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Consent or Obedience? Power and Authority in Medicine

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A recent biography of the social psychologist Stanley Milgram (*The Man Who Shocked the World,* by Thomas Blass) details the "obedience experiments" that made Milgram famous. These studies demonstrated that ordinary people could be induced by an authority to deliver to a victim what they believed were increasingly harmful electric shocks. Milgram's contribution was not in showing that human beings obey authority, but in demonstrating how powerful and potentially dangerous that predisposition is. It doesn't take evil or deranged people to do awful things to others; normal people will act that way if commanded by a legitimate authority. Sadly, although these were laboratory experiments, the results are substantiated by daily experience.

One of Milgram's Research Subjects at the Shocking Machine.

Milgram's work taught us something profoundly revealing about human nature: how prone we are to obey the commands of an authority even when they conflict with our expressed desires or moral principles. Here was a common, perhaps universal, human characteristic that came as much as a surprise to psychologists and physicians as it did to others. Indeed, the real surprise may be how little research-confirmed knowledge there is about everyday human behavior.

Milgram's research carries implications for at least two important issues in the hierarchical world of medicine: the role of inappropriate obedience as a source of abuse in the teaching hospital and the effect of obedience on patients' autonomy and consent. In the hospital, faculty members have jurisdiction over house staff, house staff have authority over students, and all these people are seen as authorities by patients. There is probably no physician or medical student who has not seen or participated in callousness (or worse) in the treatment of patients in response to an order of a resident or an attending physician.

We might simply feel bad, and let it go at that, when patients are mistreated because of undue obedience on the part of health care personnel, if it weren't for other findings of Milgram's research. For not everybody obeyed. Some research subjects who thought they were hurting someone refused to continue. In general, more subjects refused to obey when the victim was brought physically closer to them, with the greatest disobedience occurring when the subjects could touch the victims. Perhaps we should expect episodes of bad treatment of patients by people following the orders of remote authorities. Accepting this fact is necessary in order to prevent ill treatment. To some degree, obedience is a requirement of training, but abuses of authority do not have to happen in medical institutions; appropriate disobedience can be taught. It is important that this problem and its solutions be discussed and integrated into training programs.

Milgram's studies also bear on the issue of patients' autonomy and consent to treatment and research. The past 30 years have seen the gradual disappearance of the model of the autocratic, paternalistic physician who extracts consent from patients — a model that has been superseded by the concept of patient autonomy, widely translated as freedom of choice. But such a view neglects the complexity of the social world that acts on all of us. This complexity has led to increasing questions about what autonomy means in medical settings.[1]

The question of how often patients' consent really reflects their best interests (as they understand those interests) rather than

representing obedience to the physician's authority is made more urgent by the results of Milgram's research. Physicians want to believe that their authority resides in their expert advice, not their social power, and that consent to their inclinations reflects acknowledgment of that expertise. Physicians do not like the word "obedience" — even "compliance" has fallen from favor — because they reject the image of the authoritarian physician and the dependent patient that it evokes.

But the matter is not so simple. First, patients provide consent not only about the big things that require signed forms or other formal processes. In the course of an illness, sick patients, especially if they are hospitalized, consent innumerable times to interventions that they would rather not undergo — from taking medications to enduring painful procedures. Second, medicine is primarily about sickness, not health. Considerations of authority, autonomy, and consent must be informed by what we know about sick patients and their relationships with physicians. Serious illness is marked by losses of normal function in many dimensions of existence, including the ability to reason and to act (without which "autonomy" loses meaning).[2] Sick people do not do things primarily because they have single-mindedly reasoned their way to decisions based on appraisals of the relevant information, but because an authority helps them to decide.

In the aftermath of Milgram's work, other researchers attempted to explain the subjects' obedience. They described six possible sources of an authority's social power: coercive power that is also a potential source of punishment, the power to reward that is a potential source of approval, legitimate power with its right to prescribe behavior, power in authorities that are admired, power that derives from expertise, and power that follows from information given in a convincing manner.[3,4] Although these studies, like Milgram's, involved experimental subjects, not patients, we can easily identify these sources of power in the medical world — and add the power that comes from the hospital setting and the trappings of medical authority. Such power can be enhanced, diminished, used well or ill, but it cannot be disowned. For example, sometimes, in seeking consent from patients, physicians merely tell them the options and ask them to choose one. Aside from being insensitive to the facts of illness, this method complicates sick patients' efforts to be obedient, for they must first divine which option their doctors prefer.

Bearing in mind the effect of sickness on function, we should accept the propensity of sick patients to seek our approbation, celebrate our expertise, and acknowledge the legitimacy of our authority by doing as they think we wish. These tendencies present us with the difficult responsibility of, first, probing carefully to discover what patients believe to be best for them and, second, ensuring that their best interests guide both what we ask of them and our own actions.

To date, the field of bioethics has been limited in its understanding of the nature of responsibility and its basis in human relationships. Milgram's research serves medicine well if it makes us aware of the breadth of our responsibilities to sick patients. We are responsible for knowing, among other things, what patients are doing out of obedience rather than because it is best for them. The biggest thief of autonomy is sickness. One of the functions of medical care is to help patients reassert their autonomy — including their ability to make authentic decisions.

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