ISSA Proceedings 1998 – The Changing Ethos Of Physicians And Implications For Their Ability To Persuade

Physicians in the United States have enjoyed a particularly high social status during the 20th century. But increasing concern about patient autonomy and about noncompliance with prescribed regimens, as well as questions about whether doctors always act in the best interests of their patients, especially when health insurance companies are involved, have called into question the credibility and authority that physicians have enjoyed for so long. Large quantities of research about patient noncompliance have been produced in recent years (Donovan & Blake, 1992), accompanied by concerns about how patients may be persuaded to follow prescribed regimens. This concern about persuasion may be associated with changing perceptions about the character or authority of physicians in general.

Aristotle's *Rhetoric* has been read as dividing artistic proofs or interior persuaders, for which the rhetorician constructs the material, into three forms of persuasive appeal: to reason (*logos*), to emotion (*pathos*), and to the speaker's authority and character (*ethos*). In the *Rhetoric*, Book 1, Chapter 2, Aristotle states that character may be the most effective means of persuasion that speakers possess. *Ethos* involves presenting oneself so as to be believed, and plays a significant role in the success of a presentation (Welch, 1990: 139). In the context of practitioner-patient communication, it influences patients' perceptions of their physicians and the likelihood that patients will be persuaded to follow medical instructions.

Until recently the medical profession has exercised dominant control over the markets and organisations in medicine that affect its interests, but the profession's autonomy and dominance are now in jeopardy (Starr, 1982). Healers have not always been held in high regard. Ancient Roman physicians were primarily slaves, former slaves, or foreigners, and medicine was considered a low grade occupation; in eighteenth century England, physicians struggled for the

patronage of the rich; even in the United States before 1900, many doctors found it difficult to make a living and had much less influence than they have enjoyed in the 20th century (Starr, 1982, pp. 6-7). The authority of physicians in the United States may now be eroding, following increased patient autonomy and the increasing use of physicians as administrators for health insurance companies. Starr (1982) has pointed out that: “The more administrative uses the state and other institutions find for professionals, the more they may simultaneously expand and undermine their authority” as patients wonder whether their welfare really comes first (p. 12).

The health care system in the United States has been characterised as having had three important periods of development, and now entering a fourth:
The first period began in the mid-nineteenth century (1850) when the first large hospitals … began to flourish. The development of hospitals symbolised the *institutionalization of health care* for the first time in [the United States]. Before this time, health care in the United States was a loose collection of individual services functioning independently and without much relation to each other or to anything else. …
The second important historical period began around the turn of the century (1900) with the *introduction of the scientific method into medicine* in [the United States]. Before this time, medicine was not an exact science, but was instead a rather informal collection of unproved generalities and good intentions. After 1900, stimulated by the opening of the new medical school at the Johns Hopkins University in Baltimore, medicine acquired a solid scientific base that eventually transformed it from a conscientious but poorly equipped art into a detailed and clearly defined science.
With the coming of World War II, the United States underwent a major social, political, and technological upheaval whose effect was so marked that it ended the second and signalled the beginning of the third period of health care development. The scientific advances continued unabated but now they were paralleled by a *growing interest in the social and organizational structure of health care. …*
Since the early 1980s, the health care system in [the United States] has moved into the fourth phase of its development, an era of *limited resources, restriction of growth, and reorganization of the methods of financing and delivering care* (Torrens, 1993: 3-4).

Torrens (1993) has pointed out that, following developments in medical technology, medical students increasingly view "excellence as being reached through technical achievements and give decreasing importance to the more personal, nontechnical aspects of disease. … The result frequently is professional performance that is excellent in technical terms and rather poor in human terms" (Torrens, 1993: 10).

At the same time that medical students and physicians have become more concerned with the technical, and less concerned with the personal, aspects of delivering health care, research about patient noncompliance has increased significantly in the last 30 years (Playle & Keeley, 1998), and studies indicate that between one-third and one-half of all patients do not follow doctors' orders and that the situation might be improved if physicians paid more attention to developing effective communication skills and building trust and credibility with patients.

Several scholars have noted that medical practitioners interpret noncompliant behaviour as a challenge to their authority. Playle and Keeley (1998) have pointed out that physicians perceive noncompliant behaviour as problematic because it contravenes professional beliefs, norms, and expectations regarding the proper roles of patients and professionals. Donovan and Blake (1992) have stated that compliance is closely tied to the dominance of medicine and that what clinicians now refer to as compliance used to be presented more overtly as physician control. Much of the research on patient noncompliance suggests that "patients are too ignorant to understand medical instructions or that they forget large portions of what they are told" (Donovan & Blake, 1992). The assumption in much of the work on noncompliance is that is that patients have little choice with regard to complying with doctors' orders. From the point of view of physicians, noncompliance is irrational behaviour (Donovan & Blake, 1992).

The failure of physicians to persuade patients to comply with prescribed regimens has been linked to faulty doctor-patient communication. There is evidence that some patients do not comply with medical instructions because of unpleasant interactions with their doctor (Zola, 1981). Various articles have suggested that compliance could be increased by encouraging patients to ask doctors more questions (Rost, Carter, & Inui, 1989), increasing the extent to which physicians appear approachable (Mechanic, 1978), and encouraging doctors to be more empathic (Squier, 1990).

In addition to such suggestions about how medical practitioners may change their communication behaviour to become more effective, scholars have also

recommended rethinking traditional views that patients should passively receive medical information from practitioners. Given that debates surrounding patient noncompliance have centred on maintaining professional power, Playle and Keeley (1998) have suggested reconceptualising the roles of patients and professionals to involve a view of patients as active participants in their own health care. And Donovan & Blake (1992) have recommended developing more open, co-operative doctor-patient relationships.

Patients, traditionally viewed as passive recipients of health care (Playle & Keeley, 1998), have become more involved in their own health care. There is now growing interest in alternative medicines and second opinions. Patient demands for information about medical treatments increased significantly in the United States in the 1970s and 80s (Donovan & Blake, 1992). Quill and Brody (1996) have pointed out that "Medical care in the United States has rapidly moved away from a paternalistic approach to patients and toward an emphasis on patient autonomy" (763). They claim that the former paternalistic approach had some benefits in that physicians struggled to make the best decision for patients and "spared patients and their families from agonising about interventions that had little chance of working" (764).

The new sense of patient autonomy is particularly evident with regard to changes in the acceptance of deceptive communication on the part of medical practitioners. The Hippocratic oath contains no mention of fabrication or of honesty, although, as Higgs (1985) has pointed out, the related "Decorum" advises physicians that telling patients the nature of their illness can cause them to take a turn for the worse. The first mention of veracity as a principle for U.S. physicians appeared in the American Medical Association's 1980 "Principle of Ethics" which stated that physicians should deal honestly with patients and colleagues and strive to expose physicians who engage in fraud and deception (Higgs, 1985: 190).

Concealment, especially of terminal diagnoses, was common in medical practice in the United States until about a generation ago. Fitts and Ravdin (1953) reported that 32 percent of physicians who responded to their study never disclosed to a patient if that patient had cancer (57 percent usually did not tell; 28 percent usually told, and only three percent always told). Studies up to the mid-1960s showed that it was common for doctors not to inform cancer patients of their diagnosis. (e.g. Oken, 1961). Physicians were trusted to know when disclosure of a diagnosis would be harmful, and therapeutic privilege was considered to apply to situations in which practitioners withheld information from

a patient if they thought that full disclosure could be detrimental to the patient (Van Den Heever, 1993).
In 1977, however, Novack et al. reported that 97 percent of physicians who responded to their study routinely disclosed cancer diagnoses. And Hebert (1994) has stated that although deception and nondisclosure are still common, doctors have become more honest in disclosing to patients in the last 30 years.

Current expectations are that physicians will share information with their patients and, in some cases, even allow patients to contribute to decisions about treatment. It is no longer the case that patients do not question medical decisions and simply trust doctors to act in the best interest of patients. In addition to growing patient autonomy, economics have intruded on efforts to provide all possible benefits because some health insurance companies refuse to pay for certain medical interventions. Although some medical scholars have suggested deceiving insurance companies so that patients may qualify for reimbursement (e.g., Cain, 1993), many patients appear to be more suspicious about doctors having greater concern for the interests of insurance companies.
Given evidence from Aristotle that credibility is one of the first considerations in persuasion, medical practitioners might be well advised to focus on their own *ethos*, on enhancing their authority and credibility with patients, as opposed to regarding noncompliance as irrational behaviour. It appears that doctors could do more to persuade patients by developing effective communication skills to help them earn their patients' trust. This can involve recognising patients as active participants in communication interactions, acknowledging that patients' impressions of physicians' character and intentions significantly influence whether patients will do as prescribed, and trying to assure patients that their interests are of the greatest importance in doctor-patient interactions. Increasingly, it seems, patients are not merely following doctors' orders; doctors will need to make a greater effort to persuade patients to comply with prescribed regimens. As Aristotle suggested so many years ago, in addition to providing reasonable, logical evidence and possible appeals to emotion, this may involve enhancing patients' perceptions of the character of their physicians through effective communication.

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