Respect for patients’ dignity in primary health care: a critical appraisal

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Modern health care is faced with profound challenges. It is accused of being paternalistic, interventionist, reductionist and inhumane (1). In addition, it is threatened by a resource crisis and an organisational crisis, but, more profoundly, also by a crisis in communication between physician and patient and in the trust in health care professionals in general.

Many of these challenges have been attributed to modern health care’s violation of the autonomy of patients (2,3). One important term introduced in the debate on patients’ autonomy is “dignity”. Generally, it is argued that respecting and promoting the dignity of patients is a fruitful way of facing up to the profound challenges confronting modern health care (4).

Although violation of a patient’s dignity is no more prevalent in primary health care than it is elsewhere, it seems that GPs have been at the forefront in confronting profound philosophical issues such as patient dignity, particularly in Scandinavia (4).

The point of departure for this article is that I share the concern for the respect of dignity in primary health care. My objective, however, is to scrutinise whether there are limits to the ways physicians can address patients’ dignity. In other words: Can respect for patients’ dignity become undignified? A case history might illustrate this key question.

Case
Karl Karlsen, a 55-year-old salesman, comes to his GP complaining about low back pain. The GP examines Karlsen, but cannot find anything significantly wrong with him. During the examination he asks Karlsen if he can think of any reason why he has pain in his daily life. Karlsen relates that he sits a lot at his work, both at the office and in his car, but that he never had this kind of pain before. The GP asks if he knows of family members who have had back pain, but Karlsen can think of none. He asks if Karlsen can think of any other circumstances or events in his life that could be connected with the pain – sometimes mental or personal issues have bodily manifestations. Karlsen remembers that his big brother used to hit him a lot when they were children. As they talk, he recollects that he used to have some pains in his neck and upper back, because he was always afraid that he would be hit, but that they became brilliant friends later and that his brother died in a car accident some years ago. The GP asks if there are any situations in his life when he feels threatened – maybe at work, in his marriage or in his relationships with other people. Karlsen cannot think of any particular cases – he has a lovely wife, they quarrel from time to time, they have discussed divorce once or twice, but decided to stay together because of the children, and he thinks that none of them regret this today. His work is challenging, his boss is a bit fuzzy, and sometimes it is difficult to reach the nominal sale figures, but he has never thought of this as threatening before. The GP prescribes a mild pain-killer and sets Karlsen up for a new appointment after 12 days. After some days, Karlsen calls and cancels the appointment as he has been to another GP who detected haemorrhoids causing his pain.

Usually, the violation of a patient’s dignity causes ethical challenges in health care, but this case indicates how addressing and taking into account the
patient’s dignity might also constitute an ethical challenge. Hence, in investigating whether the concept of dignity can become undignified when applied as a practical and analytical category, I concentrate on certain potentially negative consequences of a “dignified medicine”.

DIVERSITY OF DIGNITY
In ordinary language, “dignity” refers to the quality or state of being honoured or esteemed. Dignity is also related to worth, which appears to have many connotations. The worth or esteem of a person can be a reflection of that person’s position or status, but might also be independent of it. It is this latter interpretation that is referred in the discussion of the urgency to respect patients’ dignity.

In this connotation, dignity is related to a person’s autonomy. This appears to be partly because dignity is related to one of Kant’s famous formulations of the categorical imperative: “So act as to treat humanity, whether in your own person or in another, always as an end, and never as only a means” (5). Hence, every person is an end in him/herself as he or she is self-legislative. Attending to every person as an end in him/herself involves concern for the person’s welfare, but also requires a certain respect and distance.

Furthermore, dignity also associates with autonomy in another way. In terms of modern bioethics, autonomy is conceived of as one of the four basic bioethical principles and conceived of as practical self-determination (3). Another interpretation of dignity in the context of health care might be integrity (bodily, mental, existential) (6).

I believe that all these connotations can be fruitful in making sense of dignity as a core concept in health care. Instead of elaborating on the concept of dignity, I will explore some of its limits. But why investigate a concept at its outer edges? Some of the core characteristics of a concept are revealed at its boundaries. For example, we can learn more about the concept of disease from the discussion on fibromyalgia and homosexuality than from cases such as heart attack and stroke.

Moreover, there is a tradition of self-restriction in medicine, and the emphasis on the limitations of medical activity can be traced back to ancient medicine (7,8). The objective is therefore to investigate the limits of how dignity can be applied as a practical and analytical concept in health care and whether it can have some adverse effects. This will be done with reference to a profound analysis of the epistemological and ethical foundations of health care.

ON MEDICAL FALLIBILITY
In a classical article entitled “Toward a Theory of Medical Fallibility”, Samuel Gorovitz and Alisdair MacIntyre discuss the constitutive fallibility of medicine (9). They argue that we tend to believe the fallibility of medicine has two sources: ignorance and negligence. Health care professionals make errors either because their knowledge is insufficient, e.g. because medical progress has not reached far enough, or through negligence and wilfulness making them culpable.

Gorovitz and MacIntyre, however, point out that this is erroneous. One frequently neglected and important type of fallibility in medicine is the fallibility in the knowledge of the particular. Within any knowledge-based activity involving particulars, generalisations are never universal, but only “characteristically and for the most part” universal. Because of this particularity, medicine constitutively is fallible. As the individual’s particularity is defined by what is good for him or her, medical knowledge can never be universal. The individual has to be understood as a whole person prospering and flourishing or failing and declining. “Precisely because our understanding and expectations of particulars cannot be fully spelled out merely in terms of lawlike generalizations and initial conditions, the best possible judgement may always turn out to be erroneous, and erroneous not merely because our science has not yet progressed far enough or because the scientist has been either wilful or negligent, but because of the necessary fallibility of our knowledge of particulars” (9, p. 62).

How, then, does this relate to our discussion on dignity as a valuable concept in health care? First, Gorovitz and MacIntyre point out that any conception of medicine has to relate to individual persons and reflect respect for their differences. In any medicine for the good of individuals, these individuals have to be taken into account as whole persons, and their particular conception of the good life and individual way of prospering and flourishing in it has to be acknowledged. That is, one has to attend to and respect their dignity.

Second, Gorovitz and MacIntyre point to a fundamental flaw in the traditional view. Medicine is not a positive, reductionistic, mechanistic and materialistic activity. It is not an applied science imposing general rules on particular cases. Medicine deals with whole persons. This is also relevant to any conception of dignity in medicine. The core of the activity is not merely to apply a general rule to a particular case, but also to understand the particular case as a person.

Third, the theory of fallibility also emphasises the value-ladenness of medicine. As medicine is con-
cerned with individuals it will also be concerned with values other than scientific values (truth-seeking and problem-solving). Correspondingly, any concept of dignity is value-laden, and to focus attention on dignity renders medicine’s value-ladenness explicit, which has become ever more important in modern technological medicine.

Fourth, Gorovitz and MacIntyre’s theory underlines an inevitable and fundamental fallibility in medicine (as well as in most sciences). Their main thesis, that any knowledge-based practically oriented activity can be wrong in judging the individual case, appears to be highly relevant to any theory of dignity. Even medicine in which the ends and goods of the individual are taken into account, striving to make life for the particular patient prosperous and flourishing might be erroneous. We may actually be wrong in our interpretation of the dignity of the other. As in the case of Karl Karlsen, the physician might be wrong in interpreting what is good for the patient, in judging what will make for a life of prosperity and flourish, and in how to respect the patient’s dignity.

Another important aspect of Gorovitz and MacIntyre’s theory of fallibility is their analysis of internal and external norms. They argue that medicine, such as any science-like activity, is ruled by internal and external norms. Internal norms are the professional’s norms about what is good medicine, and external norms are social norms of utility, honesty and openness. A traditional conception of fallibility is when internal norms dominate an activity, violating external norms. For example, the SS doctors followed internal scientific norms of science, but failed to acknowledge external norms. Accordingly, dignity can be a concept that redirects external norms to the centre of medical activity and resets a necessary balance.

Moreover, it could be argued that dignity might also become an internal norm, making professionals ignore other external norms. Medical harm might be done under the cover of promoting people’s dignity. An internal norm that has the legitimacy of an external norm might become dangerous. Here it appears to be crucial to distinguish between promoting and respecting patients’ dignity. Promoting dignity more profoundly intervenes in their private life.

However, Gorovitz and MacIntyre argue that the traditional view of the relationship between internal and external norms is erroneous. Doing what the SS doctors did is wrong not only according to external norms, but to internal norms, too. Medicine whose function towards the individual person is acknowledged cannot have internal norms that result in experiments such as those performed by the SS doctors. Thus, dignity cannot become a legitimate internal norm if it violates individuals’ conceptions of a prosperous and flourishing life. Hence, the danger of dignity is not that it might dominate the internal norms of medicine, but that a dignity-based approach will violate profound internal norms.

Hence, Gorovitz and MacIntyre’s theory of medical fallibility points to one important fact about all medical activity which appeared to be prominent in ancient medicine, but which now seems to be lost: self-restriction. Any good medicine, i.e. a medicine in which a patient’s dignity is addressed and acknowledged, has to reflect on its own limitation. Any theory of dignity that does not acknowledge the fallibility of the particular is in danger of becoming interventionist and paternalistic. Hence, any situation in which the physician pretends to know better than the patient how to address his dignity is a dangerous one.

Thus, any theory which purports to overcome severe difficulties with reductionistic, technological and materialistic modern medicine, and which does not pay due attention to its own limitations, may be as dangerous as the type of medicine it criticises. That is, it is not enough simply to address the crucial failures of the existing theories. The threat of paternalism appears not to be related to any particular kind of medicine, but seems more to be founded in the basic asymmetry in medicine: a person who is unable to cope with his or her life asking a professional for help. There may be many ways to abuse a patient’s trust, and “dignity-based health care” might be as good as any.

CONCLUSION
Dignity, a concept by which the distinctiveness of each individual patient is addressed, appears to be overlooked to a frightening degree in modern health care. It is a necessary corrective to reductionistic medicine, and makes us focus our attention on the person, particularly on the person’s basic worth, and not just the body.

The discussion also points to another important issue. Respecting patients’ dignity requires a certain distance to the patient. As K. E. Løgstrup points out, there is a zone of untouchability that has to be respected (10). This reveals that the concept of dignity is wider than autonomy in terms of self-determination. Dignity is relevant even though the patient is unconscious or incompetent. That is, it addresses some of the difficulties with the principlist autonomy (3), and illustrates that it is a fruitful concept in debates on ethical issues in primary health care. Hence, the concept of dignity is closer to Kantian autonomy than to principlist self-determination.
It is therefore important to determine whether the aim of health care is the promotion or the respect of dignity, and I have argued that the latter must be the case. In every encounter, patient dignity has to be respected, whereas its promotion is not a medical matter.

Thus, the answer to my initial question, can medical attention to a patient’s dignity become undignified, is yes. Also within a “dignified health care” it is crucial to acknowledge the basic fallibility of medicine. Every GP can err, not only in judging the patient’s biomedical condition, but also in judging his/her dignity, and according to Gorovitz and MacIntyre this error is not culpable. But GPs become culpable when imposing certain concepts of dignity on patients and in intervening in what they conceive of as the good life.

Hence, dignity, like many concepts of health care, is like a double-edged sword. It might be a source through which to enhance respect for suffering persons and correct reductionistic technological medicine, but it might also be a means by which to abuse the asymmetry between physician and patient. It might be violating patients’ dignity to “treat them like children” or to perform what has been called “white magic” (11). This may make the physician unworthy of the patient’s fundamental and unrestricted trust.

Hence, any good theory leaves room for criticism. Any good health care comprises reflections on its limits. Being able to reflect on the limits of one’s activity is a virtue which has a long but almost lost tradition within medicine. If we stop to discuss health care’s goals through its basic concepts, we have entered along dangerous paths. If we stop to debate health care’s limits, its demarcation to other related activities will dissolve into thin air.

REFERENCES
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