Paternalistic vs Egalitarian Physician Styles: The Treatment of Patients in Crisis

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According to previous reports, the quality of the physician-patient relationship plays an important role in medical outcome. A patient's responsiveness to suggestions, perceptions of treatment, and physical distress may be affected both by the type of interpersonal relationship and by the patient's anxiety. To test these hypotheses, 57 women who received elective abortions were treated by the physician in either a "paternalistic" or "egalitarian" interpersonal style. Each patient was tested for responsiveness to suggestions regarding changes in somatic perception such as heat or pain; a measure of psychological dependency on the physician was also obtained in addition to ratings of discomfort and signs of physiological distress during the medical procedure.

Patient anxiety was not related to any of these variables, but patients treated in a paternalistic manner had higher responsiveness to suggestibility ($P < .001$), felt they could depend more on the physician and perceived him as warmer and more supportive ($P < .01$), had less discomfort during the procedure ($P < .05$), and had a lower incidence of physiological distress compared with patients treated in an egalitarian manner. It was concluded that, for patients in crisis, paternalistic treatment by a physician may promote positive psychological and medical outcome.

In the everyday practice of medicine, physicians may influence significantly the patient's anxiety or experience of pain by a simple touch or a few reassuring words or positive suggestions.[1-7] The reasons why a patient would be so responsive have not been investigated systematically, although Beecher[8] has shown that the experience of pain is affected by the circumstances in which the pain occurs. Reyher[5] and other investigators[8-10] have asserted that three critical factors enhance the responsiveness of medical patients to suggestions: (1) the degree to which patients are unable to treat their own illness or injury and are obliged to wait passively for assistance from the physician, (2) the physician's style of interaction, which temporarily promotes either dependence or independence in the patient, and (3) the patient's anxiety resulting from injury or illness.

A major goal of this investigation was to study the relationship between the manner of interper-

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sonal treatment by the physician, the patient's perceptions of that treatment, and the patient's responsiveness to suggestions. Physicians who relate to patients in a kindly, protective, parental manner (referred to as paternalistic in this investigation) during a medical crisis would be expected to foster a childlike dependency in the patient.* If a childlike dependency on the physician does occur in medical patients during a crisis, as has been shown in case reports,[1,7,12] then these patients should experience intense feelings and perceptions that the physician is powerful and reminiscent of a parent. If the physician does not act in a paternalistic manner, the patient in crisis may experience a feeling of abandonment[1,13] and would be less motivated to respond to the physician's suggestions. In fact, a physician who acts in an equally kindly, but egalitarian manner, giving the patient more freedom to assert judgment and to express opinions,[14,15] would be expected to reduce even further patient dependency and responsiveness to suggestions by encouraging the patient to retain a critical, evaluative attitude.[5,6]

A second question to be addressed by this study is whether reassurance and suggestions of comfort made by a physician prior to a medical procedure results in a reduction of patient distress, and if so, whether it makes any difference if the reassurance and suggestions were offered by the physician in a paternalistic or egalitarian manner.

A third goal of this investigation was to study the relationship between the patient's degree of anxiety and both dependence on the physician and responsiveness to suggestions. Anxiety related to illness or injury appears to be a powerful motivator for patients to become more passive and dependent on the physician.[10] If so, then patients in anxiety-producing medical situations, such as a serious injury or prior to surgery, should be more dependent on the physician and, consequently, more responsive to suggestions than patients awaiting a relatively painless procedure such as a routine physical or postsurgical examination.

*This childlike dependency is what has been termed a *regressive transference.*[5] This temporary dependency is partly an unconscious phenomenon in which the feelings, attitudes, and wishes originally linked with parents early in one's life are projected onto others who have come to represent parents in current life.[11]

Methods

Subjects

Women receiving an elective abortion in a family physician's private practice comprised a patient population undergoing a relatively uniform medical procedure. These patients had been referred by other physicians and family planning centers in a rural area of central Michigan. The first 70 consecutive women referred for an abortion were invited to participate in a study of "relaxation during medical procedures" unless they required hospitalization for the medical procedure, were judged by the physician to have psychiatric problems significant enough to compromise their ability to give informed consent, or had previously received treatment from the physician. For these reasons, 13 patients did not participate. Of 57 eligible patients who were invited to participate, all accepted. All patients who agreed to participate gave written consent. The investigation, including the consent form, had received prior approval from a review committee at Michigan State University. The patients ranged in age from 16 to 43 years (mean = 21.8 years). All of the abortions were suction curettage and were done under paracervical block using 20 cc of 1 percent lidocaine (Xylocaine). Each patient also received two Donnatal tablets (.1296 mg belladona alkaloids and 16.2 mg phenobarbital per tablet) and two 5-grain acetaminophen tablets 30 to 45 minutes prior to the medical procedure.

Procedure and Materials

Each patient was assigned randomly to either a paternalistic or egalitarian treatment group at entry into the study and thereafter, from preabortion through postabortion care, was treated in either a paternalistic or egalitarian manner. The two treatment styles were operationally defined in terms of specific behaviors (Table 1). These behaviors included the degree to which the physician dictated the sequence of events, the extent to which he spoke in a directive or permissive way, for example, "You will feel better as you listen to my voice relaxing you," vs "You may feel better if you can relax yourself," and the use of physical

Table 1. Physician Behavior in Two Treatment Conditions

Type of Behavior by Physician	Treatment Condition	
	Paternalistic	Egalitarian
Degree of warmth and concern	Much	Much
Language modality of physician	Declarative	Permissive
Modality of suggestions	Directive	Indirect
Decision making	Assumed by physician	Shared with patient
Quantity of information offered by physician	Moderate	Much
Frequency of touching	Often	Seldom
Physical position of patient during interview	Recumbent	Sitting up

touch. The physician was obviously aware that the investigation was intended to study the relationship between treatment style and the responsiveness of patients to suggestion, but he was unaware of the specific study questions until after collection of the data. He made a special effort to show an equal amount of warmth and concern for patients in both groups. Written permission for tape recording was requested of a random subsample of several patients (none refused permission) to monitor the physician-patient verbal interactions and to help ensure that it varied in the manner described above. The mean patient ages for the two experimental groups did not differ.

No validated measures for a patient's feelings of childlike dependence in a medical setting are available; therefore, to determine whether the manner of treatment by the physician affected patients' perceptions and feelings toward him, all patients were asked during the postoperative recovery period to complete an open-ended written questionnaire that asked patients about anything which had either worried them or provided a sense of reassurance during the medical procedure. Patients were again reassured that their responses would remain anonymous and would not be seen by either the physician or the nurses. Two examples of the study questions are as follows: (1) "Was there anything Dr. _____ did or said that might have made you feel worried during the procedure? If 'yes,' please explain." (2) "Was there anything Dr. _____ did or said that might have made you feel safe and reassured during the procedure? If 'yes,' please explain." The response to each question was scored independently by two raters on a 4-point scale. For example, a perception that the physician was "okay," "competent," or "a nice person" was given a low score; a perception that the physician was "fantastic" or "made me feel completely safe" received a higher score. The highest scores were given to statements that indicated a psychological regression and complete dependence on the physician, eg, "I felt like a little kid," "I was safe in his hands," or "He seemed just like a father to me."

To assess the relationship between patient anxiety and responsiveness to suggestions, one half of the patients in both treatment groups were tested by the physician for their responsiveness to indirect suggestions just prior to the abortion (when anxiety was high), and the remaining one half were tested several days after the surgical procedure (when anxiety was relatively low). Assignment to these testing conditions was also random and predetermined from the beginning of the study. The physician conducted the suggestibility test in either a paternalistic or egalitarian manner, depending on the group to which the patient had been assigned, and incorporated the testing into the routine medical examination.

For those patients whose suggestibility was tested prior to the abortion, the physician also gave specific suggestions for feeling good and comfortable during the impending surgical procedure. Consistent with the experimental design, the physician also gave these suggestions in either a

Table 2. Median Scores for Patient Responsiveness to Suggestion and Dependence on Physician*

	Number of Patients	Responsiveness to Suggestions	Dependence
Paternalistic treatment	27	7.00	5.00**
Egalitarian treatment	30	5.00	3.00
		$P < .001$	$P < .001$

*Comparisons by Mann-Whitney U test.[21] Medians rather than means are presented, because data are not distributed normally
**n = 26 in this group because the response of one patient was unscorable

paternalistic or egalitarian manner.

Responsiveness to indirect suggestions was measured in terms of an 11-item suggestibility scale, patterned after the work of previous investigators.[6,16] One example of items on this scale is the physician applies light pressure to the patient's left knee and asks the patient to report whether she notices a cool or cold sensation in that leg. The other ten suggestions included on the scale are warmth in the right leg, a sudden increase in the perception of light through closed eyelids, ringing in the ears, a smell of ammonia, a sensation of a feather touching the back of the left hand, a tingling sensation in fingers of the left hand, itching on the back of the right hand, a subjective feeling of numbness in the left hand, a sensation of numbness in the left hand when both hands are tested with repeated pinpricks, and a subjective need to cough. Each suggestion is presented in a similar fashion, by saying, for example, "Now I'm going to press this spot on your left shoulder. Let me know if you notice any sensations of numbness in your left hand"; or "Now I want you to close your eyes. Let me know if you notice the sensation of a feather on the back of your left hand." After each suggestion, the physician waited 10 seconds; the item is scored positively if the patient reports that she experienced the sensation suggested. The validity of the scale has been assessed by comparisons with standard scales of hypnotic susceptibility in both normal and medical samples.[17] The scale was designed for administration in either a paternalistic or egalitarian mode.*

During the preoperative and postoperative visits, the nurses independently rated the patients' anxiety. The nurses then immediately obtained anxiety self-reports (scale of 0 to 10) from the patients. During the medical procedure, nonverbal and verbal indications of patients' physical discomfort were recorded by the nurses, and patients were also asked immediately afterward to describe the discomfort they had experienced. These nonverbal and verbal indications of pain were independently assigned a label of either "high" or "low" pain by two female raters and differences were resolved by discussion. These methods of assessing pain and anxiety are less intrusive than a formal questionnaire and have provided valid data in other clinical investigations.[18-20]

Results

Patient Responsiveness to Suggestion

Contrary to expectations, suggestibility scores were not significantly higher in those patients who were assessed just prior to the medical procedure (when patient anxiety was highest). No significant relationship was found between anxiety and responsiveness to suggestion. However, an overall comparison of suggestibility scores in the paternalistic and egalitarian treatment conditions (Table 2) showed greater patient responsiveness to suggestions that were made in a paternalistic, as opposed to an egalitarian, style of interaction ($P < .001$).** As shown in Table 3, the percentage of patients who passed each suggestion ranged between 10 percent and 100 percent.

*Copies of the scale and validity data are available from the author upon request.

**Mann-Whitney U test. A standard, nonparametric analysis used for data which are not normally distributed.[21]

Table 3. Percent of Patients Passing Each Suggestion

Suggestions	Percentage Passing: Paternalistic Treatment	Percentage Passing: Egalitarian Treatment
1. Right leg warmer	78	60
2. Left leg cooler	100	77
3. Increase in light	89	80
4. Ringing in ears	63	44
5. Smell of ammonia	30	24
6. Sensation of a feather on left hand	15	17
7. Tingling in fingers of right hand	78	60
8. Itching on right hand	38	20
9. Sensation of numbness in left hand	97	67
10. Numbness to pinprick in left hand	100	87
11. Need to cough	16	10

Patient Perceptions of Physician and Feelings of Dependence

Interrater reliability for the scoring of this questionnaire was quite good ($r = 0.84$, $P < .001$). Similar to the suggestibility scores, these "patient dependence" scores were unrelated to patient anxiety, but they were related to the manner of treatment by the physician (Table 2); that is, patients who were treated in a paternalistic manner showed more indications of intense positive feelings toward the physician and perceptions that the physician was a warm parental figure than did patients treated in an egalitarian manner ($P < .001$).

Differences in the perceptions of patients in the two treatment conditions are illustrated by some examples. Many patients treated in a paternalistic manner described the physician in superlatives and some made reference to feeling "special" or "at home." "I was being taken care of at all times, with the best knowledge." "He's a very warm man and doctor. . . . I felt special; not (like) just another patient." "(His) voice had a personal tone that relaxed and comforted me. . . ." "(I felt) good and safe in his hands. . . ." "There was a 'homey' feeling instead of a medical atmosphere."

Most of the patients treated in an egalitarian manner simply described the physician and his behavior in terms that were mildly complimentary, eg, "He was very pleasant," "(He was) reassuring," or "He did his job well." In contrast to the paternalistic condition, several patients in the egalitarian condition did not attribute any positive qualities to the physician. Rather, it was a nurse or the patient's own ability to relax that the patient perceived as helping her. For example, one patient had no praise for the physician but wrote, "I felt reassured when I heard the (suction) machine go on, and I realized it was almost over. . . ." It is important to note that none of the patients in either group perceived the physician as unkind or uncaring.

Physical Discomfort

Data were inspected on those patients who had received specific presurgical suggestions regarding comfort and well-being to see whether the patient's degree of responsiveness to suggestions was related to the degree of discomfort experienced by the patient during the medical procedure. In other words, if suggestibility is a concept with any practical importance, then those patients who are most responsive to suggestions should experience the least physical distress. Suggestibility and discomfort were unrelated for patients in the egali-

tarian treatment condition but were related ($P < .05$)* in the paternalistic treatment condition, with the most discomfort found in patients who were relatively less responsive to suggestions.

In addition to this analysis of pain-related behavior, a similar comparison was made of the frequency of severe physiological distress (usually requiring atropine), which included diaphoresis, emesis, or bradycardia. As would be expected, the occurrence of these physiological indicators did not differ between treatment conditions for those patients who had not received any presurgical suggestions. However, for those 28 patients who were given presurgical suggestions regarding well-being, fewer patients experienced these physiological indicators in the paternalistic treatment condition (one patient) compared with the egalitarian treatment condition (six patients).

Discussion

In this investigation a pattern of results provided evidence that paternalistic treatment of medical patients who are in crisis may promote strong positive feelings toward the physician and the medical treatment. There were a number of dimensions that differentiated paternalistic and egalitarian behavior as defined in this investigation, so it is difficult to say which dimensions (eg, degree of touch, degree of control assumed by the physician) may have been the most important. This question remains to be resolved by continued research.

It is striking that patients in the egalitarian condition apparently experienced no more than nonspecific effects of relaxation and "waking suggestions."[22] Their responses and feelings toward the physician and their surgical discomfort seemed to vary as a function of individual patient differences only. In the paternalistic treatment condition, on the other hand, there was a relatively greater degree of patient dependency and responsiveness to suggestion, less patient discomfort, and relatively fewer incidents of physiological distress. Of the patients treated in a paternalistic manner, those who were most suggestible experienced changes in perception and sensation associated with specific effects which are even more powerful than placebo effects.[22]

The failure to demonstrate a relationship between anxiety and any of the dependent variables raises a possibility that the interpersonal relationship between physician and patient was established quickly, and that the patients' perceptions and responsiveness to suggestions remained constant over time regardless of whether the patient was anxious. When a patient is in crisis, anxiety regarding one's physical comfort may play only a mediating role in the patient's feelings toward the physician and responsiveness to suggestions. Those patient perceptions of the physician that are established early may remain relatively constant throughout the duration of the relationship.

Another observation of interest is that, in this particular sample, most patients were able to experience several somatic changes simply by hearing the physician say something like: "As I touch your (shoulder/arm/knee, etc) let me know if you notice (numbness, tingling, itching, etc)." The relative ease with which patients experienced such somatic symptoms is cause to review carefully the manner in which physicians examine some patients. If there is reason to believe that the patient is experiencing a childlike dependence on the physician, then there is also reason to expect that some questions such as "Do you feel (numbness, weakness, dizziness, etc) when I press here?" may be sufficient to elicit the symptom temporarily. This situation would be different from malingering, in that the patient may temporarily have some difficulty distinguishing whether the symptom originated from an organic cause or an indirect suggestions. These speculations, consistent with implications of other research,[5,6] could be tested in future investigations.

An egalitarian approach to patient care has been widely promoted as the type of relationship that patients want with their physicians. However, if the results of this study can be generalized to other patients in crisis (a hypothesis that remains to be tested), then the "take-charge," protective manner of a kindly, loving parent may be an essential component in developing a strong physician-patient relationship. The egalitarian relationship may be optimal *only* for patients with minor complaints, routine health needs, or a chronic illness that is generally under good control. In such instances,

*Fisher's exact test,[21] a standard nonparametric test which analyzes the distribution of a small sample on two independent variables.

there is an obvious need for the patient to play an active role in treatment and to accept responsibility for ongoing self-assessment of health problems. In contrast, patients in crisis seem to respond best when there is relatively more psychological guidance, until the patient is able to resume autonomous functioning again.

Such concepts and behaviors can be incorporated into medical school curricula and resident education programs through a combination of reading, didactic presentations, and supervised clinical experience. Many physicians tend naturally to vary their behavior on a paternalistic-egalitarian continuum, depending on whether the presenting problem is acute or chronic. The greatest training need seems to be helping physicians to use these principles in a more conscious, deliberate manner.

The number of patients involved in this study was small, the measures were relatively crude, and the degree to which these results can be generalized to other types of medical patients is unknown. However, the results of this investigation are the first systematic and quantifiable demonstration of relationships between such variables as the physician-patient relationship, suggestibility, discomfort, patient satisfaction, and treatment outcome. These variables are obviously difficult to quantify and require an approach recently described by Burkett and Godkin[23] that is both systematic and qualitative. The present results may have immediate applications for the treatment of medical patients by physicians, psychologists, nurses, and other health care professionals. Those who care for medical patients often have a profound influence on them, intentionally or not, good or bad. Rather than ignoring that influence, the clinician-patient relationship can be used to enhance a positive outcome in clinical practice.

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