

The Balance between Beneficence and Respect for Patient Autonomy in Clinical Medical Ethics in France

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A pilot center for clinical ethics in France opened with the establishment of the “Centre d’éthique clinique” at Cochin Hospital in Paris, September 2002. Unlike the longer history in the United States of providing ethics consultation for ethical issues deriving from physician–patient interactions, this center marks a new development in bringing clinical ethics to Europe.

There has been a historical reluctance in France to embrace what has been viewed as an undesirable “American” approach to the doctor–patient relationship—that is, giving preference to personal values over traditional societal norms. The different emphasis placed on “beneficence” (highly valued from a European perspective) and patient “autonomy” (seen as the primary consideration in the United States) necessarily produces different pictures regarding the ideal physician–patient relationship.

From an American perspective, France is commonly viewed as a latecomer in clinical ethics and consultation services. However, the hypothesis presented here is that, instead of being late, a more accurate account would recognize that France’s specific historical, political, and cultural heritage allows for a different way for democratic processes to influence medical ethical decisionmaking.

The major difference that characterizes how the doctor–patient relationship is viewed in France and the United States can be traced to political roots and the respective weight each country accords to the interests of society as a whole as compared to the interest of individual citizens.

France has always been hierarchical, centralized, politically governed, and paternalistic. A possible reason might be that the country’s small size makes it relatively easy to control centrally. With regularity over the last centuries, and continuing to the present time, regional leaders have tried to extract some power from Paris. Each time these efforts have failed and these initiatives have led to national crises between the so-called “Jacobins,” arguing for centralization on the one hand, and the “Girondins,” arguing on the side of decentralization. Thus, unlike Italy or Spain, France has never had a federal background.

A second reason for France’s centralized and hierarchical character may reside in history. The emancipation of individuals in our country has often been won through hard-fought battles that are part of a group context, the most famous example being the French Revolution that succeeded in replacing the monarchy with a republic. People here seem to assume that their individual rights would never exist without the help and protection of others, either their social class or the society as a whole. Individual rights do not stand on their own, but come into existence and are protected through their links with others.

There is a sort of collective assumption that personal autonomy in France begins when and where society allows it.

A third point that should be considered in explaining the pronounced paternalism of French society is the fact that the country is primarily Catholic, a religion characterized by a much more hierarchical and normative structure than Protestantism.

The country's high tolerance for hierarchy and authority means that decisions in France, from the most important to the more routine, are politically determined from a central base. The creation in 1983, before any other country, of a national Ethics Committee is a good example of the French political and social model: giving over to a national group of eminent thinkers the responsibility of offering official advice regarding the ever emerging ethics issues and challenges being generated by biotechnological sciences.

In contrast, in the United States, medical ethics debates exist on a more local and case-by-case basis. Only subsequently do they command nationwide importance. However, in France the same sorts of issues are first explored at a national level; thereafter, the conclusions reached are used as points of reference when dealing with any specific case. In the United States, the medical decision is generally taken between two individuals inside the doctor-patient relationship. In France, the same decision is mediated by the society in the form of those who have been appointed to represent the State in exploring the wider moral dimension of the issue. The French physician is then expected to apply the agreed upon collective values to the specifics of individual cases.

In France as in the United States, doctors hold prominent positions in the social establishment in terms of money, education, and power. But in France, physicians are also strongly engaged in politics, as evident, for example, by the number of physicians who are also members of the parliament. Additionally, the French financial organization of the healthcare system contributes to the consolidation of medical power. Because they are paid by the state through the publicly funded national healthcare assurance system, physicians are less vulnerable to legal claims brought by patients. In a sense, when patients argue against doctors, they are arguing against the public system—that is, the structure that represents the whole society. Within this system, the fight is never really a one-to-one confrontation. Moreover, patients may even unconsciously integrate the fact that society's authority, represented by the physicians, is the natural counterpart of the social welfare state model that has been collectively chosen and to which they are strongly attached. It is not surprising, therefore, that patients act as if they do not feel themselves authorized to express any kind of personal preferences or demands and view their individual autonomy as less important (even from their own perspective) than a respect for the overall collective values. The national integrative model is so strong, at least up to now, that most people view participating as a full member of society to be their prime civic duty, which entails adopting society's values, even beyond their personal ones.

Finally, there is a perceived difference in the very nature of the doctor-patient relationship in France and the United States that can also be proposed as an explanation for the reluctance toward clinical ethics in France. In the United States, the doctor-patient relationship is considered more as a contract between two people, as opposed to France where the relationship is still a personal moral engagement in which the physician is entrusted by society to

guard traditional norms within the medical context. Medical training inculcates this belief and if physicians were to relinquish this power to patients, they would most likely believe this was an abdication of their professional responsibility. Any circumstance that appears to disrupt this social institution or appears to transform the doctor-patient relationship into a contractual one is viewed negatively as symptomatic of an attempt to turn ethics into an object of negotiation.

Recent events in France, however, suggest that the French population is asking for a reappraisal and a fresh look at the doctor-patient relationship and the proper balance between physician beneficence and patient autonomy.

At the end of 1998, the French government decided to consult citizen groups about their demands and expectations with regard to the healthcare system. A nationwide study was organized and carried out over a 9-month period. A thousand meetings were held, involving over 200,000 people throughout the country. The extensive and enthusiastic public response was totally unanticipated by officials, who were surprised at the large numbers of people eager to participate in this innovative opportunity to be part of direct democracy. The primary message sent by the participants to the politicians was that they wanted to refashion their relationship with the healthcare system as well as with their own physicians. In effect they said, "We are fed up with the paternalistic model of the doctor-patient relationship as it now stands; we want to be real partners in the medical decisionmaking and in the political debates on healthcare." Further, they asked to be considered as individuals, persons and subjects, rather than as patients, objects of illnesses, and they strongly expressed their willingness to assume more civic responsibility by taking an active part in public debates on issues such as allocation of resources or health priorities.

Respondents to the survey also said that medicine is not the exclusive prerogative of doctors but belongs to society and, therefore, social dimensions need to be considered as well. Of particular emphasis was the collective voice in favor of more personal and individual considerations. As is often the case in France, the fight soon acquired a political edge as the call for a more personalized medicine was, in fact, emblematic of a more general demand seeking expanded individual rights. Success in obtaining personal considerations in any part of public life has come to be seen as the best way to progress toward increased democracy.

In response to the information gained from this large and popular survey project on France's healthcare system, the government proposed to increase patients' rights, prime among them being the authorization for patients to have access to their own medical charts. Parliament voted to adopt the proposal, and the "Kouchner law," named after the former Health Minister, Bernard Kouchner, became effective in March 2002.

The reform proposal was heavily controversial, and the struggle to win it was long and hard. The arguments on both sides symbolized the differences between the physicians' and the patients' conceptions of what should characterize the doctor-patient relationship. Physicians maintained that the medical chart was a vital working tool for them, and they wanted to remain free to write in it without editing out of concern for what patients might read. They argued that the truth can actually be harmful to people and that part of physicians' duties is to protect their patients from harm where possible. They also argued that keeping charts for physicians alone would help to prevent employers and

insurance companies from discriminating against patients because of health conditions.

Perhaps the argument the physicians felt most subversive was that increased patients' rights and access to medical charts could be viewed as a governmental acceptance of an alarming mistrust by society toward the medical profession. They denounced a trend they feared could open medicine to more litigation, as they believed had happened in the United States, meaning that an increase in patients' rights could be expected to be accompanied by an increase in lawsuits.

The public's views were in direct opposition. They held that because medical charts are based on information given by the patient to the physician, the chart rightfully belongs to the patient. As adults they felt mature enough to determine for themselves what, and how much, information they wished to have disclosed, and they clearly wanted to have direct access to their own charts. They stated that confidence in the healthcare system urgently needed to be reinforced by more transparency, less power held exclusively in the hands of physicians, and a greater degree of equilibrium within the doctor-patient relationship. Instead of an increase in lawsuits, the survey participants argued that reinforcing confidence by building greater transparency in the healthcare system is actually the best way to diminish conflict and legal wrangling.

Against this background and with these two camps still very much in opposition, Cochin Hospital inaugurated a pilot clinical ethics center, including consultation services, in Paris in September 2002. The goals were (1) to offer a place in which the ethical dimension of medical decisions could be discussed on a case-by-case basis from both the physician's and the patient's points of view with the collaboration of a multidisciplinary team serving as a representative of societal values; (2) to assess whether, or in what manner, medical decisions may be negotiated differently as a result of the new patient's rights law, and (3) to observe medical decisionmaking and the ethical issues generated in the course of daily clinical practice and raise the question as to when those issues have social implications that require public participation in their solution.

What can be said at this point of the ethics "experiment" at the Cochin Hospital? First, that we were happily surprised to receive 50 requests for consultations within the first year. Of 50 requests, 40 came from healthcare workers, primarily physicians, and 10 from patients or their proxies. Consultation requests were triggered by questions involving end-of-life issues (20), living donors (15), access to reproductive technologies (7), therapeutic choice (4), consent (2), and genetics (2). Approximately 10 hours were spent on each consultation, including extensive interviews with three to five people from the health team, the patient's environment, and the patient herself when possible.

The primary lesson learned from the consults was about the widespread interest on the part of the health professionals for sharing and enlarging the discussions on the crucial ethical dilemmas they face.

A second finding suggests that the daily medical decisions as they are negotiated between patients and physicians in France and the United States may not be so very different. Even taking into consideration that the French experience is still new and requires more study before reaching any definitive conclusions, it appears that the stereotypes of unbounded autonomy in the United States on the one hand versus a rigid paternalistic model of the doctor-patient relationship in France reflects more caricature than reality. From

our own comparative experiences in both contexts, although differences of emphasis exist, the similarities are observable:

- Patients do not ask for total autonomy in weighing the burden of the decisions. More typically, they ask for respect, attention, and consideration. They want to be heard and appreciated for their unique story and personality. And they expect the physician to know what is the best decision for them and to feel responsible to take it.
- Physicians are reluctant to ask patients about their choices when they have no doubt about their best interests. But they are ready to fully respect the place of autonomy in situations of medical uncertainty and when the patient's best interest is unclear.

More striking differences between the countries may not be in the models of physician–patient interactions, but in the relative weight each country accords to the interests of the whole society versus the interests of the individual. It appears that the two countries differ with regard to their views of the link between the interest of the individual and the larger collective interests. In France, more certainly than in the United States, if the best interests of both the individual and the society are seen to be conflicting, it will often be the case that respect for the collective values trumps the preferences of a single individual.

Three additional observations support the hypothesis that the major difference between France and the United States in matters of clinical ethics are more accurately found in the political views of both countries rather than the specific interactions between doctors and patients:

1. In clinical ethics in France, as often as in the United States, the debate centers around the question of the right balance between beneficence and autonomy when the physician believes the patient's wishes are not in his or her best interest. However, in France, a third factor is raised for consideration—the question of the consequences for society of a single medical decision. This has been a critical factor in almost all of our requests for consultation. An example is the cases we examined pertaining to access to reproductive technologies. In the United States there is more likely to be a *prima facie* assumption that persons have open access to such technologies on demand. In France this is not the case. Access depends on the decision of a French healthcare team, on a case-by-case basis, after considering the extensive framework involved, as well as the best interests of the couple, the potential child, and the whole society.
2. The success so far of the first clinical ethics experiment in France at the Cochin Hospital suggests that, more than as a supplementary tool for physicians and patients, the consultation service is perceived as a relevant answer to a larger move toward more patient representation in decision-making and more collegial reflection on the ethical dimensions of medicine. It demonstrates the strength of the social dimensions of the project beyond its practical interest for individuals.
3. The difficulties encountered surrounding the passage of the patient's rights law illustrates the power of politics in the daily social life of France. Since Parliament adopted the law in 2002, the Government has moved from the left to the right. This major political change reactivated the

controversies and postponed any concrete application of the law. Thus, the political shift illustrates that the real debate in France as to the correct balance between beneficence and respect for autonomy in the doctor-patient relationship has to be understood, not on a strictly medical level, but from the political and paternalistic model of the society.

In summary, collective values have, and will continue to have, a different weight in France than in the United States. These values are so deeply etched in the French character that it is doubtful that patients in France will ever demand, or even wish to have, the same degree of control and autonomy American patients expect. However, there is reason to believe that there is movement in both societies away from extreme positions and closer to a more "golden mean" in which America turns toward a greater appreciation for a collective way of life and France sees that democracy progresses through empowering individuals.