

Of Half Gods and Mortals: Aesculapian Authority



This awesome authority, which rules out any patient participation in the decision-making process, stems from a three-pronged power base: the physician's expertise, the patient's faith in him, and the belief that he has almost mystical powers.

BEATRICE J. KALISCH

O you that are half gods, lengthen that life. . . turn o'er all the volumes of your mysterious Aesculapian science.¹

A recent and personal encounter with illness and hospitalization reminded me of the above line in Philip Massinger's play of 1622, *The Virgin-Martyr*. I can testify that Aesculapius, the god of medicine in ancient Roman mythology, is alive and well today and working in medical care delivery settings, U.S.A.

As I entered the hospital, I glanced with a practiced eye at the surroundings and judged that everything looked the same as it always did. But soon I found that the experience of being a patient was like suddenly being lowered to the bottom of a well or raised to the top of a tower; the view of the same places and the same people drastically changed. For me, the most revealing and surprising insights occurred as a direct result of the relationship between myself and the physician. These revelations derived from one important concern throughout my hospitalization: my loss of control and lack of power to determine the events that affected me.

ACTIVE-PASSIVE CONTINUUM

As any two people interact, each person assumes a degree of activity and passivity. To the extent that one person is overly active, the other individual must become passive, or a clash occurs. The activity-passivity dimension determines who will be in control, the passive partner giving way to the more active one. Control also determines the nature of the decision-making process between two people. Thus, in a patient-physician relationship, if the patient is totally passive and immobilized (as, for example, during surgery), the surgeon assumes all of the activity, and there is virtually no

interaction. The patient is a passive object, wholly submissive to the activity of the physician—a state of affairs which is obviously essential. Even when the patient is conscious and capable of reasoning and feeling, the physician may still exercise full control; he issues orders, and the patient is expected to follow along submissively.

On the other end of the continuum, a patient may assume a highly active role in the interaction, and the physician a totally passive stance. It may be difficult to imagine such a circumstance, and many would consider it altogether unprofessional. Yet it does happen, as Duff and Hollingshead have documented in their exhaustive study of hospitals, physicians, and nurses:

The practitioners acted to protect their position as physician to the patient, but they were not always free to use their best medical judgment. Many physicians responded to the demands of the sick persons or their families even when such demands had little to do with solving the patient's problems; such demands commonly involved hospitalization, a "dictated" diagnosis, and inappropriate therapy. The physician feared loss of status and income as well as involvement in the problems of the patients.²

In this last instance, the patient is controlling the physician. Thus, we see there are two possible models of physician-

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patient relationships: one based on what is known as "aesculapian authority," and the other based on joint participation.

AESCULAPIAN MODEL

Where along this continuum of activity-passivity do most patient-physician relationships fall? In the vast majority of instances, the physician holds practically all of the control. In fact, the power he wields is so remarkably potent that it has been specifically labeled as "aesculapian authority" by Paterson.^{3,4} It is utilized to convince patients that they are indeed "sick" and, furthermore, that they must submit to various treatments, hospitalization, and curtailment of normal activities.

For the person who is ill, this authority is greater than any other existing power—at least, within that particular context and for that particular moment. And he responds by meekly following along with what is ordered, no matter how embarrassing, dangerous, or painful it may be. People who are ordinarily aggressive turn passive, the dominant become submissive, and the boisterous yield to silence. Outrages are tolerated from physicians that would not be acceptable for a second from anyone else. The most surprising and perplexing characteristic of this power is that it is invisible; most people are totally unaware that it exists.

According to Paterson, aesculapian authority combines three different kinds of authority, which accounts for its extreme potency. First, the physician carries the authority of an expert, as is true of all people who have the knowledge and skills essential for rendering a needed service valued by society. An auto mechanic, for example, possesses an expertise thought to be essential by most people; he is looked upon as an important authority figure—at least, within the specific context of having one's car repaired. As contrasted with the advice of the physician, however, we find it relatively easy to reject the auto mechanic's suggestions. Granted, the seriousness of the medical enterprise accounts for a portion of this difference, but not all of it by any means. The physician wields something more than authority by expertise.

Part of this super power is morally based, derived from the Hippocratic oath. It gives the physician the right to control the patient because he is believed to be morally committed to act for the good of his patients. He is a professional, guided by certain ethical principles and thus believed to act in the client's interest rather than his own. The thought that he might not do his very best never occurs to most people.

Beyond this, there is a third type of power, perhaps of major significance here. The result of tradition that dates back to centuries ago when medicine was a product of "natural philosophy," this power stems from the concept that the physician has license to control by reason of God-given grace. People believe—in a vague and almost unconscious way—that he has special connections with the world of the unknown, philosophically and spiritually.

For the layman, in contrast, medicine is still mysterious and unpredictable, set apart from normal human affairs. The key element that sustains this attitude is the arbitrary nature

of life and death. In other words, it is the patient's fear of death and his desire to live, along with the conviction that the physician has special powers withheld from ordinary mortals, that causes the average person to believe that the physician has more going for him than expertise alone. It is somewhat suggestive of the tribal medicine man, and actually the physician does assume a half-godlike role.

I am reminded of a meeting where one of the speakers asked the audience: "What do you think the initials M.D. really stand for?" After a few moments of suspenseful silence, he answered his own question: "Minor Deity, of course." No one failed to get the point, since the privileged status attributed to physicians (how often do they get a parking ticket?) and the high order of egotism which typifies their behavior immediately came to everyone's mind. But beyond this, it is apparent that this priestly role is utilized as part of the "bedside manner" for the purpose of persuading the patient to do what is "best" as diagnosed by the physician.

ONLY ONE CHOICE

As a result, the health care system is set up so that the patient has only one major choice—that of the primary care or first-line physician. And this choice, it might be said, is usually based on such unreliable information as a friend's recommendation: "He's a good doctor." Few individuals know such basic facts as where their physician earned his medical degree, his years of experience and in what settings, and whether or not he is board certified.

After this initial choice, most decisions are made for the patient by that physician. This includes the choice of treatment, as well as the choice of specialists for referral or no referrals at all. Even the choice of hospitals is often determined for the patient.

This is quite a departure from other instances of consumer behavior. When an individual wishes to buy a new car, for instance, he not only determines which dealership he wants to patronize but also what he really would like in the way of a car and how much he is willing to pay for it. These basic decisions are not made for him, even though salesmen may inspire some upward modifications in style and price.

In summary, then, the medical marketplace can be described as follows:

The physician, not the patient, combines the components of care into a treatment. In other markets, the consumer, with varying degrees of knowledge, selects the goods and services he desires from the available alternatives. In medical care, however, the patient does not usually make his choice directly...He selects a physician who then makes...choices for him.⁵

As mentioned earlier, there does exist some variation in this pattern. For one thing, the degree of activity or control the patient is allowed to assume is related to whether he is consulting a medical practitioner with a "client-dependent" or a "colleague-dependent" practice. In the former instance, the success of the physician (usually a general practitioner, pediatrician, or internist) may depend on the kind of relationship he develops with his patients. As he continues to see and know a patient over a period of time, he may be more

inclined to share information with him, give him more control over his treatment—sometimes, to the point of yielding to patient demands for medications, hospitalization, and the like.

These client-dependent physicians participate in the professional referral system. The cases they cannot handle are funneled deeper into the medical care system to the specialists—surgeons, neurologists, urologists, radiologists, and the like—whose practices are colleague-dependent. These practitioners, who have no continuing relationship with the patient and sees him only on referral, are generally guided almost completely by their medical expertise and not by the patient's demands. This is considered quite desirable by the profession.

The patient, however, usually loses whatever degree of control he may have enjoyed with his primary care practitioner. He is usually sicker, more frightened and overwhelmed, and thus more dependent. The specialist, by virtue of the system, offers the patient very little independence and, generally speaking, interaction is decreased and less open.

The decline in client-dependent practices has resulted in an overall decrease in the input patients have in decisions about their health care. And, even in such practices, the aesculapian concept does not dispose toward sharing information about diagnostic studies, treatment approaches, prognoses, and other data with the patient. His questions go unanswered or are evaded. Obviously, without the necessary data, decision-making and controlling behavior on the part of the patient are ruled out. If he doesn't know that there are other ways in which his problem might be treated, he cannot ask for a different approach, even when the one currently being used turns out to be unsuccessful.

JOINT PARTICIPATION MODEL

Moving toward the opposite end of the continuum, a model for joint participation emerges. Here, the interaction between physician and patient comes much closer to being one of equals, and decisions are arrived at through a mutual process involving considerable two-way communication. The influence of the physician will depend not on his power and authority but rather on his persuasive and instructional capacities—on his expertise rather than his authority.

Under these circumstances the patient retains a high degree of control over events that will affect him. Where a surgical procedure seems indicated, for example, the physician makes his informed decision after weighing the feasible alternatives and the risks versus the benefits. Then he provides the patient with the right to undertake a secondary estimation and, in order to help him with this decision, he provides the needed data on other treatment approaches and the likelihood of success.

To arrive at his own decision, the patient must know the physician's preferences, as well as details on how he selects data from his universe of experience. The physician, having made his own decision, attempts to persuade and instruct the patient; but he does not flatly disagree with him, mislead him, bully him, or reject him for a questioning attitude or a

final decision that differs from his own. To do so would destroy the collaborative status inherent in the joint participation model.

In situations where the best mode of management is not readily apparent or known by the physician, then patient and physician jointly decide what is best for the patient. An example would be a newly diagnosed diabetic, whose life style, eating patterns, occupation, and other variables should all be considered as the decisions for treatment are made. The search for the answers is part of the therapeutic process.

PRO'S AND CON'S

Proponents of the concept of aesculapian authority vehemently argue that this power is quite essential because without it most patients would not undergo the treatment they need. They would be too afraid. Unlike the storekeeper whose success come from giving his customers what they want, physicians must give their clients what they really need—which sometimes means giving them what they don't want at all! To accomplish this, the argument goes, control and manipulation of the patient are mandated. Furthermore, supporters of aesculapian authority see the successful wielding of this power as an achievement whereby the patient's normal decision-making abilities are momentarily suspended, much to his own advantage.^{6,7}

Another rationale for the use of aesculapian authority is that the body of medical knowledge is so esoteric and complex that the layman would find it difficult to grasp, much less evaluate, the meaning of his diagnosis and treatment. Because of this presumed ignorance, it is argued, the patient could harm himself if allowed to share in the medical decisions.

Although many patients have undoubtedly been pressured by this awesome authority into accepting the orders of their physicians, the exercise of this aesculapian power has also led to noncompliance. While physicians have been found to underestimate the extent of noncompliance among their patients, studies reveal a rate of 33 to 50 percent.² Davis, who carried out a thorough and analytical study of the influence of physician-patient interaction on compliance, notes that noncompliance relates directly to attempts by the physician to control the patient.^{9,10}

Other situations found to foster noncompliance include occasions when the physician expresses outright disagreement with the patient, when he is formal and rejecting, and when he fails to provide feedback after extracting information. It appears, then, that when patients are involved in the decision-making process, they are more likely to accept the responsibilities imposed by their condition and go along with the necessary treatment.

HOW MUCH PARTICIPATION?

The question, then, is the relative degree of control to be assumed by both partners in the transaction. Some physicians involve their clients to the fullest extent possible in the decision-making process, but others find it difficult to relin-

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quish control even when it is warranted. Some patients, too, prefer the passive or "sick" role, finding dependency more acceptable than the need to make decisions.

Each patient's capabilities and emotional responses will influence the degree of participation that is appropriate for him. The complexity of the interaction necessitated by joint participation, for example, would make this model quite inappropriate for those of low intelligence levels or emotionally incapable of using their thinking capacities. If the problem has been so disturbing to the patient that he cannot be rational about it, he is not in a position to choose what should be done for himself. Similarly, life-threatening events must be handled with very little or no patient involvement. On the other hand, if the physician and patient have similar educational, intellectual, and experiential backgrounds and the patient is psychologically able to deal with the situation at hand, he should be allowed to participate to a much greater extent than is usually the case.

The patient's ability to participate responsibly in the evaluation of the treatment modes which the physician offers is often underestimated. After all, the public's knowledge of medicine has grown considerably in the last 50 years, as has the level of formal education of the populace. Popularized, self-help medical literature—books, newspaper and magazine articles—are read avidly these days ("I read about it in the *Reader's Digest*," the patient tells his physician), and television documentaries and medically-oriented soap operas all tend to alert the layman to issues of medical care. Therefore, even when a patient seems to accept the passive, unquestioning role, he may be harboring serious doubts and misconceptions about the way his condition is being managed. He hesitates to say so, however.

Beyond this consideration is the detrimental effect that the authoritarian stance has on the patient's self-concept; it takes away his usual status as a self-determining adult with reasoning capacity and, above all, human dignity. The sacrifice of an individual's dignity seems to be an unnecessarily high price to pay for medical treatment.

It might be said that the patient should be able to resist the authority of a physician if he were motivated to do so, but a number of factors work against the client's developing such an assertive posture. First of all, we are just beginning to learn about human response to authority in general, and some of the recent findings have been both shocking and disillusioning.

In Milgram's landmark studies on man's obedience to authority, individuals were commanded by an experimenter to administer electric shocks of increasing severity to protest-

ing, possibly endangered, victims. Most of the subjects obeyed the authority figure in spite of the fact that the directed action conflicted with their fundamental standards of morality. The author explains, "The key to the behavior of the subject lies not in pent-up anger or aggression but in the nature of their relationship to authority. They have given themselves to authority."¹¹

In short, few people were found to have the resources needed to resist authority. Then, when we remember the potency of physician authority, we can readily see the difficulty a patient would have in resisting such power. In addition, the patient has a strong desire to be accepted, liked, and cared for by the physician and a deep fear of being rejected, which stems from his enforced and very real dependency on the physician. He hesitates to disagree, to assert himself.

PATIENTS' RIGHTS

In a free society such as ours there is the philosophical question of individual rights. Basically, I believe that the issue of what is good for the individual is an issue that only he can determine. Immediate threats to life are the obvious exception. Furthermore, the fact that a client has made a choice of professional services does not mean that he has forever relinquished his right to participate in the decision-making process and to be informed of significant alternatives in diagnosis and treatment. He also retains the right to withdraw from the service if he so desires.

The whole concept of patients' rights is fairly new. Yet, gradually, there has been a rise in client demands, evidenced primarily in the escalation of lawsuits against physicians, nurses, and health care agencies. "Informed consent" for procedures has become a legal issue of growing magnitude. Prior to the early 1960's the decision to perform a medical procedure belonged to the physician alone. Since that time a number of court decisions have clearly and firmly established the patient's right of "self-determination." In a recent article in the *Journal of the American Medical Association* on this subject, Don H. Mills remarks:

He [the patient] cannot, of course, decide whether the procedure is adequately indicated, for that requires more medical expertise than he possesses. But once he is told that the procedure is recommended, he then must have enough information to decide whether the hoped-for benefits are, in his eyes, sufficient to risk the possible hazards.¹²

Mills goes on to explore just how far the physician must go in listing hazards. He suggests a middle-of-the-road approach that would be "both consistent with good medical

care and that affords reasonable legal safety." He never explains why full information disclosed to the patient would be antithetic to "good medical care," but this surely stems from the belief that the patient would be too afraid to undergo the procedure if he were acquainted with the potential dangers.

But, counterbalancing the presumed fear, what degree of rage may result when a patient does suffer a complication and has had no forewarning of the possibility and no part in the decision to take that risk? Consider, for example, the physician who recommends a simple mastectomy to a woman with breast cancer but fails to tell her that a modified radical or a radical mastectomy is another approach. I believe he has done his patient a great disservice. She has the right to decide whether the increased hazards or the degree of bodily disfigurement are worth even a small hope of greater success. Moreover, according to a study by Hershey and Bushkoff, disclosures to the patient did *not* cause clients to withhold their consent for procedures.¹³

A PERSONAL EXPERIENCE

It was when my own need for medical care arose that I learned so much about the character and effects of physician-patient relationships. My physician first interacted with me in a highly authoritarian way but, fortunately, our relationship soon developed into one that was highly facilitative and essentially based on joint participation. The difference that the two approaches made in my feelings of self-esteem and control, and thus my ability to cope with the crisis at hand, was marked.

As my illness and hospitalization began, I followed along in the usual way with what my physician ordered. I had no reason not to be compliant. Relief from pain was my foremost need. It was after the x-rays and other diagnostic tests were completed and the physician recommended surgery that I began to resist his controlling behavior. Over the telephone our conversation went as follows:

DOCTOR: Your gall bladder didn't visualize again today.

PATIENT: I know!

DOCTOR: You do? I think we should take you to surgery tomorrow (*warmly*).

PATIENT: I'm not ready for *that*.

DOCTOR: Well, we work for you! (*assertively*)

PATIENT: But I haven't had any symptoms before (*voice shrinking*).

DOCTOR: You can have a perforated ulcer without any symptoms, too!

PATIENT: (*sighing heavily*) Does it have to be done now? This is not a good time for me.

DOCTOR: If you came back to me in two weeks, I would tell you the same thing. You're sitting on a loaded pistol! (*aggressively*)

This interchange continued for a while longer, with him dictating to me from his position of authority. He was the

parent and I the dependent, deferent, acquiescing child.

This physician obviously uses authoritarianism with considerable success, and his actions undoubtedly stem from a well-intentioned belief that his patients' welfares are at stake. Surgeons may rely more heavily on this interaction model than other medical practitioners, because surgery tends to create more stress and anxiety in the patient than other methods of treatment. For me, though, the approach was devastating because I felt as if my usual identity as a self-determining adult was being replaced with that of a dependent, passive, and helpless non-being. This altered self-image was quite unacceptable; the result was feelings of anxiety, frustration, and anger.

The physician expected a child-like, unquestioning faith and trust, and I found myself unable to meet his expectations. True, I respected his abilities as a highly competent clinician and surgeon and felt physically safe in his care; this made it all the more difficult to resist his authority. But that wasn't enough. I wanted full access to the data and reasoning upon which he made his decision. Furthermore, I believed that I was in the best position to decide whether or not to undergo surgery at that time. I needed his help to make that decision, however. And I also needed to know that he saw me as an individual rather than just "another cholecystectomy."

While I was able to put up some passive resistance to his demands, it surprises me that I was not more openly aggressive in my interaction with him. In fact, as he became more dominant, I became less assertive and more passive. In normal situations, my response is just the opposite. My reaction was certainly not due to the fact that he was a physician *per se*, because over the year I had established too many professional co-equal relationships with physicians to be impressed by that fact. Instead, I attribute my response to the awesome power physicians exercise over their patients: I was no exception.

Two or three hours after our telephone conversation, the physician appeared in person. He had made the trip to help me with my decision, and his approach was entirely different this time. He provided me with much of the basis for his decision and when I decided against surgery for the time being, he said, "All right, that's fine," obviously genuine in his acceptance of me.

I remember being quite surprised and puzzled by the decided contrast in his behavior. In the next few days our relationship continued to develop according to the latter interaction pattern, and my confidence in him grew immeasurably. Eventually I decided to have surgery. Although I was moved to this decision both by the continuation of pain and by the passage of enough time to work through the shock and denial phases of my illness, I am absolutely certain that I would have continued to reject surgery if I had not had the benefit of the ensuing therapeutic relationship with my physician.

Before I felt safe enough to relinquish all control of myself and my destiny to the physician, I had to believe that he cared what happened to me and valued my existence as an

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individual. The extensive help he provided me in making the decision for surgery went a long way toward convincing me that he did, indeed, value me as an individual. In addition, his interaction with me immediately before the surgery, even when I was already in the operating room, was extremely reassuring—more so than I would have predicted. His evident concern apparently represented the much needed validation that I was still a person (even in that setting) and not just a "gall bladder."

IMPLICATIONS FOR THE NURSE

This discussion has centered on the dynamics of the patient-physician relationship and has explored a phenomenon, labeled aesculapian authority, that usually goes unnoticed, but nonetheless plays a highly significant role in the health care delivery system. An understanding of the phenomenon should help the nurse to improve both the system and her nursing care.

First of all, the nurse is in a key position to help both the patient and his family deal effectively with problems they may be experiencing, either in their relationship with the physician or with the advice he has given them. As with other problems, the patient needs the benefits of facilitative communication. Yet many nurses become extremely anxious when a patient alludes in any way to negative feelings about a physician—or another nurse, for that matter. Many times the nurse rushes to protect the physician: "You have an excellent doctor." This effectively blocks further communications on the subject and makes it even more difficult for the patient to exercise his decision-making powers.

The hospitalized patient is literally an inmate of a total institution, wholly dependent on the nurses for care and cut off from the usual sources of information and social support needed to assume an active role in making decisions. It is not uncommon for the staff to intimidate the patient in subtle ways or to exercise covert threats of rejection to get him to go along with what the physician and nurse dictate. The nurse's actions sometimes stem from her feeling of subordination to the physician. She may actually fear rejection by him or retributive measures. Instead of seeing herself as a patient advocate, she sees herself as a physician helper. It is more rewarding or less threatening for her to please the physician than it is to meet the needs of the patient.

This does not imply in any way that the nurse should feel that she must protect the patient from the physician. I say this because I have known a number of nurses who have adopted this stance as a defensive response to physician dominance. Even though the patient may have difficulty confronting or

communicating with the physician, he usually doesn't need or want protection from him. What he does need is the opportunity to talk about his concerns with a genuine, warm, and empathic helper who will help him to work out his own solutions.

It should be pointed out that the patient is not too likely to think of the nurse in this way. He probably feels that his physician is the only person that he can count on to take care of him on a continuing basis and be concerned with his needs over time. With the prevailing nursing care system, the patient receives care from innumerable nurses during hospitalization, and rarely do opportunities exist for in-depth, continuing relationships. Primary nursing is an exciting departure from the traditional system and promises to go a long way toward improving this situation.¹⁴

Offering advice and opinions is not appropriate, as is true in all instances of therapeutic communication. Moreover, the nurse is obviously not in a position to advise about medical decisions. It is the physician's responsibility to present the patient with his medical opinion and the data he bases it on, although the nurse should assume responsibility for clarifying any misconceptions on the patient's part of a physician's explanations. Primarily, however, she helps the patient to work through his feelings by means of a helping relationship based on a high level of empathy. Knowledge of the phenomenon described here should offer valuable data for this empathic interaction.¹⁵

As a patient, I was fortunate to have this kind of help. On only one occasion did a nurse argue with a decision I had made. Several nurses, however, erred in the other direction, for it is equally unwise to agree, unreservedly and on all occasions, with a patient's point of view. As Rogers explains:

In almost every phase of our lives...we find ourselves under the rewards and punishments of external judgments...But in my experience they do not make for personal growth, and hence I do not believe that they are a part of a helping relationship. Curiously enough, a positive evaluation is as threatening in the long run as a negative one, since to inform someone that he is good implies that you also have the right to tell him he is bad. So I have come to feel that the more I can keep a relationship free of judgment and evaluation, the more this will permit the other person to reach the point where he recognizes that the locus of evaluation, the center of responsibility, lies within himself. The meaning and value of his experience is in the last analysis something which is up to him, and no amount of external judgment can alter this.¹⁶

Decisions, then, to be good ones for the individual making the choice, should emanate solely from within that person.

As has been pointed out, one of the key ways to keep patients from exercising control is to restrict the information they receive. Throughout my years of practice, I have made it

a habit to do just the opposite; while this generally goes against established policies, I believe that it is quite essential for the nurse to break down the barriers. As a patient, I wanted to know my vital signs, the drugs I was being given, the results of diagnostic tests, and all other data on my "case." To get this information, I usually had to ask for it, sometime with quite a bit of determination and forcefulness in my voice.

In other words, nurses and other health team members weren't in the habit of volunteering this information and sometimes felt quite uncomfortable in doing so. I got my share of stylized responses such as "Your temperature is fine." I didn't want reassurance; I wanted exact information. In one instance, a staff nurse brought in a new medication and when I asked what it was, she responded, "I can't tell you! You of all people should know that!" That made me angry, even though I knew I could ask another nurse who would tell me. It seemed illogical, indeed, that this nurse had the right to know more about my treatment than I did myself.

After surgery a nurse colleague who was taking care of me let me look at the pathology report. This was very reassuring, not because I would have doubted her truthfulness if she had simply told me the results, but because she was allowing me to exercise my usual way of assessing a patient—this time, myself. All the concrete knowledge I had about myself increased my feelings of power and control as well as my self-esteem.

There are a few patients who definitely do not want this kind of information; they are less anxious if they assume a position of blind dependence. Then, again, many people may not *seem* to want to know; when questioned, however, they express a deep-felt desire to be informed, but say they "didn't feel" that it was their right. Therefore, it is absolutely essential for the nurse to make keen assessments as to each patient's needs and capabilities.

MORE THAN ONE VILLAIN

Physicians are not the only ones to exercise aesculapian authority. Nurses are often authoritarian, too, so, while medicine has been singled out here, it is little more of a villain than nursing. The pervasiveness of the medical model accounts for some of this behavior; however, it seems to me that the nurse sometimes uses her authority to build up her professional status as well. How often, for instance, is the patient allowed to participate in decisions about his nursing care? Here is where the nurse can considerably enhance the patient's sense of control, by encouraging him to participate in innumerable decisions, ranging from whether or not he will have a public health nurse referral to the determination of the time of his treatments and medications.

As is true in medical management, the nurse who allows the patient to participate in these decisions runs the risk that he will choose an alternative that she does not believe to be in his best interest. If attempts to instruct and persuade the patient fail, then the nurse must have enough humility to allow him the greater value of the dignity of his own choice.

If she imposes her own notion of what is good onto the patient, she will at the same time reduce his dignity.

IN RETROSPECT

An unexpected encounter with hospitalization and surgery has prompted this attempt to provide some insight into the almost mystical relationship between physicians and patients. Half-gods, physicians resemble. Yet for patients to acquiesce completely with this concept, without demanding some reasonable degree of participation in the decision-making, seems unreasonable. Certainly this whole process, especially as it relates to the third party in the person of the nurse, deserves much more attention than it has received.

In the same play from which I quoted at the beginning of this article is the following exchange:

DOCTOR. Take again your bed, sir;
Sleep is a sovereign physic.

ANTONINUS. Take an ass's head, sir:
Confusion on your fooleries, your charms!
Thy pills and base apothecary drugs
Threaten'd to bring unto me? Out, you imposter!
Quacksalving, cheating mountebank! Your skill
Is to make sound men sick, and sick men kill."

Strong language, perhaps, and medicine has come a long way in the over 350 years that have passed since those words were spoken. Nevertheless, today's society is more and more an outspoken and critical one—one that demands to *know*, rather than just be *told*. An unresponsive, dictatorial attitude on the part of either physician or nurse is increasingly likely to evoke a reaction that could strongly resemble that of Antoninus—three centuries later.

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