Autonomy and the doctor-adolescent relationship

Hubert Doucet, Ph.D.
Dean, Faculty of Theology, Saint Paul University
Ottawa, Canada

Jean Wilkins, M.D.
Director, Adolescent Division, Hôpital Saint-Justine, Montreal, Canada

With the development of ethics over the last twenty years, autonomy of the patient has become a key issue. But the concept of autonomy currently accepted does not meet the needs of adolescent medicine, because it does not take into account the reality of adolescence.

The issue of autonomy and the physician-adolescent relationship will be approached from the angle of the interpersonal dynamic specific to education. The principle that determines our point of view is that any doctor working with teenagers learns by experience: adolescent medicine must be practised with an educational aim in mind. The first part of this paper will briefly consider how the issue of autonomy arises in this branch of medicine. The second section will study adolescent medicine in relation to the very meaning of medicine itself and in relation to the various theories of the doctor-patient relationship. These elements should make it possible to propose a model for the doctor-adolescent relationship that will help the adolescent to attain his or her autonomy.

The problem

In current literature, the question of autonomy seems to arise in its most demanding form in connection with difficult, serious medical situations. This context may lead physicians to forget that the issue of autonomy comes up in the daily routine of their practice.

Let us recall some situations within which the issue of autonomy arises. First, an adolescent refuses to see a doctor. In such a situation, if he finally shows up with parents for appointment, he will feel "coerced". Second, let us mention follow-up: the problem is reaching out to the drop-out. For example, what does one do when a teenage girl or boy misses an appointment? The third situation can occur when an adolescent denies that he is ill. What does the doctor do? Use charm, manipulation, persuasion, coercion if necessary?

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How should a physician should act when dealing with a teenager? In order to answer this question we would like, first of all, to consider the meaning of adolescent medicine and how it harmonizes with a series of recent studies on medicine itself. This will make it easier to describe the therapeutic relationship adolescent medicine should emphasize.

When Dr. Roswell Gallagher established the first medical clinic for adolescents at the Children's Hospital Medical Center in Boston, he did it because he recognized that this group had specific

health needs (1). The new reality of adolescence that had appeared in all western societies has brought new pathologies in its wake. If medical care of the adolescent is to be satisfactory, it must accept the whole individual, i.e. it must deal with the patient as he or she really is. A health professional cannot treat an adolescent without being aware of his situation. Unwanted pregnancies, drug abuse, suicide, depression and accidents are linked to a whole series of factors which flow from the nature of adolescence, the longer duration of adolescence, the development of a teenage subculture, and major changes in family and school.

Some examples may help illustrate the social and health effects of the subcultures. The disco style demanded that one be thin and it led adolescents to change their eating habits so that they would lose weight (2). Ballet dancers who manipulate their diet in the same way experience an elevated incidence of menstrual disturbances (3). We might allude to the adolescent athletes who dedicate themselves to sports in pursuit of good health; joggers develop their own specific orthopedic pathology (4). The marked increase in the incidence of anorexia nervosa is linked in part to social pressures favouring slim bodies (5). A sick body cannot, therefore, be separated from the person as a whole.

Considering what has presided at the birth of adolescent medicine and that has continued to characterize its practice, analytical ideas, as used in medicine, cannot be used when considering adolescent medicine. "The analytical thought is, by its essential nature, depersonalizing, as each step in the explanation of the body moves further from the individuality of one's body to the universality of biological process" (6). The concept of adolescent medicine is biopsychosocial and not biomedical, to use the distinction of George L. Engel (7). This kind of medicine is intrinsically a dialogue since "the process of evaluation of the person is dialogic in nature, involving a give and take between patient and physician"(6).

This does not mean that adolescent medicine has thrown scientific procedure aside. It remains medical, nevertheless, since its object is "to provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care (7). Its basis "resides in the clinical event". Adolescent medicine conforms in a striking way to the attempt at a definition of medicine made by E.D. Pellegrino and D.C. Thomasma. It is "a kind of craftsmanship" "that involves healing the body with the body" and that is "placed within an imbalanced relationship" (8).

If "patient and physician mutually enter into a healing relationship (8), what will the model of their interaction be in adolescent medicine? There are many possible models. We will limit ourselves, first of all, to presenting the two models that are dominant in the sociology of medicine.

The first model has a contractual nature. As explained by Talcott Parsons, there is a common enterprise in which "patients are conceived as `cooperating` with their physicians or therapeutic `teams` (9). Solidarity is the bond creating cooperation because there is a "presumed consensus on goals and means and consequent legitimacy" (10). Collegiality does not mean that there is complete equality between patient and physician because of the existence of the "competence gap". However, this should not be exaggerated because one must remember "that other kinds of knowledge are involved in medical relationships" (10). This model certainly seems to represent a high ideal especially when it is applied to an educational purpose "based on the assumption that

much of the assistance of long-term value to the patient depends on his willingness to come to terms with his own behavior and problems in his life"(11). This collegial model is unsuited to physician and adolescent in a clinical setting. The fact is that confidence is often lacking or it would take too long to build it to the point where it would be the essential characteristic of the relationship (8). The patient suffering from anorexia nervosa is a clear example. The same is true of the teenager who has been pressured to visit the doctor by his parent or some other authority. It can be the other way around, the health professional lacking confidence in the adolescent patient. For example, because of the limitations of oral contraception as a mean of adolescent contraception and because of the inability of the adolescent to make a long-term commitment, the professional can be justified in not having full confidence in the adolescent (12). Also, we could think of chronically ill teenagers who are unable to accept their illness. One could also find physicians who unconsciously refuse to acknowledge that a diabetic adolescent wants to develop his own identity. While, on the one hand, these patients are afraid of being dominated, it could be, on the other hand, very difficult at this age to assume full responsibility for their treatment. This model, then, does not meet the needs for clinical interaction between physician and adolescent.

The model of dominance stands opposite to the model of solidarity. Eliot Freidson has particularly highlighted the authority structure in the "clinical relationship". The subordination to doctors "is based on the assumption that a professional has such special esoteric knowledge or humanitarian intent that he and he alone should be allowed to decide what is good for the layman"(13). Freidson's description of the therapeutic relationship is no doubt actualized by many physicians dealing with adolescents. Because of the physician's image of his profession and of adolescents, he functions as an authority figure who knows what the young person should do. Dominance fails to recognize that the adolescent is a person and thus it ignores the fundamental characteristic of adolescent medicine.

These two models do not correspond to the reality of adolescent medicine because they are both founded on static relationships while clinical interaction with the adolescent is in evolution. We need to discuss a model of progressive interaction that will have the development of the young person's autonomy and sense of responsibility as its goals. The nature of this model will be clarified by considering autonomy and the physician-adolescent relationship.

Autonomy and the physician-adolescent relationship

Terrence F. Ackerman note that "patient autonomy has become a watchword of the medical profession"(14). It is surprising, then, that this key word is not even mentioned in the Encyclopedia of Bioethics. The words considered are paternalism, patients' rights, etc. The Encyclopedia of Bioethics is an example of an American point of view that bases its ethical interpretation on a legal model. The same is true of James F. Childress for whom paternalistic approaches as opposed to an emphasis on autonomy "characteristically focus on the patient's needs rather than his or her rights" (15). Studies have drawn attention to the limitations of this ethical-legalistic point of view (16), (17), (18).

One must not forget that the understanding of autonomy, as apart from and opposed to paternalism (19) and as seen from a legal point of view, in a way come from Kant and his 'obligation morality' (19), (20), (21). Kantian autonomy emphasizes the self-control of the

rational subject (22), but it does this by negating the person. As Beauchamp himself pointed out: "Kant also regarded acting from desire, impulse and habit as heteronomous" (19), (22). The person, with his contradictions and desires seems to be outside morality's domain. Because the Kantian approach to autonomy is "contrary to the intimate structure of action" (23), it separates the principle of morality from the ability to desire and, in this way, it reduces the reality of the person.

This limitation which is inherent to Kantian understanding of autonomy is felt at the level of doctor-patient relationship. Ackerman, for example, notes that "knowledge of the patient's psychological and social situation are also necessary to help the patient act as a fully autonomous person" (14). Beauchamp implicitly recognizes the importance of the total dimension as an element integrating personal reality when he declares that many cases "illustrate how complex the interactions sometimes become in an attempt to balance considerations of autonomy, beneficence, con-maleficence, and justice, in the treatment of patients" (19).

The clash between paternalism and autonomy makes the physician-patient relationship emerge as a dialectical war between opposing parties who face one another as strangers or as rival brothers. Does the tension between opposing forces provide the only model for an ethic that can recognize the priority of the person as a responsible subject? We do not believe so. The ethical model that governed the development of hospices in England (18) seems characteristic of another ethic based on a chain of communication to encourage the patient to assume responsibility(24). The same thing is true in adolescent medicine.

The practice of adolescent medicine begins, as we have shown, by looking at the whole subject as it really is. In fact, "the factors that interfere with optimal functioning and health are not the classic causes of morbidity and mortality but, rather primarily focus on relationships with other people, particularly family, peers, and teachers" (25). In this context, where the quality of relationship is fundamental to the health of adolescent, we must ask the physician how he intends to live this relationship with his patient. The example of confidentiality may serve as our guide.

If the health professional wants to respect the reality of the adolescent, he cannot consider him as a child for whom dependence has priority over autonomy nor as an adult for whom autonomy holds the central place. He ought to welcome the personhood of the adolescent for what it is, even though the professional cannot do this without placing himself in a delicate situation. He cannot forget, among other things, that the parents are concerned with their teenager and have legal responsibility for him. What attitude should the practitioner take toward them when he knows that confrontation with their parents is one of the characteristics of adolescents? It is the physician's duty to be concerned about the teenager he is dealing with, and to realize that confidentiality is of capital importance to him or her. This duty is an obligation not only because the right to confidentiality belongs, per se, to medical ethics but also because it must be recognized as a fundamental aspect of the individual. When their secret comes out, teenagers feel as though their whole life has been exposed. It is catastrophic. Non-confidentiality would destroy a young person all the more because, despite adolescent difficulty with the adult world, he dared to trust one of them.

In a context like this, how does one respect both the aspirations of the teenager and the expectations of the parents? From an educational point of view, we should not address the

parents directly, but equip the teenager so that he can dialogue with his parents. A whole series of "transactions" must take place. But how can such a course of action be encouraged unless there is an interdisciplinary team to support the teenager and the physician through such a process? Research is needed to discover what will enable a teenager to be respected when dealing with health professional but will also encourage him to enter into dialogue with his parents. This is an important ethical task in a society like ours (12) and it is all the more pressing since laws have been designed in the U.S.A. and in Great Britain that would hinder an educative course of action.

When, in the case of adolescence, the right to confidentiality is opposed to health threat, the physician does not have any other choice of action than to protect the health of the person. Even then, this decision should be looked upon with an educative perspective. The law that demands treatment should not be presented as a repressive tool used by society in order to control minor persons. If the obligation to health supersedes the right to confidentiality, the aim is to allow the teenager to survive as an adult. Especially, in such a situation, those who are involved in the decision should value the quality of the relationship with the minor person.

The example of confidentiality highlights concrete ways in which the health professional serves the whole person. The adolescent should feel that his progress toward autonomy and his affirmation of personal integrity are taken seriously. Being concerned with the development of the whole person requires that "the physician transcends his profession, and as a person, becomes a role model, a model educator, for better or for worse, whether he wants it or not" (26). In order to act in this way and to respect the progress of the adolescent, the physician must stand as a separate individual, i.e. as an adult concerned with letting the teenager grow. If the adult disappears as a distinct entity in his effort to get closer to the teenager he hoodwinks the young person - this is the paradox of education. Unless the teenager feels that someone is concerned about him, he feels diminished. At the same time he will not be able to engage in a "decentering process" unless this appreciation comes from another person and not simply from a minor image of himself. The experience of educators shows far better than any scientific survey that no matter what an educator's ideology, if he or she is close to young people, sensitive to their dreams, respectful of their anxieties, the teenagers benefit from a strengthening and liberating relationship. This is true if also the adult is able to express clearly and sometimes bluntly his or her objections. The adult's role in the educative process consists of being close and different, committed and detached. This approach allows a young person to become positive about himself without living through an intermediate person.

What protects youth from paternalism is not non-intervention but the way a concrete situation is handled. A person becomes autonomous by undertaking a psychological journey in which love plays a fundamental role. In today's societies many children and adolescents suffer from a lack of affection. Consequently, being mothered may lead to autonomy if it brings the teenager to interpersonal exchanges with an important adult who inspires confidence (27). There may be a long and painful road to get to that point. One must take the adolescent where he is, with his strengths and weaknesses as they are. A certain degree of paternalism is the road to autonomy.

Conclusion

This paper has given preference to an ethical model involving a dialogic process that is meant to promote the autonomy of the adolescent person. In this model the physician-patient relationship looks upon this process as an essential element of the clinical interaction, since this interaction is based on the whole person involved in the situation. The practice of adolescent medicine should, accordingly, favour the development of the concept of autonomy so that it might recover the fundamental dimensions it enjoyed before Kant clipped its wings.

Originally, the word autonomy had a political dimension as Thucydides tells us (28). From the beginning the word provoked a question: "Does autonomy imply sovereignty? Can it be accommodated, on the contrary, to certain arrangements of mutual dependence or even subordination (29)? It was only with Aristotle that the idea moved from policical realities to the individual human being (30). And, when the notion reappeared in socio-political history in the modern era, the question was the same one the Greeks had asked: does being autonomous mean being independent? In relation to autonomy, the question remains: can one be free and bound at the same time? Can one simultaneously experience the liberation it brings and the limitations it imposes? The work refers to freedom but to a freedom that has a particular context and, if the word is ambiguous, that ambiguity derives, no doubt, from the reality of its human subject. The physician-adolescent relationship directs our attention back to the original meaning of autonomy.

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