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# CAN WE TALK?

## A Review of Jay Katz, *The Silent World of Doctor and Patient*

ARTHUR CAPLAN\*

*The Silent World of Doctor and Patient*<sup>1</sup> is an eloquent plea for recasting the doctor-patient relationship. Professor Katz convincingly demonstrates that both the medical and legal professions have not done enough to insure that honest and open communication in doctor-patient relationships will prevail in both therapeutic and experimental settings. Physicians, as Katz perceptively notes, are "well trained to attend caringly to patients' physical needs" (p. 130). But, as he observes, little in their training prepares them to attend with skill or zeal to patients' decisionmaking needs.

Philosophers, theologians and legal scholars place much emphasis upon patient autonomy in their writings in analyzing the norms that ought to constitute the researcher-subject and physician-patient relationships.<sup>2</sup>

But the harsh reality is quite different from the idealized norm. As Professor Katz argues convincingly through his careful analysis of legal cases, clinical case studies, and the close examination of codes of professional conduct in medicine, physicians have been unwilling to actually share decisionmaking authority with their patients, and the legal system has been, at best, reluctant to attempt jurisprudential reforms that would challenge or disturb this reluctance.

Professor Katz cites a number of factors relevant to our understanding of the gap between theory and practice, or perhaps more accurately, ideology and practice. In part, he notes, medicine's professional dominance and social prestige in Western societies has been secured by cloaking the details of medical skill and knowledge in

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

2. H. T. ENGELHARDT, JR., *THE FOUNDATIONS OF BIOETHICS* (1986); R. VEATCH, *A THEORY OF MEDICAL ETHICS* (1981); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *MAKING HEALTH CARE DECISIONS: THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP* (1982); Miller, *Autonomy & the Refusal of Lifesaving Treatment*, HASTINGS CENTER REP., Aug. 1981, at 22-28.

a thick fog composed of equal parts mystery and secrecy.<sup>3</sup>

Esoteric knowledge is critically important if medicine is to retain its position of dominance both with respect to patients and with respect to social institutions that might attempt to regulate or weaken professional control and discretion. For centuries, medicine has been able to keep those outside the profession at bay epistemologically by the use of technical jargon, strange rituals, and through the rigid control of education and licensure regarding health and medical practice.<sup>4</sup>

The desire to keep laymen ignorant of medical beliefs and skills has been exacerbated by a number of social and economic forces in the post World War II era. The introduction of more technology—therapeutic, palliative, and diagnostic—has brought with it an increasing emphasis on specialization within the medical profession. Economic considerations have encouraged the institutionalization and centralization of the delivery of medical services. Not only is professional sovereignty propped up by a cult of mystery within the profession, but health care is now delivered in settings that are themselves distant, mysterious, complex, imposing and awe inspiring both in size and in technological ritual. As medicine becomes, and is encouraged to become, increasingly faceless and bureaucratic in the name of cost containment, efficacy, and competition, as fewer and fewer patients know or have any sort of personal, intimate relationship with a specific physician, the prospects for conversation and open communication become increasingly dim.

If nothing more than greed, power, and control were at fault for the failure of physicians to give greater weight to dialogue and communication, it might be difficult as a practical matter to change the norms of the doctor-patient relationship, but it would not be difficult to articulate a moral basis for doing so. After all, liberal individualism is alive and well in Western societies, and few Americans feel tolerant of those who would rob them of their rights to control their own bodies and lives. The prospects for effecting the kind of moral reform sought by Professor Katz are greatly complicated by the fact that good as well as evil underlies medicine's long-standing commitment to silence rather than conversation in doctor-patient relationships.

Professor Katz suggests it is professional greed mixed with a healthy dose of professional embarrassment that has hindered the evolution of conversation as the mainstay of interpersonal relationships in therapy and experiment. But this analysis places the burden

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3. C. B. CHAPMAN, *PHYSICIANS, LAW AND ETHICS* (1984).

4. P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

of responsibility for the promulgation of secrecy and silence solely on the medical profession. If medicine has often reached back to its quasi-religious roots for its professional authority and autonomy, then it is equally true that its clientele has felt an equally powerful need to maintain and support these values as defining the kind of virtues it wants its healers to exemplify.

Medical professionals are not alone in bearing responsibility for allowing silence to dominate doctor-patient and researcher-subject interactions. Subjects and patients are at fault as well.<sup>5</sup> Patients have allowed silence to substitute for conversation as a result of a conviction, shared and reinforced by their doctors, that healing can be brought about only when the patient exemplifies the virtues of trust, obedience, and compliance. Medical uncertainty and ignorance have long been seen as the primary threats to patient hope, and thus to the efficacy of medical interventions, not just by physicians but by their patients as well.

While medicine has eagerly seized the role of priest or even deity in formulating the values that constitute the boundaries of healer-patient interrelationships, it is equally true that patients also have received a great deal of satisfaction in having someone occupy this role. Physicians may have been quick to fill the void left by the decline of authority accorded organized religion in Western societies, but it must be recognized, as Professor Katz seems less willing to grant, that it is their clientele who have been equally eager to have someone occupy this social niche.

Professor Katz suggests that "patients rightfully have felt cheated" (p. 206) by the "duplicities, evasions, and lies that have infiltrated conversations with patients and made meaningful disclosure and consent a charade" (p. 206). I would agree that there is far more empty ritual and half-hearted compliance with the much ballyhooed norms of disclosure and consent on the part of the medical profession than the contemporary rhetoric of medical ethics would lead one to expect. My own observations of patients interacting with their doctors in a wide spectrum of clinical and experimental settings compel me to disagree that the failure to behave wholeheartedly and enthusiastically in accordance with the ethical strictures of disclosure and consent has been met with protest or resentment on the part of patients or those

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5. Siegler, *The Doctor-Patient Encounter and Its Relationship to Theories of Health and Disease*, in *CONCEPTS OF HEALTH AND DISEASE* 627-44 (A. Caplan, H. T. Engelhardt, Jr., & J. McCartney, eds. 1981).

who serve as the subjects of biomedical research (chs. one, two, and seven).

The challenge faced by Professor Katz and others who desire a more open and honest exchange of information between doctors and their subjects or patients is that a commitment to the power of magical thinking is based upon benevolent, not malevolent motives on the part of health care providers and an equal commitment to the power of blind faith, miracles, and the healing power of hope on the part of patients. Obedience, compliance, and trust are, in the appropriate settings, virtues not vices. This is what makes it so difficult to inject more conversation into physician-patient interactions. Both parties understand that a commitment to the open and frank exchange of information about what is and is not known concerning risks, benefits, prognosis, and efficacy will require the abandonment of other values believed, rightly or wrongly, to be instrumentally useful in their own right.

There is little empirical evidence to show that blind faith in medical expertise hastens or aids the power of medical interventions in the struggle against disease. (I suspect a random clinical trial would show that those who are atheistic or agnostic about the divine status of their healers do as well as devoted believers in the powers of the medical priesthood in confronting serious disease and disability.) Indeed there is some evidence that demonstrates that compliance and obedience are facilitated not by blind trust and obedience to authority, but rather by informed human beings who recognize each other's fallibility and limits.<sup>6</sup> Nonetheless, the myth of the power of faith to heal when grounded in benevolent motives on the part of physicians and strongly felt needs on the part of patients and subjects will not die easily.

There is a bit of a moralizing tone to some of Professor Katz's analysis which may turn off some of his physician colleagues from the important message he would like them to hear. Katz suggests that the burden physicians incur by remaining silent rather than talking openly with those in their charge is enormous (pp. 171-75, 198-99). It is the physician who must feel guilt when medical regimens do not produce the expected and hoped for result. It is the physician who is the object of disappointment, frustration, and scorn when death, as it always eventually does, terminates the doctor-patient relationship.

I worry that physicians may not heed the words of support and sustenance Professor Katz offers if they are blinded by their anger at

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6. See generally C. W. LIDZ, A. MEISEL, E. ZERUBAVEL, M. CARTER, L. SESTAK & L. ROTH, *INFORMED CONSENT: A STUDY OF DECISION MAKING IN PSYCHIATRY* (1984).

the suggestion that they have somehow consciously plotted against the public to maintain the norm of silence in an effort to secure wealth, prestige, and autonomy for themselves. There is a very real danger that those who need to attend most closely to the recommendations Professor Katz offers will not do so since he is not alone in diagnosing the source of silence in the desire for authority and prestige. A number of important studies of the history of medicine in the United States, such as those by Paul Starr,<sup>7</sup> David Rosner,<sup>8</sup> Ruth and Victor Sidel,<sup>9</sup> and others<sup>10</sup> have also laid the charge of conspiracy at the door of the medical profession.

Professor Katz and these other analysts define the cause of the problem of silence in a way that physicians know is simply not true. It is not just greed and a lust for power that has led medicine and the law to tolerate too much silence in physician-patient communication; patients and subjects have desired silence as well.

Can any profession, class, or group, even one as mysterious and insular as medicine, retain sovereignty over those they serve and, indeed, over social institutions generally, without some willing compliance on the part of those who are the recipients (beneficiaries? victims?) of their services? After all, physicians have no means of forcing people into their offices and hospitals. Whatever else may be wrong in doctor-patient relationships, those who are the victims of silence are still there voluntarily.

The harsh reality is that it is not only physicians who believe in the need for secrecy, silence, and mystery where healing is concerned. Patients believe it, too. It is true that many patients and research subjects are attempting to assert themselves, to be heard and to indicate their willingness to listen closely and carefully to what their physicians have to say. But the imposition of paternalism and the subjugation of autonomy are not, as many medical ethicists suggest,<sup>11</sup> the central sins of moral life in health care settings. The most common phrase heard in both experimental and therapeutic encounters is, "I don't know, doc—you decide. You're the doctor."

Physicians are still as likely if not more likely to be confronted by patients and subjects who do not want to listen, who do not want to

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7. P. STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* (1982).

8. D. ROSNER, *A ONCE CHARITABLE ENTERPRISE* (1982).

9. V. SIDEL & R. SIDEL, *A HEALTHY STATE* (1982).

10. See, e.g., E. R. BROWN, *ROCKEFELLER MEDICINE MEN: MEDICINE AND CAPITALISM IN AMERICA* (1979).

11. S. BOK, *LYING: MORAL CHOICE IN PUBLIC AND PRIVATE LIFE* (1978); Buchanan, *Medical Paternalism*, 7 *PHIL. & PUB. AFF.*, 370-90 (1978).

engage in a conversation, but rather who are more than willing to waive their autonomy in the hope that others who know better, who are more powerful, or who are more intimately connected with the mysterious forces of healing will make decisions for them rather than with them. The real moral challenge facing medicine and those such as Professor Katz who wish to create an environment in which open and honest communication can flourish is to decide what behaviors are legitimate in the face of patient indifference or even hostility to full participation in the conversations that guide medical encounters.

Paternalism is an easy target for those outside the medical profession to attack. Far more discomfiting, but, I believe far more important, is the issue of to what extent the medical profession ought to be held responsible for restoring or enhancing autonomy when it is denied, given away, or repressed in the name of healing or out of laziness, fear, or indifference.

Professor Katz suggests that educational reforms are in order within medicine if secrecy and silence are to give way to communication and open conversation in the doctor-patient relationship (pp. 150-54). In this he is surely correct. Little emphasis is placed upon the skills of interviewing, listening and communicating in most medical school curricula. But is a greater emphasis on communication skills and even, as Professor Katz hints, critical self-examination of one's character and behavior, enough?

Some medical educators<sup>12</sup> have recognized that a selection process which rewards expertise in the natural sciences and an aptitude for performing well on standardized examinations is not necessarily one which will produce physicians inclined to listen closely, talk openly and admit their limits and their ignorance when they exist. It may be necessary to change not only what is taught in medical school, as Katz suggests, but who is there to learn in order to assure more conversation on the part of medical professionals.

The economics of medical practice also hinder conversation. Patients often complain that they spend far more time waiting to see doctors than they actually spend with them. At the same time, most methods of reimbursement in health care, both retrospective and prospective, are much more closely attuned to paying the doctor on the basis of what is done than to paying the doctor for time spent in conversation. Conversation, as Professor Katz makes clear, is essential

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12. See, e.g., D. CALLAHAN, A. CAPLAN & B. JENNINGS, *APPLYING THE HUMANITIES* (1985); E. CASSELL, *THE PLACE OF THE HUMANITIES IN MEDICINE* (1984); Pellegrino, *Educating the Humanistic Physician*, 235 J. A.M.A., 1288-94 (1974).

for both doctor and patient if both are to bear the costs, physical, emotional, psychic and financial, imposed by disease and disability. In our present health care system, however, talk is cheap—too cheap to get many physicians to attend to it seriously.

Medicine has seen a revolution in the organization of its practice and settings in recent years, fueled by attempts to control costs. Our highways are lined with Emergicenters, Surgicenters, MedFirsts, and any number of other “doc-in-a-box” practices. Health Maintenance Organizations and Preferred Provider Organizations have grown rapidly in response to the desire of corporations to lower their health costs by contracting with plans that will render services under guaranteed contracts at a discount. Private practice is slowly being replaced in many medical specialties by group practice.

These changes may bode well for cost containment, but they do not, unfortunately, bode well for conversation. The ability of large numbers of patients to seek care from the specific physician of their choice is eroding. Indeed, it is becoming more and more common for patients (and even a few research subjects!) to have relationships with groups, companies or corporate entities rather than individual physicians.

Groups, companies, and corporate entities have many virtues, but conversation is not one of them. Anyone who has received a letter from a group health plan announcing a change or revision in the scope of the plan would not, I suspect, be overcome with a powerful desire to engage in a dialogue with the author of such a communication (if such a term can be applied to these missives) if in fact an author does indeed exist.

The organization and structure of medicine is moving rapidly along a path that has characterized much of medical practice in this century: more centralization, more economies of scale, more institutionalization, more teams, more monetarization, and commodification. Talk of revitalizing the need for conversation will fall on deaf bureaucratic ears unless care is taken to preserve intimacy, liability, and responsibility in the increasingly impersonal world of medical practice.

I am a bit unfair in arguing that Professor Katz does not give any recognition to the need to face the reluctance of patients to exhibit autonomy and participate fully as partners in conversations about their health and well-being. Professor Katz does argue that patients as much as physicians must accept an obligation to “participate in the process of thinking about choices” (p. 122). He enthusiastically en-

dorses Mill's observation<sup>13</sup> that, while we ought not coerce people or interfere with their liberty, everyone is fair game for criticism, exhortation, education, or, to use Professor Katz's term, conversation.

Nevertheless, there are serious flaws in his solutions to the problem of what to do with those who balk at autonomy and refuse to deliberate. First, there are many such people. It might be possible to have physicians act as amplifiers of moral autonomy if the need were small, but I fear it is not. The amount of exhortation, encouragement, and entreating required is likely to tax the patience of even the staunchest proponent of personal freedom.

Second, in Professor Katz's analysis, it is the physician who must entreat patients to deliberate when they do not wish or are afraid to do so. But this obligation, of course, puts the mantle of authority squarely back on the physician's shoulders. It is only the physician in this view who can see the need for autonomy and entreat the patient to converse as an alternative to simply dumping autonomy into the healer's or researcher's lap.

If the only source of autonomy enhancement in health care is the physician, then has very much progress been made in removing the stifling veneer of authority that so hinders communication? The power relationship between physician and patient, particularly when resources are tight and physicians control access to them, is not conducive to assigning the task of exhortation to autonomy solely to those who are the gatekeepers of the system.

Lastly, patients, like physicians, often have a great deal of vested interest in avoiding deliberation where matters of therapy or research are concerned. The dying cancer patient, offered the latest immunological wonder potion of genetic engineering, complains "What choice do I have but to take the damn drug?" Those who wish to keep the embers of autonomy glowing in such an unfortunate soul can offer choices about slow and rapid death, painful and less painful death, and knowledge that may or may not benefit others, but from the point of view of the dying patient, this may look like a terrifyingly scant menu of options. While neither the patient nor the treating physician or researcher may believe that deliberation will adversely effect the prognosis, can we really say that it is morally preferable to face the prospect of imminent death or severe, disabling disease reflectively rather than with an attitudinal mixture of denial, repression, and magical-thinking?

I suspect that if patients are going to be encouraged to talk, it will

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13. J. S. MILL, ON LIBERTY 21-23 (1947) (1859).

take more than exhortations from physicians. I think patients will require help from both medical and non-medical sources. Some traditional sources of help in getting people talking about uncomfortable or disturbing matters, the schools and the churches, seem strangely quiet about matters pertaining to health care. Abortion aside, our colleges, secondary schools and elementary schools, and our churches and synagogues have little to say about what one ought to know, scientifically or spiritually, in talking to the doctor.

I would venture to say that the average priest or rabbi is better prepared to deal with dead bodies than with bodies that are sick, impaired, or possible candidates for resuscitation or intensive care. Our high school graduates emerge from school ready to deal with computers, but ignorant of the difference between a hospital and a nursing home, and blissfully unaware of what their rights and obligations might be when they fall into the maw of medicine. Key social institutions must exert greater efforts to educate the public about health care if the foundation for autonomous behavior is to exist.

Patients and research subjects need help in accepting their autonomy inside the medical system as well. Research subjects need to have standard means available for hearing other voices besides the siren-like call of the researchers who wish to recruit them. IRBs might play this role, but their willingness to do so seems to be faltering in the face of institutional and peer pressures to the contrary.<sup>14</sup>

Those who seek therapy need more than an offer, even if it is a serious one, of conversation before the CAT scanner hums or the scalpel is wielded. They need to talk to others with medical knowledge but whom they are not afraid to offend, repudiate, or embrace. Nurses and social workers would appear to be likely sources of informed medical opinion and even encouragement to autonomy in the face of physician power and authority. Both these groups have acquired a fair amount of expertise at how best to preserve autonomy in the face of authority within health care contexts. Neither group is likely to frighten or intimidate the patient in the way that a physician, whether willingly or more likely unwillingly, will probably do.

Professor Katz has made a persuasive case for conversation as the linchpin of doctor-patient relationships. I have tried to suggest that, while endorsing his argument, there are additional steps that will need to be taken both within and outside of medicine if the probability of

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14. Levine & Caplan, *Beyond Localism: A Proposal for A National Research Review Board*, IRB, Apr. 3, 1986, at 7-9; Sheldon, *The IRB's Responsibility to Itself*, HASTING CENTER REP., Feb. 1985, at 11-12.

conversation occurring is to increase. Physicians and patients will have to be willing to relinquish values and norms that both have found fulfilling if talk is to replace silence in medical encounters. However, the rewards of conversation, as Professor Katz's book reveals, are far greater than continuing to pay the high costs silence imposes on both physicians and patients.