Hastings Center Report

Volume 42, Issue 6
November-December 2012
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perspective

Clinicians' Power and Leadership

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First published:
8 November 2012 Full publication history

DOI:
10.1002/hast.97 View/save citation

Cited by:
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Abstract

Despite medical leaders' increasing acceptance of the idea that the whole person should be the focus of care, empirical studies show clinicians generally remain focused on narrower goals: disease categories, standardized treatment procedures, and objective measurements of health improvements. We assume doctors want to do a good job, consistent with their perception of the goals and norms of their profession, so they practice medicine based on the illusion that clinical medicine is "knowledge treating disease," not people treating people. We believe that doctors'

seeming reduction of patients to clinical objects results from not seeing themselves as leaders for their patients or accepting their constructive power in clinical encounters.

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Perspective

Despite medical leaders' increasing acceptance of the idea that the whole person should be the focus of care, empirical studies show clinicians generally remain focused on narrower goals: disease categories, standardized treatment procedures, and objective measurements of health improvements. One example, published last year by Kari Milch Agledahl and colleagues in the *Journal of Medical Ethics*, reports the findings from videotaped consultations of seventy-one doctors in various large nonpsychiatric hospitals. The doctors, cheerful and friendly, showed little interest in patients' personal losses and their experience of sickness. They focused instead on biomedical facts and objective problems, and patients were left "puzzled and unable to voice any protest."

We assume doctors want to do a good job, consistent with their perception of the goals and norms of their profession, so they practice medicine based on the illusion that clinical medicine is "knowledge treating disease," not people treating people. We believe that doctors' seeming reduction of patients to clinical objects results from not seeing themselves as leaders for their patients or accepting their constructive power in clinical encounters. Empirical findings and everyday experience suggest that medicine as practiced diverges from its universally supported patient-centered principles.

There is an error in how sickness is often understood that has a crucial bearing on the roles of both patients and doctors and on their relationship. The manifestations of sickness are thought to be only symptoms or phenomena resulting from the pathophysiology of disease. Patients sick enough to require care in bed, however, no matter their disease, acquire certain problems in thinking and changes in behavior that put in doubt not their autonomy, but their ability to make independent judgments. Patients sick like this feel disconnected from the world, lose the usual sense of indestructibility and omniscience, and experience a loss of control. These patients' thinking changes to the extent that their cognition is like that of children in what Jean Piaget called the preoperational stage (ages six to ten). They lose normal executive function and have impaired emotive thought. These same patients will mostly be judged to have decisional capacity because they pass mini-mental state exams, but in order to exercise their autonomy, require help from their doctors. (No one can be autonomous completely alone.) They need assistance to understand the information that bears on decisions and their situation and to evaluate their choices. They remain, however, the only ones who know their values and what is most important to them.

Our society thinks of physicians as experts on the mecha-nisms, diagnosis, and treatment of disease. Doctors' actions toward the person who is diseased have been characterized, somewhat pejoratively, as the "art" of medicine. Devaluing attention to the life challenges facing patients fits the sadly incom-plete picture of the sick as persons enduring only the physical manifestations of disease.

When a patient's declaration of need is met by the clinician's offer to help, a doctor's power emerges.

That power, wrote the sociologist Per Maseide, "is possibly abusive, often benign, and always necessary."[1] Clinicians have power over patients' well-being, perceptions, expectations, and decisions. Patients rely on and interpret their doctors' words and actions (or lack thereof) in ways that may affect their perceptions of themselves, their situations, and their ability to deal with disease, sickness, suffering, or death. Doctors who know this use their power to support and strengthen their patients' efforts to get better and adapt. Clinical leadership is the ability to accept, appreciate, and channel doctors' professional power into support for patients' autonomous functioning and adaptation to loss.[2]

The relevant medical skills should be rooted in an understanding of personhood, of how sickness afflicts personhood, and of how doctors must recognize and exercise their power and leadership functions to truly support patients.

1 P. Maseide, "On Power and Domination in Medical Practice," *Sociology of Health and Illness* **13**, no. 4 (1991): 545-61.

CrossRef

2 E. Schei, "Doctoring as Leadership: The Power to Heal," *Perspectives in Biology and Medicine* **49**, no. 3 (2006): 393-406.

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