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THE PHYSICIAN-PATIENT RELATIONSHIP AND INDIVIDUALIZATION OF TREATMENT FROM THE VIEW OF TRADITIONAL CHINESE MEDICAL PRACTICE

I. INTRODUCTION

Behind every system of medicine hides a set of ethical values that immanently dominate persons' attitudes toward disease and death, and exert a subtle influence upon both the physician-patient relationship and paradigm of medicine in society. With the development of increasingly sophisticated technology, the specialization of modern medicine and the rise of the civil rights movements, we increasingly fall into ethical dilemmas concerning the physician-patient relationship. Now, we should open our eyes to a usually neglected fact that "modern medicine suffers from the loss of the authentic personal relationship crucial in medicine and medicine care" (Hui, 1996, p. 5).

Obviously, the possibilities of rational orientation for a harmonious physician-patient relationship lay neither in a sophisticated technology itself, nor in the specialization of medicine, but rather in the development of a new paradigm of medicine, and in communication, understanding and coordination between physician and patient, and in intercultural, multicultural or transcultural dialogue and cooperation of different systems of medicine.

I believe modern medicine might draw some inspiration and wisdom from traditional Chinese medicine and thereby recover the importance of the relational dimension intrinsic to the clinical encounter between physician and patient. I shall proceed in this paper by first demonstrating the limitations of four models of the physician-patient relationship. Then I shall state the main problems with the physician-patient relationship in society. Finally I shall clarify the principle of individualization in traditional Chinese medicine and its meaning for the paradigm of modern medicine.

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II. THE LIMITATIONS OF THE AUTONOMY MODEL

Generally speaking, there are four possible models of the physician-patient relationship: beneficence, entrustment, partnership, and autonomy. Despite this generalization, there is not always a very clear demarcation among them in actual clinical practice, and sometimes several models co-exist, probably depending on the concrete situation (Wolff, 1994).

Hippocratic medicine has been treated as the beneficence model in which some kind of ethical paternalism is involved. On the beneficence model, a physician should regard it as a "categorical imperative" to maximize the patient's medical benefits regardless of what kind of demand the patient has made on him. At the same time, "the patient should obey the doctor's commands and even must place himself in the physician's hand" (Beauchamp, 1990), since the well-being of the patient takes precedence over everything else. Before the ideas of a right-based ethic gained worldwide dissemination in the 1960s, the beneficence model played a dominant role in almost every society.

In traditional Chinese medicine, it is the highest principle for a physician to help patients rid themselves completely of their ailments and to help seriously ill patients to take a turn for the better. Until now, "conscientious in medical treatment and miraculously bringing the dying back to life" has been the highest praise for a physician. Confucian ethics of virtue emphasizes that a physician should first have the heart of benevolence and the sense of duty of a noble man. This conception was completely kept even if other ethical values were destroyed during the Cultural Revolution of the 1960s and 1970s.

The entrustment model states that the physician-patient relationship is something like the relationship between lawyer and client, where the physician autonomously offers special diagnosis and treatment, such as laboratory tests, local anesthesia, general examinations, etc., without the special permission of the patient. On this model, the interests of both sides are considered at the same time. From the beginning, the patient transfers his right of decision-making to the physician; the physician by himself decides how to serve the patient. This model, which is usually employed only by those patients who are not severely ill, is characterized by a balance between the right of the patient and the objective of the physician, based on the trust, honesty and autonomy of the patient. The ethics of entrustment may provide the foundation for this model.

The partnership model states that the physician acts as an advisor-expert to the patient, who is an active partner, responsible for himself. But generally the model is only applied to cases where the patient hopes to get advice from the physician about how to prevent, limit or improve various chronic diseases such as heart disease, hypertension, diabetes, etc. Under this model, the responsibility of the physician is mainly to help the patient to help himself, but the patient's self-orientation, self-determination and self-responsibility always take priority over other considerations in the physician-patient relationship. To make an important contribution, the patient must have some experience with self-observation and self-examination of the main symptoms such as blood pressure, blood sugar, pulse and so on, in order to adopt further effective measures to control the illness. The success of the partnership between physician and patient depends on the intelligence, medical knowledge, life experience and meticulousness of the patient. Discourse ethics in Habermas' sense may provide foundation for this model.

The autonomy model states that mentally competent patients have the right to make the final decision on treatment plan or surgery when there is a conflict between the patient's wishes and the physician's advice about the best possible treatments. On this model, the physician has a duty to present all information and to act on the patient's wishes even when the patient refuses some treatment (for instance, the refusal of blood transfusion by some Jehovah's Witnesses). In this case, the physician can tell the patient all kinds of advantages and disadvantages of treatment and then wait for the patient to make the decision. The physician need not be morally responsible for any failure of treatment (including the death of the patient) derived from the false or foolish autonomous choice of the patient. Therefore, to follow the dictate of the patient seems to be the ethical imperative for the physician. Here, we could find that the autonomy model deals with the physician-patient relationship only in light of the patient's wishes, so we would call it the subjective model. On the contrary, the beneficence model deals with the physician-patient relationship in light of the best results of treatment, so we would call it the objective model. In comparison with the beneficence model, the autonomy model is mainly concerned with the rights of the patient. This explains why the autonomy model could not play a dominant role in medical practice before the right-based ethic began to dominate in Western society. As Thomas Murray said, "autonomy sometimes appears to be regarded as a kind of universal moral solvent" (Murray, 1994).

However, the uncritical acceptance of the autonomy model in any case is leading to the crisis of the physician-patient relationship (Hoshino, 1997), which is a symptom of the trust crisis in modern society. On the one hand, faced with the crisis, modern medicine needs self-reflection and self-criticism; physicians should ask themselves what destroyed patients' trust in physicians. On the other hand, we should ask if we have lost the ethical value of respect for life, which is, in my opinion, the highest value of human beings and the final reason for the existence of medicine. What kind of choice is rational when respect for the life of a patient and respect for the right of a patient clash? In a developing society with terrible shortages of medical resources, allowing unlimited autonomy can sometimes harm the common good, because the physician lacks time and energy enough to explain every detail of all treatment alternatives again and again. Suppose that the physician had to treat 100 patients one day; if one patient takes too much of the physician's time, many other patients would not get treatments immediately. Therefore, in a society short of medical resources, the beneficence model is still the only realistic choice, but it should not exclude the possibility of patients participating in the decision-making of treatments. It should be admitted that this model has its problems, especially in a society with increasing emphasis upon the right to individual self-determination. When a skillful physician does not know what kind of treatment is best for the patient, the patient must know if a possible treatment is worth the expense.

Clearly, it perhaps increases unease and anxiety to set aside the wishes of the patient. Once the patient becomes a passive object without any subjectivity in the beneficence model, we could not rule out the possibility that a few physicians use patients as objects of experiments for the purpose of personal academic achievements. As is now known, some physicians under the Nazi regime even carried out involuntary euthanasia on deformed persons under the pretext of beneficence. For these reasons, the traditional strong beneficence model should be changed into the weak one by introducing the autonomy of the patient into clinical life. That is to say, in the majority of cases the patient's right of self-determination should be respected, but if there is conflict between respect for life and the right of autonomy, we should value the former over the latter. Since society forbids drivers to drink alcohol, forces motorcyclists to wear helmets, and prohibits drug-taking or smoking, why does society not go so far as to allow the physician to save patients who ignore his wishes

when it certainly means death for the patient to refuse some kind of treatment?

In fact, we need a kind of autonomy grounded in the respect for life, which is the starting point and the highest goal of all systems of medicine. At any rate, we should ask ourselves what kind of autonomy is rational and what kind of autonomy is irrational. If autonomy were rational in any case, drug takers would have good reason to say that ingesting cocaine is rational. In contemporary society, autonomy is often abused. Etymologically, the term autonomy is derived from Greek *autos* (self) and *nomos* (rule, law, or governance), which means self-determination as well as self-limitation based on some universal principle. As Confucius said, "Do as you please, but not beyond limits of rule" (Confucius, 1996, p.31).

As inheritors of the Greek spirit, Westerners should understand this point. Only acting freely on a universal moral imperative can be classified as real autonomy as opposed to heteronomy in the Kantian sense. Regrettably, some people separate absolutely the two aspects of autonomy. In other words, they try to keep the "self-determination" part of the meaning, but exclude the "self-limitation on the basis of a universal rule" part, so that acting on one's own will becomes an overwhelming value to some people.

However, there can be no harmonious and fruitful physician-patient relationship if the physician and patient act only on their respective wills without commonly recognized ethical principles, among which the respect for life, I think, is the first. The crisis of the contemporary physician-patient relationship is the crisis of both the traditional beneficence model and the autonomy model, whereas total autonomy is a radical reaction to strong paternalism. Among a number of factors related to the crisis, the most important are the rise of civil rights movements, the marketization of medicine, the specialization of medicine and the wide use of high-tech equipment.

The rise of the civil rights movement awakens the consciousness of self-determination in people and thus makes patients unsatisfied with simply following the commands of physicians. In this way, "When applied to the practice of medicine the idea of a right-based ethic clashed with the Hippocratic model of beneficence. The dawn of the patient autonomy movement changed the paradigm of ethics from a physician-based model of beneficence to a patient-based model of autonomy" (Voth, 1996). For this reason, the feminist movement is a strong