ON MEDICAL ARROGANCE

On Christmas Day forty years ago (December 25, 1980) an article appeared in the *New England Journal of Medicine* with a simple one-word title: *ARROGANCE*. It was based on a lecture that had been delivered at Harvard Medical School three years earlier (May 5, 1977) by famed gastroenterologist Dr. Franz Ingelfinger shortly before he retired as Editor of the *Journal.* Indeed, Dr. Ingelfinger, affectionately known to his colleagues and students as "The Finger," had died of cancer earlier that same year leaving his lecture notes still only partially edited. Evidently he could not persuade himself that his lecture deserved publication and had allowed the unfinished manuscript to languish in his files until his death. The Editors disagreed and with the permission of the doctor's family published an abridged version posthumously. I submit that Ingelfinger's words then still have resonance today — perhaps even more so.

When I was a medical student in Boston during the early 1960s, I sometimes had occasion to hear "the Finger" speak at conferences and always admired his wisdom and wit. I've often cited this article when lecturing about bioethics and the following selections extracted from *ARROGANCE* begin with a rather pedantic discussion of various forms of medical behavior — some good, some not. Dr. Ingelfinger starts by developing the thesis that a certain measure of authoritarianism, paternalism, and domination is essential to good medical care.

(The complete article can be found at: https://www.nejm.org/doi/full/10.1056/NEJM198012253032604)

> *In distinguishing between science and society, "some things can be stated in the language of science they are unanswerable by science. In a medical context, failure to recognize that a regulation or recommendation may be concocted in a vacuum of knowledge is to my mind a manifestation of the arrogance of ignorance." I must make a distinction here: I do not assert that conclusions reached in the absence of reliable fact are per se arrogant. Such conclusions unavoidably characterize politics, science, and medicine, especially when the need for action is urgent. Arrogance enters when those reaching various decisions in the absence of adequate data fail to recognize or admit how empty their cupboard of information is. Superior scientists or doctors, I should like to believe, are always aware of how little they know. Doubt tempers arrogance, and for this reason perhaps some bioscientists might be credited with sophrosyne rather than condemned for its opposite, hubris. (I admit I never heard of sophrosyne before I prepared this lecture, but it has all the prerequisites for becoming a stylish word.)*

Sociologists, ethicists, and others like to speak disparagingly of what they call the doctor's authoritarianism, paternalism, or domination. Such a position, I submit, is unrealistic and untenable. The physician is a person to whom patients go because they need or think they need help. Let us assume that the physician they select is competent and compassionate. In spite of these virtues, there is usually little the physician can do physically. that is, by cutting or by a chemical manipulation, to eradicate the cause of the patient's distress. That is why epidemiologists keep pointing out…that the physician's intervention has done little to prolong life or eliminate serious morbidity. The figure generally quoted — although it may be an arrogant figure in that substantiating data are fragmentary — is that 90 percent of the visits by patients to doctors are cause by conditions that are either self-limited or beyond the capabilities of medicine.

In other words, if we assume that physicians do make patients feel better most of the time, it is chiefly because the physician can reassure the patient or give medication that is mildly palliative. Even an operation may once in a while make a patient feel better, although it does not prolong his life or eradicate the source of his problems. If the physician is to be effective in alleviating the patient's complaints by such intangible means, it follows that the patient has to believe in the physician, that he has confidence in his advice and reassurance, and in his selection of a pill that is helpful…Intrinsic in such a belief is the patient's conviction that his physician not only can be trusted but also has some special knowledge that the patient does not possess. He needs, if the treatment is to succeed, a physician from whom he will accept some domination….I'll go further than that. A physician who merely spreads an array of vendibles in front of the patient and then says, "Go ahead and choose, it's your life," is guilty of shirking his duty, if not of malpractice.

The physician, to be sure, should list the alternatives and describe the pros and cons but then, instead of asking the patient to make the choice, the physician should recommend a specific course of action. He must take the responsibility, not shift it onto the shoulders of the patient. The patient may then refuse the recommendations which is perfectly acceptable, but the physician who would not use his training and experience to recommend the specific action to a patient — or in some cases frankly admit, "I don't know" — does not warrant the somewhat tarnished but still distinguished title of doctor. Although I have subscribed for some time to the principle that the physician must be authoritarian and paternalistic to some degree, my experience as a patient has substantiated that belief in the strongest way

possible. If you will forgive me for being anecdotal and personal, let me tell you how the lack of authoritarian decision brought agony to my family.

What makes Dr. Ingelfinger's speech especially poignant comes at this point when he doffs his professorial white coat to describe his own experience as a confused patient confronted with a fatal disease.

About a year and a half ago it was discovered that I had an adenocarcinoma, a glandular cancer, sitting astride the gastroesophageal junction. Ironically, this had been an area of the gut to which I had paid much attention in my professional career as a clinical investigator and consultant; therefore, I can hardly imagine a more informed patient. The need for surgery was indisputable if I hoped to continue to be able to swallow. But after a successful operation my real dilemmas began. The surgeon had found no visible evidence that the cancer had spread. But this proved nothing, because cancers can spread to form tiny nests of cancer elsewhere — micro metastases. The current medical practice is to assume that a patient who has had an operation for any variety of cancers (including the type I had) should also be given prophylactic treatment in an effort to eradicate the micro metastases before they enlarge. For this purpose both chemotherapy and radiotherapy are being used extensively. So one question was: Should I have chemotherapy, with all its side effects? And if chemotherapy, what kind? Even more debatable was the question of whether I should have radiotherapy. There is no generally acceptable evidence that residual nests of adenocarcinoma cells will respond. In addition, radiation would involve a number of complications, such as fibrosis of the lungs and the possibility of a host of less frequent but nevertheless serious side effects.

At that point I received from physician friends throughout the country a barrage of well-intentioned but contradictory advice. The question of prophylactic radiotherapy was particularly moot. As a result, not only I but my wife, my son and daughter-in-law (both doctors), and other family members became increasingly confused and emotionally distraught. Finally when the pangs of indecision had become nearly intolerable, one wise physician friend said, ***"What you need is a doctor."*** *He was telling me to forget the information I already had and the information I was receiving from many quarters and to seek instead a person who would dominate, who would tell me what to do, who would in a paternalistic manner assume responsibility for my care. When that excellent advice was followed, my family and I sensed immediate and immense relief. The incapacity of enervating worry was dispelled, and I could*

return to my usual anxieties, such as deciding on the fate of manuscripts or giving lectures like this.

If arrogance in the sense of paternalism and dominance is an ingredient of beneficial medical care, these qualities have to be used appropriately. To the extent that paternalism and dominance are infected by some of the other meanings of arrogance, a physician's conduct with patients is correspondingly worsened. Thus, if paternalism is accentuated by insolence, vanity, arbitrariness, or a lack of empathy, the care he attempts to provide his patients is nullified. In other words, a physician can be beneficially arrogant, or he can be destructively arrogant. Physicians as a class, I suspect, are probably no more vain or insolent than any other people. Some are presumptuous and condescending, others self-effacing and sympathetic. Although arrogance in some of its more nefarious meanings — vanity, insolence, and ruthlessness, for example, — cannot, I believe, be identified as a general characteristic of the medical profession, the profession as a whole is affected by a brand of arrogance subsumed under lack of empathy.

Doctors for various reasons find it difficult to put themselves in the patient's place; they do not sufficiently appreciate or perhaps do not have the time to appreciate, how the patient feels and how he reacts to the medical information and procedures to which he is exposed….Many patients to be sure, are acquainted with medical terms and use them and it has been proposed that teaching the patient about medicine…might improve communication between the two parties….[but] even if the patient uses words such as 'myocardial infarction," does he really appreciate the spectrum of pathologic, diagnostic, prognostic and therapeutic implications that this common expression conveys to the physician? All but the most medically sophisticated patients need to be informed, I suspect, in nontechnical terms and the physician who ignores this obligation is guilty of a form of arrogance….

In medical school, students are told about the perplexity, anxiety, and misapprehension that may effect the patient as he enters the medical-care system, and in the clinical years the fortunate and sensitive student may learn much from talking to those assigned to his supervision. But the effects of lectures and conversations are ephemeral and are no substitute for actual experience. One might suggest, of course, that only those who have been hospitalized during their adolescent or adult years be admitted to medical school. Such practice would not only increase the number of empathetic doctors; it would also permit the whole elaborate system of medical-school admissions to be jettisoned.

As Dr. Ingelfinger noted, sometimes it's necessary for some one *other* than the patient to take charge to some degree. Of course, what works for one patient might not work for another, but the ultimate goal is for the patient to feel better – not only physically but emotionally as well. "What you need is a doctor." What a novel idea and, yet, in this day and age not so easily achieved — at least not the kind of doctor that Dr. Ingelfinger had in mind. His speech about paternalism was delivered just one year after New Jersey's Supreme Court's landmark ruling in the case of Karen Ann Quinlan that forever altered the dynamics between doctors and patients.

Karen was 21 years old when she lapsed into a persistent vegetative state. Her physicians refused to accede to her family's request that she be removed from a respirator that was presumed to be maintaining her in a permanent coma. The Court considered medical opinion in this case to be irrational and ruled 7-0 in favor of Karen's parents. The ruling established that constitutional guaranteed privacy rights assured an adult patient's prerogative to forgo life-sustaining medical treatment, and that—in this case—a parent could make the decision for their daughter. Later judicial rulings expanded on the so-called principle of patient autonomy that protects and promotes a patient's ability to make informed decisions. Not only were adult patients presumed to be competent to choose for themselves, but physicians would be required to tell whatever a sensible patient would need to know in order for *them* to decide.

This reversed a venerable tradition that dated back some two millennia to Hippocratic times. Consider these words of wisdom spoken by 18th and 19th century American medical titans:

> Benjamin Rush (1789): Do not condemn or oppose unnecessarily the simple prescriptions of your patients. Yield to them in matters of little consequence, but maintain an inflexible authority over them in matters that are essential to life.
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> The American Medical Association's first Code of Ethics (1847): "Doctors should unite tenderness with firmness and condescension with authority" so as to inspire the minds of their patients with "gratitude, respect and confidence….The obedience of a patient to the prescriptions of his physician should be prompt and implicit….He should never permit his own crude opinions influence his attention to them."
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> Oliver Wendell Holmes, Sr. (1872): "As far as possible, keep your doubts to yourself, and give the patient the benefit of your decision. Firmness, gentle firmness, is absolutely necessary…Your patient has no more right to all the truth you know then

he has to all the medicine in your saddlebags….He should get only just so much as is good for him."

William Osler (1889): "[Don't] expect too much of the people amongst whom you dwell. In matters medical the ordinary citizen of today has not one whit more sense than the old Romans, whom Lucien scourged for a credulity which made them fall easy victims to the quacks of the time…Deal gently then with this deliciously credulous old human nature in which we work, and restrain your indignation."

Still another luminary who feared that the emerging concept of patient consent might detract from a physician's responsibility to act unilaterally for his patient's welfare was Harvard's Francis W. Peabody. In 1926, at age 45 and already a full professor of medicine, he had exploratory surgery which disclosed an inoperable sarcoma of the stomach. While convalescing he began writing a talk which he delivered several months later and shortly before his early death. It anticipated Dr. Ingelfinger's address by eleven years and may have been the most often quoted speech in medical history. Its words were burned in the minds of generations of students and although they may sound quaint to modern ears, they speak eloquently to the essence of medicine — the doctor-patient relationship. Dr. Peabody began by telling the students that "the most common criticism made at present by older practitioners is that young graduates have been taught a great deal about the mechanism of disease, but very little about the practice of medicine — or, to put it more bluntly, they are too "scientific" and do not know how to take care of patients." Here are just a few of the more memorable lines:

The practice of medicine in its broadest sense includes the whole relationship of the physician with his patient. It is an art, based to an increasing extent on the medical sciences, but comprising much that still remains outside the realm of any science. The art of medicine and the science of medicine are not antagonistic but supplementary to each other…The treatment of a disease may be entirely impersonal; [but] the care of a patient must be completely personal….One of the essential qualities of the clinician is interest in humanity for the secret of the care ***of*** *the patient is in caring* ***for*** *the patient.*

Since the famous judicial rulings of the 1970s and 1980s, the law has continue to evolve and the current consensus favors a partnership model of "shared" decision-making between doctors and patients — each side respectfully considering the other's perspective. Although it is usually proclaimed that medical decision-making should be

“evidence-based,” even this model can be flawed; after all medical evidence may be weak or lacking and at the bedside some degree of uncertainty is normative.

Some old-timers like me are nostalgic for the old-style of physician paternalism, but it’s too late to put the genie back in the bottle. Indeed, almost unnoticed, a new kind of paternalism has been emerging in which neither physician or patient is in control, when arbitrary decisions are being made by faceless institutions and organizations. Empathy too often seems to be in short supply among today’s stressed health care workers performing their duties within an impersonal, business-oriented profession. Many medical practices are being bought by hospitals or large groups and treatment decisions are being informed by arbitrary guidelines and algorithms. Increasingly, either government or private insurers are determining decision-making by controlling what’s covered and what’s not. I suspect that Franz Ingelfinger, “The Finger,” would be appalled by this new style of arrogance, one that’s definitely *not* the good kind.

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