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Patient Morality: Compliance, Perseverance and Other Athletic Virtues

William Ruddick

SUMMARY: There are two current, conflicting models of good patienthood: the Good Child and the Smart Consumer. But neither fits the medical circumstances of most patients; nor does a plausible intermediary, the Good Client of professionals. More suitable, less biased are the Good Soldier and the Good Athlete, both persevering and optimistic despite known risks. Soldiers, however, are subject to their superiors' orders. Athletes, by contrast, are coached, not commanded; reproached for noncompliance, not reprimanded for disobedience. If patient virtues are to support, not subvert, patients' rights, then the Good Athlete is the preferable model. Moreover, it synthesizes and transforms attractive aspects of the other models (the Child's trust, the Consumer's choice) into the very characteristics the patient rights movement seeks to foster (patient consent).

What is the "game" physicians and patients are playing? What methods may physician-coaches use to make patient-athletes optimistic, persevering, and compliant? May poor players be thrown out of the game? Are the poor, as players, more liable to expulsion than the well off? Two cases are taken to suggest that they are not.

What is it to be a good patient? The answer seems obvious: a good patient gets better. But what about patients who improve while resisting doctors' orders? Or patients who try to improve but fail? Or patients who refuse "heroic" or highly "experimental" therapies? What exactly can we expect, or demand of patients? What obligations do they have to their caretakers, families, and fellow sufferers?

For us, these may seem to be odd, even reactionary questions. They were discussed in the 19th century, but our medical ethicists are concerned with patient rights, not patient obligations and virtues. Indeed, why raise these topics just when the movement for patient rights is gaining ground? Rights protect us from abuses of power, as do the obligations which rights impose on the powerful. How could it be that patients have obligations, given physicians' various therapeutic, economic, and psychological powers?
Doesn't the very concept of good patienthood presuppose the medical paternalism of the past? Aren't good patients, like "good wives" and "good employees," bound to be subservient to those who "know best"?

This traditional conception of good patients is, admittedly, still very appealing to patients, as well as to physicians and nurses. When ill, weak, and fearful, many of us naturally long for physicians with paternal protective powers and maternal attentive sympathies. But we know how increasingly unrealistic those longings are. Whether we use emergency wards, walk-in clinics, or the referral network of private specialists, we are unlikely to find physicians who could, or who would want to play the part of Super Parent. (Physicians I encounter are either too young, feminist, overworked, worldly, or anxiously legalistic to foster storybook familial relationships with patients.)

Accordingly, we must reject the Good Child paradigm of patienthood. But should we, for the sake of patients' rights, reject the very concept of a good patient altogether? I think not. If patient rights are to be fully recognized in medical practice, they must be included in a general "moral economy" of coordinated rights, duties, virtues, and ideals for all the participants in health care. Physicians and nurses will not respect rights which subvert their own ideals of good practice, and those ideals will include at least minimal standards of patient conduct. To be good in one's work, one must have patients who recognize and accept at least some of the demands of that work. If patients assert rights unqualified by these demands, physicians and nurses will resort either to more ritualistic respect or to adversarial, "defensive" medical treatment. (If, for example, patients assert a right to know the risks of a recommended procedure, physicians may either rush through them or take costly, painful, and overelaborate precautions.)

Given the variety of interests in a hospital, the coordination of moral rights and ideals will be complex and incomplete. But conflict can be reduced and moral harmony fostered by defining various rights and ideals jointly, not in a piecemeal way. For the sake of this "moral economy," we should then keep the notion of good patienthood and look for a paradigm which supports, rather than subverts (as does the Good Child) the definition and recognition of patient rights.

The first candidate to mind is the Good Consumer. The very antithesis of the Good Child, the Good (or "Smart") Consumer is wary, not trusting; demanding, not obedient; threatening, not cooperative or grateful. In exercising autonomous judgment and choice, the Good Consumer seeks information, makes comparisons, calculates benefits and costs, avoids impulsive or emotional responses, and is generally self-knowing and worldly wise—in short, the very model of modern maturity in our culture. Moreover, the Good Consumer reflects recent legislation and advice about medical matters. Indeed, consumer protection legislation has been a pattern for legal definition of physicians'
responsibilities of "due care. 3 And we are urged, by critics and physicians alike, to become more judicious, skeptical, informed and comparative in our choices of physicians, treatments, and hospitals. Only thereby can we survive, it is said, the current greed and carelessness of medical institutions and entrepreneurial "producers of health goods and services."

Even if exaggerated, these claims make childlike patients seem dangerously self-indulgent, asking too little of themselves and too much of their physicians. (How can even the most devoted physicians be lovingly attentive to each of a large group of patients?) On the other hand, the Consumer paradigm seems to have the opposite faults, asking too much of patients and too little of physicians. How can even educated and socially confident patients secure the medical and statistical information necessary for a judicious comparison of physicians, treatments, and hospitals? And even if such information could be elicited, how can people suddenly or seriously ill make use of it? Disease and injury often do reduce us to the condition of ignorant, dependent children. In such circumstances, "caveat emptor" seems callous, pointless advice. Moreover, the Consumer model of patienthood fosters a corresponding Producer model of doctoring, with its lower, impersonal standard of due care. Producers and consumers keep one another at arm's length, but patients want and need the laying on of hands.

What we must find or devise is some intermediary between the overdependent Child and the autonomous Consumer, some relationship between the familial and the commercial. Let us search the medical world itself for something less paternalistic than the Child paradigm, and yet more appropriate to a range of medical conditions than the Consumer model.

Everyone associated with patient care is now called a "health care professional." Could the Good Client be a model for the good patient? Like good children, good clients trust the judgment and good will of the professionals they consult. But they do not assume loving devotion, undivided attention, or general assistance from professionals. There is a limited range of interests to be addressed at an appropriate "professional distance" for a stated fee. Consequently, clients (unlike children) are free to disregard advice and to change advisers. Indeed, like good consumers, good clients retain a clear and lively sense of their own interests and the costs of professional service. Nonetheless, they (unlike consumers) are slow to "change brands." ("Doctor-shopping" has been condemned from classical times.4)

In short, the Good Client would seem to be a happy synthesis of our inadequate, conflicting models of Good Child and Good Consumer. But unfortunately, whatever its merits, it has a serious social defect: relatively few people have access to professional aid, and even fewer achieve the happy relationship with professionals just described. Only the well-off have the opportunity to learn "good clienthood." To take clients as
A model for patienthood would foster the view that medical assistance is a costly commodity, available to the fortunate few who are able to assess and employ physicians. The Good Client is, for the most part, an upper middle-class version of the Good Consumer. Even if, as some social critics claim, there is far less consumer choice in our society than we like to believe, consumers far outstrip clients both in numbers and class diversity. If our paradigm is to apply to a spectrum of patients and circumstances, we must look further.

The medical world has another candidate: the Good Soldier. There is a pervasive military ethos in hospitals, both in ideology and organization. Physicians and nurses speak of battling death and disease (and, increasingly, bad lifestyles). Patients are praised for fighting for life to the end—especially when, as clinical research subjects, they have taken part in the "war" on cancer, heart disease, and other "enemies of (Western) Mankind." Such military metaphors seem natural in hospitals, organized as they are along military lines: strict chains of command, with "chiefs of service," house officers, support staff (nurses, social workers) and supply corps (pharmacists, technicians). Insubordination, it seems, is a worse fault within some services (especially surgery) than grave, even fatal, errors of technique.

However suited to our current medical ethos, the Good Soldier-patient is an old familiar. In the Hippocratic Corpus, good patients are defined as helping physicians combat disease, and if "under orders," they will not "give up the struggle." But how are we to construe these "orders" and the "help" patients give their physicians in their battles?

In military life, soldiers are kept in battle by stern commands and threats from their superiors whose reputations and promotions are often as decisive as the larger cause. Indeed, officers tend to be rewarded for the valor of their troops. As Good Soldiers, patients would be subject to similar discipline and exploitation. Military ethics is not noted for its emphasis on personal autonomy, consent, or welfare—the staples of current medical ethics. Even if patient autonomy is exaggerated or inapplicable to many medical circumstances, we surely want patients to have more scope for choice, consent and refusal than any soldier is allowed. (And, if "heroic measures" are to be employed, we should want patients to count as the heroes, not the physicians.) Military discipline reflects and employs the class structure of civilian life. Basic training only intensifies and formalizes the subordination most soldiers have previously experienced. Hence, the Good Soldier paradigm has social problems of its own. Indeed, if the Good Client is an upper-class version of the Good Consumer, the Good Soldier is a lower-class version of the Good Child.

Military life, however, is not the only realm of combat, victory and defeat. There is the world of sports, perhaps
even more fundamental to our culture than its more militant neighbor. (Strategists seem to "athleticize" past and future battles more than coaches militarize athletic contests.) Although quasi-military, athletics has far less hierarchy, coercion, and mindless obedience. The very notion of a player carries a suggestion of voluntary participation, and the notion of a coach is one who instructs rather than commands. A coach may, in the manner of a sergeant, bark orders at athletes. But they are free to comply or refuse to follow those orders without fear of punishment. Refusal may provoke reproach or the dog house, but not, as in the disobedient soldier's case, reprimand or the guard house. Players are subject to humiliating dismissal from the team, but not dishonorable discharge or worse. Even the most dictatorial coach must recognize these differences between military and civilian authority, and must respect individual motives and welfare of his players, if they are to continue playing. This is especially so in individual sports (field, track, swimming, fencing) where team loyalty has less hold.

But how can athletes, individually or in teams, possibly illuminate patients' proper conduct? How can paragons of health and vigor be models for the ill and weak? Seriously disabled or debilitated patients, of course, cannot emulate athletes, or perhaps anyone else; not so, however, the majority of patients. Moreover, the contrast is overstated. Rather than paragons of health, athletes in their efforts to push their bodies beyond normal or natural limits are continuously coping with stress, pain, and injury. Moreover, like patients, athletes—whether healthy or not—tend to be obsessed with diet, sleep, and signs of bodily condition. And the task for both is to improve on one's own previous "performance." Other athletes may (as do other hospital roommates) provide additional competitive incentives. But, especially in individual sports, one is competing primarily against oneself, or Nature as embodied in one's own recalcitrant instantiation. The primary rewards are not public praise, but better times and distances. Just as athletes try to run faster than yesterday, post-operative patients try to walk farther.

Good coaches, like good physicians, inspire such individual efforts with praise and reproach, moral and otherwise. These methods can, of course, prove coercive and reduce compliance to obedience. To protect patients from such moral coercion, Institutional Review Boards can consent forms for subtle appeals to altruism or loyalty to their research clinicians. Only by such scrutiny can the (conceptual) link between compliance and consent be maintained against the Medical-Military complex we should resist in favor of its Athletic alternative. But are all moral appeals or criticisms of the ill to be avoided? Are there some moral demands we can make on ourselves and others when ill? We are back again to our initial question, What is it to be a good patient? Let us press the Athletic metaphor for help: What are an athlete's (and by extension, a patient's) distinctive virtues and vices?
According to Philippe Foot’s analysis, the virtues enable us to resist natural temptations and to compensate for deficiencies of motivation. Training and competition make abnormal demands on an athlete’s body. Accordingly, athletes are especially prey to the desires underlying the celebrated vices of sloth, gluttony, and lust. And to the extent that they risk or suffer injury and pain, they are prone to the failures of nerve and heart that underlie cowardice. Of the classical virtues, the most appropriate would accordingly seem to be temperance and courage, or steadfastness.

On Alasdair MacIntyre’s more sociological account, the virtues are roughly those traits essential for the “internal rewards” of participation in certain “practices” established in a society. We would seem to get temperance and steadfastness once again, and also something akin to an underlying virtue of hope. To the extent that athletes are competing against their own physical limitations, they must have the belief that with effort they will transcend those limits, will improve upon their previous performances. Without such hope, athletes are unlikely to maintain the steadfastness necessary for gradual improvement and the rewards, personal and public, “internal” to athletic practice.

Such hope depends less on evidence and probability than on the optimism which transcends objective assessment of risks and chances of success. Hope is part of the optimism of action, where the value of the goal—not the odds of attaining it—is the focus of attention. As such, it helps agents (here, athletes) accept losses without debilitating despair. Good coaches know how to foster such invigorating hope (“You can do it!”), and thereby perseverance (“Hang in there!”).

The medical analogies for both athlete and coach are obvious. Since Hippocrates physicians have in good conscience used silence, fear, deceit, and social authority to foster hope and perseverance in their patients, despite the medical odds. And as patients, we knowingly conspire with this professional optimism. Even wary review boards allow physicians to speak of “risk/benefit ratios,” as if dangers are improbable and benefits certain. (Speaking accurately and too objectively, we should say rather, “risk/opportunity ratios” or “harm/benefit probabilities.”) Likewise, treatments—however unproven—are called therapies.

The good patient needs two kinds of confidence for optimistic perseverance: confidence in the good will of the various therapists and in their skills and remedies. Such confidence is not the blind, ignorant trust with which children are said to invest their loving parents. Nor is it, of course, the kind of confidence consumers have in their own knowing preferences and choices. It is an intermediary kind reflected in informed consent to the treatment explained and recommended by competent advisors. Such confidence and consent synthesize (a la Hegel) the child’s trust and obedience with the consumer’s distrust and “free” choice. These antitheses are transcended and transformed into confident consent and hopeful compliance.
With this double confidence in good will and skill, with optimism and hope, the Good Patient, like the Good Athlete, stays in the game. But what exactly is the "game"? What are the goals? Do the current rules and standards serve those goals? Are the socially worst off and beat off equally likely to be dismissed as "poor players"?

By way of elaborating and testing our Medical-Athletic analogy, let us consider two patients to whom physicians might wish to refuse further treatment. The first is a street person who returns periodically to the outpatient clinic of a public hospital for treatment of ulcerated ankles. The other is the suburban accountant who, having had coronary bypass surgery, comes for regular examinations by his private cardiologist. Despite their social and economic differences, both patients are alike in not altering their lives in the ways prescribed by their therapists. The panhandler continues to drink too much, eat and wash too little, and applies the prescribed medication only fitfully. The accountant continues to eat and work too much, exercise too little, and also neglects prescribed medication. And each seems so entrenched in his way of life that reproaches and general warnings about possible catastrophe have little effect.

May physicians coerce these patients, threaten them with denial of treatment, or deny it? Are they to be treated alike? Or, is one (the paying accountant?) deserving of gentler, more tolerant treatment from the "coach"? Certainly, hospital residents and nurses often think of derelicts as wasting their time, talents, and other scarce public resources. But may they throw such recidivists out of the game? That depends on what game they are playing. Is it a game against death and disease? If so, then the panhandler is staying in the game, even if we might wish he stayed in training and came to the arena more regularly. But there are other hospital games: for example, the Administrator's game of using time and talent efficiently, or the Social Worker's game of fostering socially useful lives. But these are secondary: the staff's prime opponents are not inefficiency or social non-productivity. Expulsion of the panhandler seems, therefore, unjustified.

Contrariwise, may residents keep the panhandler in the hospital for treatment against his will? If the patient wants his leg healed, he may have to conform to a strict or painful hospital regimen, on the principle that "whoever wills the end wills the means." But this is no argument for holding the man in the hospital if he decides that the cure is worse than the disease, even a life-threatening disease. Coaches may force players to play in a certain way, but not to stay on the field.

The accountant and cardiologist are, by contrast, engaged in a rather different game, whose rules and point are somewhat obscure. The accountant comes for prognosis, not treatment. In the absence of symptoms or signs of deterioration, he is prepared to risk the increased risk of early death. He wants
to continue the life of accountancy with its large business lunches and long sedentary work. To do so with pleasure he wants the physician’s help in the form of regular medical “balance sheets,” not unlike the financial assessments he provides his own clients. He treats her as a professional consultant, or as a coach in his life’s game, but will not shift to her game of Life-Prolongation. What should she do?

If imaginative, she might use inducements borrowed from his game, for example, fees that vary directly with his weight on successive visits. Or she might calculate the financial losses he would suffer if he had further cardiovascular accidents or surgery. (Likewise, the residents might tell the panhandler how repeated ulceration would diminish the life he was leading, if they had any convincing conception of a life so far removed from their own. Like coaches, physicians must be able to make leaps back and forth across gaps of gender, race, class, and cultures—feats of sympathetic imagination not usually learned in organic chemistry, pathology, or the suburbs.) But such plays failing, a physician surely must have the right to threaten non-players with dismissal, and to dismiss them. To refuse the accountant further examinations is not to abandon a patient; it is to refuse to attend to someone who will not become a patient. Like the panhandler, he will not train, but unlike him, the accountant never goes on the field. He does not enter the medical game, even irregularly.

On these athletic readings of the two cases, then, it seems the socially worse off is more deserving of medical attention than his social better. This fits with the fact that athletics is less subject in our society to distinctions of class (and race) than any other activity. (It also fits with the actual attitudes of the residents who raised these two cases for discussion.) Accordingly, the Good Athlete is more socially qualified than any of the other paradigms for patienthood we have considered.

A final defensive remark on method. Why take such a metaphorical, inconclusive approach to patient morality? As in poetry, metaphors help us escape unrecognized ruts of language and thought. Medical ethics is, I think, becoming rutted with many separate physician duties and patient rights. This brief survey of models of patienthood is an effort to widen the road. This approach and some of the materials are not new: Plato likens physicians to trainers and contrasts them with dictators—and with cooks who “flatter” the body.11
NOTES

My thanks to Raziel Abelson, Louis Lasagna, James Rachels, and David White for their "coaching."

1. Humphrey Osmond and Miriam Siegler approach patient obligations by way of various patient roles in Patienthood. But this sociological analysis is far less direct than, say, the first AMA Code of Medical Ethics (1847), Article II ("Obligations of Patients to their Physicians"). The present AMA Principles of Medical Ethics (1980) has nothing on the subject.


3. See Angela Holder, Medical Malpractice.

4. Robert Burton quotes Seneca against changing physicians: "nothing hinders health more." He counts "constancy" among a catalogue of patient virtues, along with not being "niggardly or miserly of purse," ashamed of, or indifferent to symptoms, and self-doctoring. (Anatomy of Melancholy, Pt. 2., Sect. 1, Mem. 4, Subs. 2, 6th edition, 1651.)


6. Epidemics: "The art [of Medicine] has three factors, the disease, the patient, the physician. The physician is the servant of the art. The patient must cooperate with the physician in combating the disease." And Precepts ix: "...we physicians take the lead in what is necessary for health. And if he be under orders the patient will not go far astray. For left to themselves patients sink through their painful condition, give up the struggle and depart this life."


9. Such secular hope is akin to the Christian virtue, the hope for salvation and grace, undeserved gifts from a Creator whose very existence in unsupported, or even contradicted by public evidence.
10. Such advisors are like the "free" physicians Plato praises in *Laws* (IV.720c–e); Unlike slave physicians who never talk with their (slave) patients except to issue commands "in the brusque fashion of a dictator," the free practitioner "goes into things thoroughly and from the beginning in a scientific way, and takes the patient and his family into his confidence." He "steadily aims at producing complete restoration to health by persuading the sufferer into compliance."

11. See *Gorgias*, 464b and *Laws* IV.720c.