BIOETHICS OUTLOOK

John Plunkett Centre for Ethics in Health Care

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In this issue

♦ The idea that one might enjoy or suffer moral "luck" seems an odd one. How could something for which we are responsible also be (or be affected by) a matter of chance? And what have these ideas got to do with our being good health care professionals? These are some of the questions discussed in John Quilter's "Morality: Life's Meaning and Human Equality".

♦ In "Trust me, I'm a doctor!" Martin Kelly argues against a contemporary model for understanding the doctor-patient relationship: that it is a contract between two equal partners. Whilst admitting there are grounds for being cautious in the trust we place in our doctors, he claims that faith in a contract is no substitute for faith in the doctor.

♦ "Unanimously" is the key word in the title of our most recently published proceedings: *Why the Select Committee on Medical Ethics of the House of Lords unanimously rejected the legalization of Euthanasia.* For some of the members of the Committee were known to think euthanasia ethically unobjectionable. Nonetheless the Committee was unanimous in its recommendation that euthanasia should not be legalized. Details on how to purchase copies of Luke Gormally's talk on this subject (together with the discussion which followed his talk) can be found on page 11.

♦ Note also the programme for our third annual Intensive Bioethics Course to be held on the weekend of 12th April to 14th April.

Morality: Life's Meaning and Human Equality

John Quilter

Though we may not think about it a great deal, one of the things we are usually grateful to morality for is that it leaves our success in life up to us. Bad luck may mean that life fails us in love, good looks or athletic prowess. But the loss of the heart of a beloved to another, a crooked nose with too much hair growth and the inability to be a quicker runner than Aesop's famous tortoise is just bad luck and does not reflect deeply on *us*. (Of course, it may but there is a limit to how far it can: that limit is set by how relevant luck has been to what happens). But if we fail morally, it is *our* fault. It is us on whom it reflects if we act selfishly, meanly refuse to show a kindness or vengefully seek to make another suffer. These are things which present the agent in a bad light. They show the agent to be someone whose life is no good because of something the agent herself is or does.

But those dimensions of the good in our life which are up to the gods are not quite like this, even though, like having the good fortune of finding the right mate, they can make an enormous difference to the satisfaction we can take in life. Lack of success in these things is not like lack of success in the moral life. For the

latter, unlike the former, is ultimately up to us: if things do not go well for us as moral agents, we only have ourselves to blame.

Moral destiny

Another, closely related, thing about morality for which we can be grateful is that since people's "moral destiny" is their own doing, morality is an ultimately just and fair ground of the equality of human beings. Differences of respect and honour which we accord people in regard of (for example) their beauty or their family connections, are differences which arise through no effort of the people. Most of us would rate Elle McPherson at a higher rank than Mother Theresa in the physical beauty stakes. But Ms McPherson's advantages in this regard are not just the result of her efforts and the good sister's neglect. There are innate factors in play here and neither woman has any control over them. Likewise, part of the difference between Sir John Kerr and Sir Roden Cutler in regard to their different handling of their position as Head of State is reasonably well traced to their differences in family background and the differences for which they make in the two men's abilities to handle power and authority easily.

Again, these differences are not things over which a person has control: one is a product of one's social class even as one tries valiantly to overcome it: some of us have to try valiantly to overcome and others do not. And one's social class background is just a fact about us over which we have no control.

But with *morality*, we say, it is different. Over our performance in that sphere of life we have control. We have the wheel when the question is whether to be a decent person: I should pay my bills and it is up to me whether I do or do not. I should not pursue the spouses of other people and whether I do or do not is up to me. Thus, discriminations we draw between people in regard to their moral characteristics are not distinctions based on the good luck of some and the bad luck of others. The are based squarely on differences over which the people between whom the distinctions are drawn have control. We rate the honest as more deserving of praise than the deceptive.

We rate the killer as more deserving of reproach than the saver of lives. We honour the philanthropist more highly than the traitor. And which side of such distinctions one falls on is entirely up to oneself. Morality guarantees the justice of equality between human beings by ensuring that inequalities are fairly drawn, that is, by ensuring that they are based on differences which we have control of rather than lucky or unlucky difference between us.

Maggie's case

But consider the case of Maggie. She is a chipper 76 year old with a bit of a weak heart who is otherwise quite well for her age. She enjoys life as best she can in her hostel care. But every now and again she protests when she sees old friends being rushed off to the nearby acute hospital to end up on ventilators and "jumped on" in cardio-pulmonary resuscitation. There will be none of any such thing for her. She insists that when her time comes, she just wants to go quietly without heroics. She would just like to wait till Collingwood wins another Grand Final and she sees Laurie Daley's first child!

Maggie has just developed a mild arrhythmia. So, the young registrar, Dr Smith, checks the matter with a cardiac specialist, Dr Ho, who recommends X, a new drug. X has been well tested and Dr Ho is confident it will be good for Maggie. Dr Smith asks another cardiologist, Dr Grand, who suggests drug Y because he has not had experience of X. Dr Smith goes with Dr Ho's advice, being of the view that Dr Ho is a little more conscientious about keeping up with her discipline than Dr Grand is (though Dr Grand's reputation is slightly better established). Of course, there is a remote chance, something like 1:40,000 that Maggie will react badly to X. But there is really no reason to expect this, given what is known about Maggie's allergies, etc., and the chemistry of the drug. And she is not at all eager to be walked through all these details even though Dr Smith tries to do the right thing in these days of *Rogers vs Whitaker*. But Collingwood is on the TV this afternoon and she wants to be finished with Dr Smith so that she can be right to see the game.

Nurse Power administers the injection and before Dr Smith has got down the first few steps

to leave for her next visit, Nurse Power is screaming that Maggie is fitting. She is anaphylactic and things looks bad. Dr Smith has to act quickly or risk losing Maggie. Dr Smith's thoughts race quickly. Training and instinct tell her to administer hydrocortisone quick-smart, but something in her is unsure: she is mindful of the significant, though not large, risk either that Maggie may come out of this 'ventilator-dependent' for at least some time or that something worse may happen requiring cardio-pulmonary resuscitation even with the cortisone. And Maggie was adamant that nothing like that was to be allowed to happen to her.[1]

Of course, there are as many ways of thinking through the ethical question here as there are ethical outlooks (I have nothing to say to those for whom this scenario raises no ethical issue; such a person forgets she is dealing with another human being). No doubt the right thing to do is to do what one can to reverse the anaphylaxis as quickly as possible and reevaluate things from there. But the interesting point is that, while may one do one's moral best, for the most impeccable of ethical reasons, this will not be of much consolation if *the gods are not with Dr Smith.*

Dr Smith can be beyond ethical criticism. However, her ethical relation to the decision to do what she decides to do will be determined in major part by what happens to Maggie subsequently. And over that, Dr Smith has no control. It is up to the gods. It is a matter of luck. It is, you might say, 'moral luck'.

If Dr Smith is lucky, and Maggie comes out of the cortisone injection and goes off to watch the footy, she will thank her lucky stars and reconsider Dr Grand's advice regarding the arrythmia. If Maggie comes out of the anaphylaxis but only after a certain amount of damage to the brain and requiring support from a ventilator, Dr Smith will not be consoled by the thought that her deliberation before the fact was as good as it could be. For the point of it all – Maggie's well being – got lost and Dr Smith was the one who made the difference.

If the gods are unkind to Dr Smith, it is, of course, the right thing for her not to be down on herself, not to punish herself with a litany of hypotheticals. Still, this point will not help either. One's first serious 'morbidity', like one's first lost patient, is no laughing matter. One toughens up with age. One grows into that urbane, self-confidence which rolls with the punches and looks over its spectacles to point out that medicine is an art with its inexactitudes and one must learn to handle the occasional failure as part of the work. That is fine, but it does not remove the point that a human being's life and welfare can, with just a dash of bad luck, be lost at your hands. And when it happens, the fact that there is nothing one can do about it does not soften the force of the fact that one has done it.

This is not just a point about medicine, of course. Family lawyers face such facts. Criminal defence lawyers advise how to conduct a defence, and then their client gets life because of some unlucky element in the proceedings. Parents struggle to raise their children well and work for their happiness. Then, when the child goes off to work or to study, on the parents' advice and encouragement, something happens and it ruins the child's life. This is not just the professional life, the point applies to life.

Of course, some will want to say: "But since when things go wrong on one like this, unluckily, we really should not blame ourselves; and since it would just be morbid to dwell on the bad luck, how can one say this sort of bad luck is relevant to one's moral life? If one is not to blame when things go wrong like this, how does the way things unluckily turn out make a difference to one's success or failure as a *moral agent*?"

Moral agency

This response involves a very natural and common conception of morality. But it must be wrong. For if morality is so unrelated to such judgements as Dr Smith suffers from if things go badly for Maggie and one's moral success or failure is not borne upon even though one's children's life is ruined because they followed

one's advice, it is hard to know, quite seriously, what one's success or failure as a moral agent is. [My uncle "gave the nod" to his step-brother to go duck shooting at Lake Cargellico after the cut-out of a shearing season in the south west slopes in the early 1950s and the young man drowned while fetching a duck; my uncle never forgave himself.]

Life is pervaded by luck. This does not mean we should retreat into our inner psychic cloister and not live life. But it may mean that we cannot pretend that there is the only venue for our meetings with morality. Morality is a central part of life, all life, professional life no less than the rest of life. Because life is not our oyster, and because a good bit of it rests in the lap of the gods, our moral success and failure is, to some extent, a matter of luck. (There is more to be said than this, of course. But it cannot be said here.) We can only pray for forgiveness and God's consolation (this is one of the meanings of "God"); and we can only be humble about inequality before the bar of the moral law.[2]

Notes

[1] This case is adapted from Freeman and McDonnel (eds) (1989), *Tough Decisions*, OUP. I support Maggie's wish for the future of the AFL.

[2] The argument here is a development of the very difficult argument of Bernard Williams in his famous paper "Moral Luck" in his (1981) *Moral Luck*, CUP.

Notes on the Centre

♦ We are very pleased to announce that Dr Anthony Fisher, O.P., has recently become a Research Associate at the John Plunkett Centre. Dr Fisher, who has a distinguised international reputation in the field of health care ethics, is a lawyer by original training.

He has qualifications in both Theology and Philosophy and recently completed a D. Phil at the University of Oxford. The subject of his thesis, soon to be published, was "Justice in the allocation of health care resources". As Dr Fisher teaches Theology and Philosophy at the Melbourne campuses of Australian Catholic University, he will participate in our activities from over the border!

♦ Dr Martin Kelly was awarded First Class Honours in Philosophy at Macquarie University for his thesis on the doctor-patient relationship. Martin has accepted a scholarship to undertake a PhD at Macquarie University.

♦ Mr Keith Joseph has been reappointed to a position as Lecturer at Australian Catholic University and Research Associate of the Centre for a further two years.

♦ Ms Katherine Irvine, a graduate in Science from the University of New South Wales will be affiliated with the Centre in 1996. Katharine is currently completing a law degree.

♦ Mr John Quilter has been appointed Course Coordinator of the Master of Arts in Applied Ethics (Health Care). The first intake of students into this programme will complete the two-year part-time course at the end of the first semester in June this year.

A second intake of students has recently commenced study. Some classes are being held in the meeting room of the John Plunkett Centre at 17 Leichhardt Street, Darlinghurst. Here, students have direct access to the specialist bioethics library which is available at the Centre.

"Trust me, I'm a doctor."

The challenge of contracts to the role of trust in the doctor-patient relationship

Martin Kelly

Must patients place their trust in doctors? Or would they be safer to rely on contracts (real or implicit) to regulate the clinical relationship? There is a climate of opinion amongst consumers of medical services that caution, rather than trust, is the appropriate attitude to have towards one's doctor. From where does this sense come? Is it reasonable? If a "climate of caution" hardens into an "ethic of distrust", will that turn out to be harmful to the interests of patients? Can trust really be eliminated from the clinical setting? In particular, can a contractual relationship really substitute for a trusting one?

It is true that the models we use to understand the clinical relationship are changing. However, I shall argue that trust is ineliminable from the doctor-patient relationship. This is not a call for blind trust - which is really recklessness, in any case - but rather a recognition that we need to develop a realistic ethic of trust, an ethic which involves a reasonable mix of trust and vigilance. To trust is to take "not-so-calculated risks", rather than taking ill-judged ones.[1] When we trust someone, we give that person power over something we value. Trusting a doctor matters. It means taking risks with something which matters to us, as our life and health do, even though doctors may let us down sometimes.

The case of Lawrence

Consider the example of Lawrence, a patient who is recovering from pneumonia, who has just been diagnosed as having a terminal illness. Lawrence, otherwise in reasonable health, agrees to take chemotherapeutic agents in order to prolong his life, despite being aware that they will not cure him and may cause significant side effects. There is one part of his medical management about which he wants to have considerable say. He does not want to have his life prolonged by "artificial ventilation in the terminal stages of life". An ideal patient, Lawrence is well educated, articulate and assertive. He asks to speak with his doctor to make sure his views are known and to ensure that in the future she will make the kind of decisions about his care that he wants her to make.

In this case, the patient and the doctor discuss the matter at considerable length. The clinician raises a number of scenarios in which ventilation might be considered in the future, (such as a recurrence of his pneumonia after an operation, and so forth). Lawrence concedes that he might change his mind in the future, but says that at this time he "cannot foresee" a situation in which he would want ventilation. The doctor agrees to respect her patient's autonomous decision, and they document his instructions in the chart. Do they have a contract? The terms seem clear, a deal has been struck, and it is documented in writing. Would it be legally binding?

As the doctor is about to leave the ward, she is called back. Lawrence, (prior to going home) has just been given his first dose of an oral antibiotic and has suffered an acute allergic reaction to the drug. He rapidly becomes oedematous, goes blue and loses consciousness. Ordinary treatment for this patient calls for adrenalin, IV fluids, intubation and artificial ventilation until he recovers, which could reasonably be expected to happen within a couple of hours. Failure to treat will be rapidly fatal.

The terms of the contract - "I do not want ventilation in the terminal stages of my life"- seem clear. Should the doctor wait until Lawrence stops breathing, then pull the sheet

over his head and go home? If she treats him, is she guilty of medical paternalism? Is this situation sufficiently unlike the others they discussed for the doctor to discount the prohibition of ventilation "at the end of life." The doctor has recently discussed the patient's values, his choices and why he made them. If the doctor decides to treat, do we charge her with a breach of contract, or do we applaud the wise use of her discretion in the care of the good (his health) which Lawrence had entrusted to her? If the doctor decides she is bound to inaction by Lawrence's instructions, do we applaud her respect for his autonomy? Or do we accuse her of too-literal an interpretation of those instructions?

Whatever the doctor chooses to do, there will be some who will argue that she has failed to live up to the trust the patient placed in her to honour their contract. Trust is of central ethical importance in clinical situations, because it is via the patient-doctor relationship that the clinician is able to achieve the goals of medicine. The problem, however, is that many people argue that it is unreasonable to trust doctors. Given the importance of what is entrusted to doctors and the risk of abuse or exploitation of patients, trusting a doctor (they say) may be unwise.

One response to this wariness about trust involves conceiving of the relationship between patient and doctor as one involving a contract to provide medical services with reasonable care and skill. Can the drawing up of a contract replace trust in the clinical setting, or is it only an illusory solution?

In the next part of this paper I will look at the reasons some argue that trust in doctors is unreasonable. Then I will consider a contractarian model of the clinical relationship as a response to the problem of trust and distrust, and show that contracts offer no real solution. In the concluding section, I will speculate about the possibility of a realistic ethic of trust.

"Trust me, I'm a doctor"

It is unlikely that many patients would find this simple invitation to trust their doctor reassuring. Indeed, it might make one wary of trusting a doctor who used the line in anything but jest. In this section I would like to look at the reasons some people think it is no longer reasonable to trust your doctor. These reasons relate to the power of the doctor's knowledge, to changes in medicine and society, to the vulnerability of the patient and to the phenomenon of illness itself.

The nature of professional knowledge

The nature of the doctor's knowledge creates a considerable inequality of power between patients and doctors[2]. The doctor's professional knowledge is not only formal, theoretical knowledge which, by being certified by the institutions of medicine, is additionally authoritative: it is also practically useful. It is knowledge the patient needs, about areas of his life in which he has no skill or expertise. Further, we entrust to the doctor not just our possessions, but ourselves, even our life and future possibilities. The patient trusts that the doctor will place her knowledge and expertise at his disposal and will not subvert the patient's interests to her own.

The doctor also comes to have knowledge about a patient whose nakedness is more than figurative. The patient may be stripped not only of clothes, but also of his or her roles and privacy. The practice of medicine sometimes requires that the doctor has access to the patient's body, mind or behaviours, perhaps in ways that might be denied even to a lover. Occasionally the most personal details may be the key to the medical situation. The doctor, often a stranger, is not exposed to the patient in corresponding ways.

Changes in medicine and society

If the knowledge doctors can deploy has considerable capacity to increase human health and well-being, why is there a climate of caution about trusting doctors? There are various reasons for patient uncertainty and scepticism, reasons which relate to changes in medicine and the profession itself, changes in the social setting of medicine and medical scandals.

Ours is a time of rapidly-changing medical knowledge, understanding and expectations. Doctors intervene in crucial ways in the lives of others. But as the capacity to achieve favourable outcomes increases, so does the risk of causing harm. Complexity causes uncertainty, even scepticism. While medical knowledge has come to be seen as the preserve of the "expert", the number of conflicting medical opinions available to the public increases. Which expert is right? A trend towards institutionalising illness and death adds feelings of alienation to uncertainty and doubt.

The social setting of medicine is also more complex, institutionalised and bureaucratised than it used to be. Medicine is more specialised and fragmented, delivered by "anonymous experts" who rely on investigations rather than information derived in consulting rooms to populations which are increasingly mobile. The resultant distancing and lack of continuity increases the risk of error while undermining the clinical relationship. It is harder to trust a stranger. At the same time, public expectations of medical outcomes increase as do government and institutional pressures for cost containment. There is thus considerable scope for dissatisfaction.

Finally, not all doctors live up to the faith that patients place in them. Public exposure of medical self-interest, fraud, over-servicing and malpractice, often compounded by failure of public or professional bodies to deal with abuses and scandals in a timely way, undermines public faith in doctors. Even worse, there are accounts of doctors acting in good faith with catastrophic effect. It seems that there is scope for caution about placing one's trust in doctors.

The vulnerability of the patient

One peculiar features of the clinical relationship is that one of the parties is in a position of vulnerability, while the other has a potential to exploit that vulnerability. The patient's vulnerability is caused only in part by the asymmetry of the clinical relationship. There are other factors. Let us consider the asymmetry first.

Clinical relationships are inherently asymmetrical. In the first place there is an asymmetry of knowledge and skill. It is unreasonable to expect that in a consultation a doctor can impart sufficient information to redress this imbalance. Indeed, increasing the patient's knowledge may increase rather than decrease the patient's sense of vulnerability. Increased awareness of the risks and options may be frightening rather than liberating. It may increase uncertainty which is disempowering. It may thus, paradoxically, decrease the patient's freedom.

It is true that patients do have some resources to assess the knowledge and practice of the doctor. However these will inevitably be limited and may be negligible in cases of emergency or serious illness. Further, the patient may not have the expertise to challenge a doctor's assessment that an outcome was optimal, given the particular circumstances of a case. After an operation the quality of workmanship may not be as open to external assessment as is the work of a builder, for example.

There are other asymmetries. The clinical setting serves to increase the doctor's role, prestige and security. The setting is familiar to the doctor but may be alienating for the patient. The patient and the doctor also come with different aims and goals. The patient sees himself as central in the consultation. To the doctor, the particular patient is one among many. The stake is different for each. The patient, anxiously awaiting the results of tests, theatre booking times, discharge, sees these as central. To the doctor they are merely tasks to be fitted into the day. For patients, delays contribute to a subjective experience of helplessness and dependency.

In addition, there are structural imbalances in the respective roles. The prestige of the doctor, and his or her possession of knowledge and skill which the patient needs, tends to set up a supplicant-benefactor dynamic. The patient negotiates from a position of need. The doctor determines how much information to impart, how long the interview proceeds, and so on.

The patient is aware that there are other calls on the doctor's time. Indeed doctors can use their 'busyness' to restrict the time, information and services they give to patients. There is potential for the clinical relationship to be dysfunctional.

There are other factors which work against the patient's sense of trust. Illness, pain and drugs may impair judgement. Illness may also disturb the patient's sense of identity. There is a sense of nakedness, of exposure (on the patient's part) which the doctor does not experience. The patient must trust that the doctor will respect his privacy and not exploit this vulnerability.

The trust we place in doctors is quite unlike the trust we have in a friend. In friendship, a sense of trust is developed and tested over time. In the medical situation the patient may need to trust a stranger with his life and future possibilities. There is often a degree of necessity. The patient is forced by circumstances to "trust" his or her doctor. There is also a vicarious aspect to this trust. Not only does the patient trust the doctor who operates on him, but the doctor represents a whole range of other people, processes and products, of which the patient is unaware, but on which his successful recovery depends.

The experience of illness

Illness undermines the patient's sense of trust. Sickness causes inconvenience, loss of freedom, dependence on others, forces a person to seek treatment which he or she may not want. In particular, illness disrupts a person's sense of security, disrupts the patient's roles and relationships with the world and others, and teaches that the person's body itself cannot be trusted. The once-familiar body can no longer be understood. It becomes a source of unwanted experiences, possibly even of threat.[3]

Then, there is the fact of mortality. The disease may be incurable. The doctor may be inadequately trained, careless or mistaken. Or the patient may be unlucky, and have an unexpectedly bad outcome from an illness or surgical procedure. The patient may have to face the prospect of death or irreversible pathological process.

In the face of the asymmetry in the clinical relationship, the vulnerability of the patient, community scepticism about medicine and the doctor's real capacity for harm, it is not surprising that trust in doctors may come to seem unreasonable.

The place of contracts

One response to this is the attempt to equalise the power relationship and protect the patient from abuse of trust by medical professionals by relying on contracts instead. On the one hand, there are calls for changes in the social division of medical labour, for example, for a "case management" approach, in which some other member of the team acts as a patient advocate. On the other hand, there have been medico-legal changes. The use of "living wills" or durable powers of attorney, the development of notions of informed consent, and the attempts by courts to define, interpret and regulate the obligations of doctors, even to the point of defining what investigations, disclosure or treatment are "appropriate" in a particular situation, are all symptoms of the trend towards contractarian "solutions" to the problem of distrust.

Robert Veach, in *The Patient-Physician Relation*, proposes a model for understanding clinical relationships as contracts.[4] Veatch imagines the typical doctor-patient relationship as being one of free agreement. He imagines a three-tiered contract. At the lowest level, a society negotiates its basic ethical system and the principles on which the society is based. At a second level there is another social contract between the community and the profession which regulates the basic norms and rules for the profession as well as the minimal standards of its members. At the third level is the individual patient-doctor relationship. Here there is room for discretion, as the two parties are free to negotiate whatever arrangements are mutually acceptable within the constraints set by the preceding agreements. Where no specific agreement is negotiated, there may be "default rules" (for example, the assumption of respect for privacy if the community determines that this is one of the role-specific duties of members of the profession).

Veatch's model seems to have much to recommend it. It gives an account of the complexities of clinical relations according to a simple paradigm. And it does not ignor the social framework of the practice of medicine. On Veatch's account, the patient and the doctor are equal partners negotiating the delivery of medical services. They have a contract which regulates the exchange. They do not need to negotiate every aspect of the relationship because the norms of medical practice have already been agreed upon between the profession and society.

In particular, there is no room for medical paternalism on Veatch's account. The patient is not an inferior but an equal party. She seeks and is given enough information to choose wisely from the menu of options presented by her doctor. The basis of the doctor's right to treat is the free, informed consent of the patient

Nonetheless I shall argue that the idea of a contract is not an adequate model for understanding what happens between a patient and a doctor. It is reductive. It tends to gloss over what cannot be spelled out. It ignores power inequalities and the patient's vulnerability. Let me spell out some of these criticisms.

"Hidden" assumptions

When we talk of contracts we assume that the parties are free, rational, self-interested, equal and mutually-wary individuals who negotiate a contract and are rationally bound it. The assumptions underlying this model are crucial. In the first place, the model idealises the self of reason. It assumes that both individuals are impartial, aware of their motivations, and negotiating in clear awareness of the stake. Second it assumes that the patient's autonomy is not restricted by illness, ignorance, uncertainty, urgency, emotions or commitments to others. In the absence of alternative options, a coerced contract can masquerade as a free relationship.

Third, it assumes that the parties negotiate from positions of approximate equality, which is unlikely given the patient's vulnerability and the asymmetry of knowledge. This inequality of power is exaggerated because it is doctors who interpret the contract. Patients are in a weak position with regard to enforcing the contract or seeking compensation.

Conceiving the clinical relationship in terms of a contract gives the illusion of equality between the parties while obscuring the reality. Making the inequality invisible increases the vulnerability of the patient.

Embodiment overlooked

Construing the patient-doctor relationship in terms of a contract model leaves out the importance of embodiment. This matters for two reasons. First, we are embodied selves, and that has an impact on the way we relate to others. For example, a person approaching death might, in the usual course of events, experience stages of depression, anger or denial. The state of the body affects the way the person sees and interprets things. Disease can affect the nature and quality of the clinical relationship. So the body affects the patient's ability to enter into and negotiate contracts.

The second point about embodiment is that human bodies are biological systems. They are marked by complexity, uncertainty and unpredictable responses. This means that no clinical contract can cover every possible situation. There is always room for discretion, judgement, interpretation about how best to deal with apparent conflicts of duties when the clinician is faced with unexpected situations. No contract can eliminate this discretion. Indeed, one of the things we trust our doctor to do is to put her clinical judgement at our disposal, and to use her discretion to take care of our interests.

The case of Lawrence illustrates the fact that even when two intelligent, informed and well-intentioned people have gone to some lengths to arrive at an agreement about even a single part of the treatment, there is still room for interpretation when a novel situation arises. Contracts cannot take account of the non-standard nature of clinical situations. They

cannot remove the need for the doctor to use judgement and some discretion in interpreting how to fulfil her obligations to the patient. Contracts by their nature depend on a trusting relationship. They take competence, judgement and lack of ill-will for granted. "Every contract is an invitation to trust."[5]

Is there a place for contracts in medicine? Yes. Contracts, explicit or implicit, can play a role in enabling the patient to participate in the medical management and decision-making, in clarifying the values, expectations and decisions of both patient and doctor and allowing them an opportunity to negotiate the differences between them. But to explain the clinical relationship solely in terms of contract is to misunderstand it.

Conclusions

Those who seek to put their faith in contracts, in an attempt to eliminate the need to trust doctors, are bound to be disappointed. Contracts are only an illusory alternative to trust in the clinical setting. The contract model hides rather than redresses the inequalities in the doctor-patient relationship. The challenge in seeking to understand the clinical relationship is to give meaning to the notion of respect for the patient's autonomy in a setting of inequality and asymmetry. That requires a more complex understanding of the role of trust and trustworthiness in developing clinical relationships.

There is a real tension here. On the one hand, patients have grounds for being cautious in trusting doctors. On the other, a degree of trust is necessary to achieve the goals of medicine. Trust is necessary for the relationship to flourish, to ensure that there is exchange of information in sufficient detail, to ensure compliance, to avoid bad decisions and to be reasonably efficient. Both parties need to be honest in the exchange, and the patient needs to assume that the doctor has the knowledge and skill needed and that he will place them at the patient's disposal.

It is true that some doctors have violated trust relationships, and that trust cannot always be guaranteed. But this does not diminish its importance in professional (or other human) relationships. However, it makes one wary. This reality invites us to be more thoughtful about trust, to be careful about whom we trust, and with what. We must be alert to the pathologies of trust. Absolute notions of trust are unsound. They always have been.[6]

There are no simple tests for trust which assess which doctor is trustworthy, when to encourage trust, and when it is wiser to distrust. But trust in the clinical setting is like trust more generally. Children learn to trust at the same time as they are being taught to be careful with strangers. They learn to be discriminating in their trust, to have a "functional mix of trust and vigilance."[7]

More work needs to be done to elucidate the role of trust and distrust in the clinical relationship, to elucidate the pathologies and vulnerabilities of trust. This requires a complex account of the patient-doctor relationship, together with a nuanced account of trust. A simplistic notion of trust may increase the vulnerability of patients to exploitation by doctors, just as a facile reliance on contract solutions can do. What can we say for now?

Faith in contracts is not a substitute for faith in doctors. What matters is whether trust in doctors as a profession, and in one's individual practitioner, can be sustained. Can patients learn to discern climates of trust? Does this doctor, and does the medical profession, work towards empowering patients. Is the doctor accountable and trustworthy? Or is there a reliance on the power of the knowledge and the role to increase the asymmetry between parties in the clinical relationship? Would a clinician who said "Trust me, I'm a doctor" be as reassuring as one who behaved in a trustworthy manner, and worked to develop accountable and mutually trusting relationships in clinical situations?

Notes

[1] **Annette C. Baier, "Trust and its Vulnerabilities", in *Moral Prejudices*, Harvard University Press, Cambridge, Mass., 1995, p. 196.**

[2] Robert Sokolowski, "The Fiduciary Relationship and the Nature of Professions" in Pellegrino, et al., *Ethics, Trust and the Professions*, Georgetown University Press, Washington, 1991, pp. 23-44.

[3] Richard Zaner, "Trust and the Patient-Physician Relationship", in Pellegrino, et al., *Ethics, Trust and the Professions*, Georgetown University Press, Washington, 1991, p. 50.

[4] Robert Veatch, *The Patient-Physician Relation - The Patient as Partner, Part 2*, Indianapolis University Press, Indianapolis, 1991, pp. 29-42. In this article I present no more than an outline of Veatch's "contractarian" account of the doctor-patient relationship.

[5] Annette Baier, *Moral Prejudices*, op. cit., n. 5, p. 341.

[6] Edmund Pellegrino, "Trust and Distrust in Professional Ethics", op. cit., p. 76.

[7] Annette Baier, "Trust and its Vulnerabilities", *Moral Prejudices*, op.cit., p. 189.

NOTEBOOK

Publication of latest seminar proceedings

The talk by Luke Gormally, the Director of the Linacre Centre for Bioethics, London, entitled *Why the Select Committee on Medical Ethics of the House of Lords unanimously rejected the legalization of Euthanasia* is the subject of our most recent seminar proceedings publication.

The seminar was presented to an invited audience in the Francis Spaight Room of the Sacred Heart Hospice on 10 November 1995.

In this talk Mr Gormally explains why the Select Committee, containing as it did, several members who were known to think euthanasia ethically unobjectionable, came to the unanimous conclusion that it ought not to be legalized. In doing so, Mr Gormally raises many of the complex social and public policy issues involved.

This volume also contains the substance of the discussion which followed Mr Gormally's talk. It is a valuable contribution to the debates about the legalization of euthanasia in Australia.

Intensive Bioethics Course

This edition of *Bioethics Outlook* contains a flyer together with a brochure and application form for the third Intensive Bioethics Course. The course will be held at the Ave Maria Retreat Centre of the Franciscan Missionaries of Mary at Point Piper in Sydney on the weekend of Friday 12th April to Sunday 14th April.

The John Plunkett Centre has been fortunate to have attracted prominent clinicians, ethicists, lawyers and philosophers to present participants with the current challenging issues in health care. Speakers include Professor Donald Chisholm (Medicine, University of New South Wales), Mr Terence Tobin, QC of the Sydney Bar and Dr Anthony Fisher (Theology and Philosophy, Australian Catholic University).

The keynote address will be given by Professor John Malony, the noted Australian historian who is currently a Research Professor in the Institute of Advanced Research at Australian Catholic University. Professor Malony is the author of a biography of John Hubert Plunkett after whom our Centre is named.

It would be appreciated if information about the course could be passed on to others who might be interested and, if appropriate, the flyer could be displayed in some suitable place.

A limited number of scholarships is available for those wishing to attend the course. For further details contact Barbara Reen on (02) 361 2869.

Subscriptions for 1996

Thank you to those subscribers who have already renewed their Associate Membership of the Centre for this year.

If you have not renewed your subscription to *Bioethics Outlook* for 1996, please use the subscription renewal reminder form in this issue.

If you wish to pay by Bankcard, Mastercard or Visa, the details can be phoned through to Ms Barbara Reen or Ms Sam Reeve on (02) 361 2869 or faxed to the Centre on (02) 361 0975.

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