is then at liberty to ask for more information should he/she so desire it. When the patient's additional questions are answered, he/she then "authorizes . . . the recommended intervention or an alternative one." The physician knows he/she has told the patient enough once this standard of transparency has been reached.

Brody expands his discussion of power beyond the informed consent issue and discusses a wide range of concerns including confidentiality, substituted judgment, quality of life, cost containment, medical economics, and futility. These analyses offer an original treatment of these subjects and illustrates the applicability of power considerations to each of them. Brody's related discussion of the

rescue fantasy and the power to define medical futility are especially well conceived. Brody contends that when "well-accepted ethical principles appear routinely to be ignored or misapplied in a category of cases, one might ask whether something like the rescue fantasy is at work." His examination of rescue and its corollary, futility, provide a plausible explanation of why American society is enamored with high tech medical care and with dramatic life and death court cases.

Brody's conception of the doctor-patient relationship, written from his perspective as a family practitioner, might be criticized in a fractured health care system in which many fail to have any access to health care much less an on-going doctor-patient relationship. Although his vision of the clinical encounter appears at first glance romantic, his analysis is anything but sentimental in its introduction of power considerations. Brody's argument for a virtue ethics among physicians and the incorporation of a primary care attitude in all medical specialties may be an important and effective way to address the health care crisis.

Although the book's natural audience is physicians and medical ethicists, lawyers will find this volume provocative as it illuminates the complex ethics of the clinical arena and analyses the influence of law on medical ethics.

In imagining the epitaph that William Carlos Williams might have liked for himself, Brody wrote: *There was about him the constant will of a man trying to recognize.* Indeed that is the impression that most readers will have of the author of this wise and thoughtful book.