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Professor Jay Katz, in his provocative book *The Silent World of Doctor and Patient*,[1] describes a poignant encounter with a patient, Iphigenia Jones, a young woman with a circumscribed breast malignancy (p. 90). Her case is used to scrutinize problems posed by medical authority and to address critically physicians' demands for trust that their esoteric knowledge may or may not require. The case material in the book revolves around the near sacrifice of Iphigenia's breast through the performance of an ill-advised mastectomy. To Professor Katz, this surgical procedure appears to represent both the height of odiousness for its mutilation of the human body and the nadir of the medical profession's recognition of the universal themes of uncertainty and ignorance in their scientific corpus. Surgical removal of Iphigenia's breast is averted when the surgeon explains to the patient the still unresolved controversy surrounding management of breast cancer in the medical profession. Iphigenia elects a lumpectomy, without removal of the breast, which bears no scars to mar her future entrance into marriage. She is plucked from sacrifice by a happenstance conversation with her surgeon, an encounter that Professor Katz portrays as virtually absent from medicine; even when it occurs, it falls far short of the idealized conversation he believes all patients desire and in which they deserve to be engaged.

The choice of the name Iphigenia is an allusion to the classical myth concerning the near sacrifice of the daughter of Clytemestra and Agamemnon. The sacrifice, deceitfully advertised as an impending marriage to Achilles, was an act demanded of Agamemnon by the gods in order to permit the beached Greek fleet to set sail for Troy. It is only through the intervention of other gods that Iphigenia is saved from her wedding/sacrifice and transported to the land of Tauri. Agamemnon is subsequently killed by his wife upon his victorious return from Troy; his death a punishment and apt retribution for attempting

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1. J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).

the ultimate anti-paternalistic act by sacrificing his own child. The loving bonds and responsibilities of parenthood were lower priorities for Agamemnon than his reputation as a leader and his avaricious need to conquer Troy.

Iphigenia Jones in *The Silent World of Doctor and Patient* is a symbol of the maiming and sacrificing of patients by physicians from antiquity to the present time. According to Katz, the deliberate failure of physicians to engage their patients in conversation and informed consent is a re-telling of the Iphigenia myth. Such deceit deprives patients of what Katz perceives as the most important element of the doctor-patient relationship—self-determination in the patient's choice of medical options. In depriving patients of this autonomy, Katz contends, the medical profession has persisted in a paternalistic stance by sometimes acting in the best interests of patients without their consent. This paternalism, which Katz perceives as paralleling physicians' failure to enter conversation with their patients, is more offensive and threatening to him than the choice of a bad medical outcome by the patients (pp. 90-100).

The myth of Iphigenia is an apposite but ironical metaphor for the current assault on the medical profession. Physicians are accused of using deceit to seduce patients to participate in their sacrifice to medical investigation and to shore up the faltering structure of physician omnipotence and omniscience. The patient and doctor are not considered united in the common purpose of restoring health but disunited by the specter of unilateral decisions and paternalism on the physician's part. Katz's new myth places the highest priority upon the process of medical decisionmaking and not upon the outcome; in this realignment, trust in the physician to strive for the optimal medical outcome is sacrificed to patient autonomy. Agamemnon was killed for attempting to sacrifice his own daughter; but paternalism is the basis for Katz's indictment of the medical profession. This Agamemnon-like fate is ill-considered and tragic for the profession and society.

The failure to engage in conversation is the stake upon which Professor Katz impales the profession of medicine throughout the book. His polemic is buttressed by excerpts from the annals of experimental heart transplantation, with Christiaan Barnard's monologue serving as a model of physician manipulation and misguidance of the patient (pp. 131-41). Most of his examples of physician deceit focus upon the controversial surgical handling of breast malignancies (pp. 125-84). Katz's silent world is restricted predominantly to the surgeon and patient with little attention paid to conversation which occurs with the internist, the nursing staff, or other patients with the

same illness. His patients are almost always in the hands of surgeons without any corresponding description of the journey which brought them there. He describes a tragedy that unfolds with only two characters on stage, the patient and the unfettered villain-surgeon. Where is the chorus which comments upon misaction and points out the uncertainty that is common, though not universal, in medicine?

The world of medical care is not comprised of just surgical suites and unpremeditated cutting. Surgery represents an infrequent punctuation in health care delivery and is rarely chosen without the consultation and counsel of a non-surgeon. Because surgeons usually do make surgical recommendations, it is the responsibility of the referring physician to determine the appropriateness and extent of these recommendations and counsel the patients accordingly. Katz depicts the patient as a solo journeyer through the threatening maze of medicine without the patient encountering a trustworthy Diogenes in the form of a physician or non-physician. There is a singular absence of the family physician who engages in conversation over a prolonged period and establishes the backdrop of trust against which the discussion of therapeutic options and interventions takes place. This emissary of the patient engages in dialogue as part of the detente between internist or family physician and surgeon. The patients' primary physician, their Diogenes, represents the patients in professional conversations in which each party leans against the other. In this fashion, the physician may guide the patient through the complexities of diagnosis and treatment in fulfillment of the patient's trust and confidence in the physician. Because there have been lapses in the system and because the public is being encouraged to act autonomously, little attention is paid by Katz to this system of checks and balances. He flatly rejects any authoritative role of the physician with his misguided paternalism, and encourages the patient, after engaging in conversation, to decide on his own. This is not a propitious re-orientation of medicine; it is a denial of medicine's strengths and a patient's vulnerability.

But Agamemnon's fate for the physician is today a popular stance espoused by the legal profession and ethicists. According to these groups, the failure to engage in conversation vitiates informed consent, and without informed consent there is loss of autonomy, the animus of the doctor-patient relationship. No physician would be so foolish or so arrogant as to deny the importance of conversation with patients and their informed consent; what is contested is the pre-eminence of autonomy over medical outcome, of self-determination over the norms of medicine. Exploration of Professor Katz's position helps clarify aspects of this contest for both the patient and physician.

Central to Katz's thesis of conversation are his roots in psychoanalysis and his recommendations that both the patient's conscious and unconscious needs must be addressed for truly informed consent to occur. Such inner knowledge of the patient may be attained by the analyst over years and by the primary physician over a lifetime, but this ideal is beyond the realistic reach of most physician encounters with patients. In its stead, the physician relies upon the body of knowledge which constitutes the corpus of medicine and which defines the biological and clinical norms which have classically been the end of medicine.[2] In his enthusiasm for conversation and informed consent, Katz has found it necessary to debunk this scientific basis of medicine and to present it as having no underpinnings of certainty. His friendly contempt of the science of medicine echoes the charges frequently applied to psychoanalysis where a one-on-one visage constitutes the total therapeutic relationship; this intensity of gaze, where the world is the doctor and patient, is not the provenance of the non-analyst. Other physicians incorporate conversation into the several components of their craft; knowledge of the patient is coupled with knowledge of biological norms. Just as most psychiatrists are trained in neurology and internal medicine in order to recognize organic contributions to mental disease, the non-psychiatrist is trained to recognize the converse. Katz's model of the doctor-patient relationship appears to blur the distinction between the two groups; this is a disservice to both members of the relationship. While Katz admits that his views of the doctor-patient relationship are colored by his psychoanalytic background, he errs in universalizing the analyst's stock-in-trade to the remainder of the medical profession and in finding them wanting when such skills are not in evidence.

The medical profession does not assert that conversation is a barrier in the path of informed consent and patient autonomy; all would agree that Professor Katz's call for dialogue is an ideal to obtain. The impasse is created by the strictness of the demand for autonomy of the patient and for rejection of medical paternalism.[3] The doctor no longer knows best and is accused of arrogance if he or she adheres to that adage and acts in a patient's behalf. The profession is guilty of hubris in the eyes of society, a remarkable fall from grace and a dramatic shift in the tradition of medicine. This situation has occurred in the face of awesome accomplishments in technology and therapy

2. Clements & Sider, *Medical Ethics' Assault Upon Medical Values*, 250 J. A.M.A. 2011-15 (1983).

3. Callahan, *Autonomy: A Moral Good, Not A Moral Obsession*, HASTINGS CENTER REP., Oct. 1984, at 40-42.

which ironically have contributed to the criticism surrounding the doctor-patient relationship. Paternalism was tolerable when the art of medicine was not overshadowed by the science of medicine, when the outcome of the therapeutic relationship was not dramatically altered by the physician's intervention and when paying attention to another's needs in illness was the core of the caring relationship. Doctors are now portrayed as adversaries engaging in sinister practices on their patients; all doctor-patient encounters are couched in terms of medical experimentation wherein patients need to be protected by protocol and informed consent.

This perception represents a loss of honor for a profession which once was thought to possess moral authority and discretion. These attributes and powers belonged to the members of the medical profession because good health was a shared value of both patient and physician. The restoration of health constituted the ethos of medicine; physicians' knowledge and wisdom permitted them the authority to advise and instruct patients about illness. Affixed to this medical imperative was a devotion or calling; a charisma that made them uniquely suited to aid their patients. Beneficence, with some paternalism, was valued over patients' rights and some patient autonomy was sacrificed in exchange for the knowledge, expertise and authority of the physician.

In a society in which many forms of traditional authority have been attacked and destroyed,[4] it is not surprising that Agamemnon's fate would befall the medical profession. Paternalism with its authoritative stance is incompatible with total autonomy and with an ethos of medicine based on patients' control over what is done to their bodies. Katz has correctly attacked paternalism for lacking respect for the civil rights of others, a cardinal offense in a world now focused upon liberty of the individual and thoroughgoing self-determination. The public is also justified in challenging the failure of medicine to gain better control of the reign of technology and to place a higher priority on quality of life rather than maintenance of life. Physicians have been guilty of permitting a gross imbalance to develop in the therapeutic ratio of the art and science of medicine; their ranks have lacked wise healers of prescience and power to resist seduction by so much scientific promise. At the same time, physicians have been guilty of imposing their relative values upon patients as absolutes, and directing care from an aloof and authoritarian stance. The call to discard the

4. R. SENNET, AUTHORITY (1980).

mantle of medicine has found a receptive audience in a patient population that has been cloaked by the suffocating structure of medicine.

But does respect for total patient autonomy represent the most appropriate response to the hubris of the medical profession? Should beneficence and altruism be rejected outright because of the taint of paternalism? Is thoroughgoing self-determination an appropriate ethos for the profession of medicine? Katz's description of the doctor-patient relationship is one in which there is a dispassionate exchange of information between a physician and client—similar to consulting a lawyer or an accountant. The depiction is one dimensional, with inadequate attention paid to the attending role of the physician and the sometimes shattered role of the patient. This is especially important in the circumstances in which suffering and pain in the course of an illness might determine a patient's decision to prematurely halt therapy.[5] Here, the danger of autonomy is a double edged sword because of subtle but real attitudinal changes on the part of both physician and patient. The physician is the individual in our society who witnesses the trajectory of illness and dying over a broad terrain; he or she can use that experience to anticipate and advise regarding the outcome of illness. The physician has traditionally stood by and suffered with patients in an attempt at sustaining them in the agony of illness. It is a paternalistic act wherein the physician decides that the patient should not give up, that the trajectory of the illness will have a positive outcome. Within a climate of strict patient autonomy, the fight may be less spirited or not even embarked upon by the doctor. Similarly, the patient may make decisions that are dictated by the concerns and fears of the moment, exactly the circumstances under which autonomy and prudent decisionmaking break down.[6] The desolation of a moment may lead many patients to choose an unnecessary, albeit autonomous, death; illness makes it near impossible to know what one does not know.

The flight from paternalism may have additional negative impacts upon medicine. Caring for the sick carries with it the risk of acquiring diseases. Tuberculosis was a commonplace interlude in the lives of many physicians of an older generation. Hepatitis and AIDS pose a similar risk. Patient autonomy obviously would not eliminate risk taking but it would change the guise with which such attention was of-

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5. Siegler, *Critical Illness: The Limits of Autonomy*, HASTINGS CENTER REP., Oct. 1977, at 12-15.

6. Jackson & Younger, *Patient Autonomy and "Death with Dignity": Some Clinical Caveats*, 301 NEW ENG. J. MED. 404-08 (1979).

fered to patients. The receipt of patients' trust and the entrustment of their lives to physicians' care made risk taking part of what contributed to the elevation of the physician's role in society. The willingness to act on behalf of another human being, especially at the risk of one's own life, may weaken as the commitment to patient autonomy grows stronger. Before rejecting paternalism, our society should ponder these considerations.

Other physicians and ethicists have also addressed the limitation of the autonomy model; the invitation to wed medicine to libertarian philosophies has not gone without serious attack. Eric Cassell has found the autonomy model lacking because he believes that autonomy evolves out of the healing relationship as the patient is restored to wholeness by a return to health.[7] Obviously autonomy cannot function as the cornerstone of the doctor-patient relationship if the impact of disease on personal integrity results in the patient's loss of autonomy. Katz's autonomous patients stand in contradiction to the patients for whom most physicians care and recognize. Another dimension lacking in the autonomy model is its fixation upon procedure rather than substance. Callahan describes it as a minimalist ethic that fails to recognize human relatedness and the moral ecology of our lives in society.[8] It is also a model which is strictly rooted in American culture and not applicable to the rest of the world; informed consent and personal autonomy are almost impossible goals in societies in which most medical choices are not options for all patients.[9] Most importantly, the autonomy model fails to recognize the complex realities of medicine, the fashion in which diagnoses are made, the inability and/or the unwillingness of some patients to seize responsibility for their decisions and the attractiveness of being able to trust another human being when one is ill.[10] As Eric Cassell explained, illness robs patients of their autonomy. What he describes is the phenomenon well known to most physicians and documented by studies among patient populations: the patient desires to be informed and educated by his doctor but, in the majority of cases, wishes the physician to make the choice of therapy. Paternalism exists in medicine, not as some evil perpetrated by the profession upon the patient, but rather to fulfill a need created by illness. In assuming such a posture, the physician

7. Cassell, *The Function of Medicine*, HASTINGS CENTER REP., Dec. 1977, at 16-19.

8. Callahan, *Minimalist Ethics: On the Pacification of Morality*, HASTINGS CENTER REP., Oct. 1981, at 19-25.

9. O'Neil, *Paternalism and Partial Autonomy*, 10 J. MED. ETHICS 173-78 (1984).

10. Lidz, Meisel, Osterweis, Holden, Marx, & Munetz, *Barriers to Informed Consent*, 99 ANNALS OF INTERNAL MED. 539-43 (1983).

does not wrest some right from the patient but supplies with care what illness has made wanting. The cry to install autonomy in its place appears to ignore the reality and sadness of illness.

There are other models of the doctor-patient relationship if one rejects paternalism and autonomy as the core of this relationship. Professor William May has written inspirationally on the model of the covenant in medicine where gift, fidelity and promise are the concourse of the doctor-patient relationship.[11] He re-orients the traditional covenant which exists among doctors and calls for a redefinition of the covenants between doctors and their patients.[12] Under May's covenant, doctors would perceive the richness in their roles from being patient-oriented rather than profession-oriented. Mays' call for a patient-centered medicine would receive universal assent; the means of attaining that goal is what constitutes the debate. His own theological mantle may be a bit too pious for medicine to wear, however, and may fail because it attempts to float a secular profession on a religious course.

Physician-philosophers Clements and Sider have challenged loudly the autonomy model and would substitute the return of medical norms to a clinical ethic as the primary issue in medical care.[13] They argue that autonomy causes an abandonment of the value of the patient's best interest and an abandonment of the value system of medicine; the strength of their disdain for the autonomy model is revealed in their characterizing it as an unethical act in the doctor-patient relationship. The primacy of patient choice is considered by them to be "philosophically inadequate, professionally damaging, and clinically harmful."[14] Clements and Sider are polar opposites to Katz's posture. Their call for making the medical imperative the moral imperative would certainly make them candidates for Agamemnon's fate in some circles.

No single model or orientation appears to do justice to the complexities of the doctor-patient relationship and the infinite number of variables that affect it. The difficulty is heightened by the many perspectives that its critics bring to the controversy; the elephant and the blind men are confronting the dilemmas in peoples' lives. Professor

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11. *See* May, *Code, Covenant, Contract or Philanthropy*, HASTINGS CENTER REP., Dec. 1975, at 29-38.

12. *See generally* W. MAY, THE PHYSICIANS COVENANT, IMAGES OF THE HEALER IN MEDICAL ETHICS (1983).

13. Sider & Clements, *The New Medical Ethics: A Second Opinion*, 145 ARCHIVES OF INTERNAL MED. 2169-71 (1985).

14. *Id.*

Katz brings his psychoanalytic plea for conversation and his legal bias for informed consent and autonomy. Many lawyers favor contract as the basis of medical ethics, while philosophers condemn this strictly legalistic model of the doctor-patient relationship.[15] Another law professor, Robert Burt, depicts the profession as Janus-like with oscillations between beneficence and maleficence.[16] Professor May incorporates his theological background into the covenant. Physician-philosophers Clement and Sider are resolute in the centrality of the clinical ethic while Pellegrino focuses on the existential condition of the patient.[17] Thomasma would have the physician's conscience as the essential determinant of the doctor-patient relationship.[18] Each observer speaks passionately and eloquently with compelling aspects to each argument. The censorious examination of the doctor-patient relationship forces the profession to re-define its ethos in modern times by answering its critics but still maintaining its standards.

All would agree that a patient-centered medicine is the essence of the doctor-patient relationship and that the profession exists to save patients rather than the reverse. Professor Katz has performed a very important service with his clarion call for conversation with patients, an investment that only can give the patient the leading role in any doctor-patient relationship. Informed consent and truth telling are essential to maintaining the trust and confidence of the patient in this moral relationship; this relationship also demands a mastery of knowledge of the body that is the basis of the clinical norms which Clement and Sider have as their beacon. This scientific knowledge is the source of authority and expertise in the physician's role. But what is transcendent in the role is that special moral imperative that pervades every encounter in the doctor-patient relationship. As described by Professor Kass, medical knowledge is not dispensed with an ethically neutral technique but is an activity tempered by a notion of the good.[19] Every medical act involving a patient is an ethical act with the end of medicine always being beneficence; the moral imperative of beneficence is the backdrop against which any medical imperative is per-

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15. Master, *Is Contract an Adequate Basis for Medical Ethics?*, HASTINGS CENTER REP., Dec. 1975, at 24-28.

16. R. BURT, TAKING CARE OF STRANGERS: THE RULE OF LAW IN DOCTOR-PATIENT RELATIONS (1979).

17. E. D. PELLEGRINO, HUMANISM AND THE PHYSICIAN (1979).

18. Thomasma, *Beyond Medical Paternalism and Patient Autonomy: A Model of Physician Conscience for the Physician-Patient Relationship*, 98 ANNALS OF INTERNAL MED. 243-48 (1983).

19. *See generally* L. KASS, TOWARD A MORE NATURAL SCIENCE: BIOLOGY AND HUMAN AFFAIRS 211-23 (1985).

formed. This has been the ethos of medicine from ancient times to the present.

This beneficence may include paternalistic acts on the part of the physician when the circumstances dictate; when autonomy is present or restored, there will be no need for this contribution to patients' needs because of ill-advised ethical or legal enthusiasm for autonomy. Rather, it should examine closely any propensity to overstep the autonomy of patients and welcome the policing of the legal and ethical profession in that task. In the doctor-patient relationship, the medical profession should always err on the side of beneficence. Professor Katz and his colleagues should continue to lean against this posture of the profession. In the tension created, the imperatives of medicine will smack of paternalism when autonomy restoration is the goal. A poor medical outcome should not be allowed to evolve due to a respect for autonomy. What Professor Katz has guaranteed in his model is that medical imperatives should not dictate endless support of life or cloaking of ignorance or uncertainty. With this response, the medical profession should avoid the imposition of Agamemnon's fate, and should attain a proper end of medicine in a world of the doctor and patient — a world which is no longer silent.