Helplessness and power in health care
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Doctors, by virtue of their knowledge, are often in a position to exercise power over their patients. The authors, considering that some doctors seek to abuse this power, reflect on the nature and ethics of medical treatment.

It is so obvious that most people do not notice it: hospitals and other health facilities are commonly painted white. Maybe this is a mask to hide death, the blackest aspect of existence, and its ever-present, dreaded precursors such as old age, madness and pain. The white façade is perhaps a symbol of our impotence in the face of tragic events.

Everybody dies
Nothing within the scope of medical science can triumph over death. Death is more or less accepted by all humanity. Even the person with no time for intellectual disciplines cannot but be interested in the subject. It has been said that if there were no death we would have no interest in life. It is certainly true that there can be no life without death and no death without life. In this sense we are all patients waiting for the inevitable.

Therapeutic knowledge is concerned with death in a general sense and, more specifically, in relation to curing, or failing to cure, disease. The word “therapeutics” comes from a Greek word meaning “helpful, looking after something or someone”, and is associated in particular with the relationship between patients and the persons looking after them during illness.

In the final analysis the therapeutic act is doomed to failure, just as, in Greek mythology, Sisyphus’s attempts to roll a heavy stone to the top of a hill never succeeded: whenever he approached the top it escaped his grasp and rolled back to the bottom. The struggle against disease and death has a predetermined outcome. Socrates said “When I was born, Nature passed a death sentence on me”, yet it should be remembered that we are all part of Nature.

Power
The word “patient” derives from the Latin patients, meaning “one who endures affliction”. In the sense that the affliction of death hangs over us all we are patients throughout our lives. Patients have to hope that those with the power of technological and scientific knowledge will be able and willing to meet their needs. They
have to be patient with themselves and with illnesses, pains and problems which cannot be cured with the waving of a magic wand.

Health, or the lack of it, can be a lever for exercising power. Illness presents the social system with suffering individuals who must abide by institutional requirements, since this is the only option they have for recovery. A kind of ideological manipulation is in play, reflected in every health establishment.

Tolstoy’s Ivan Ilych decides to stop trying to bear the pain to which his doctors are subjecting him “and turns his face to the wall”. Not only has he lost interest in controlling his cries of pain, he has lost interest in living. He tells his wife to go to the devil with her admonitions to continue with his treatment. Thus, in a way, power passes from the doctors to the patient, since he makes the decision as to what should happen to him.

An example from real life of the denial of medical power was provided by Fr. de Dainville, a Jesuit priest suffering from leukaemia. Being perfectly aware of his condition and sensing that death was near, he was cooperating bravely, lucidly and calmly with the staff of the hospital to which he had been taken. He agreed with the consultant that in view of his desperate state there should be no radical treatment in an attempt to prolong his life. One day, however, seeing that the patient’s condition was deteriorating, a house physician had him transferred to an intensive care unit in another hospital, which proved to be terrifying. He was placed in a sterilized room; he had two tubes in his nose for inhaling and a tube for exhaling which sealed his mouth; an apparatus kept his heart going, a drip was attached to one arm, a transfusion line to the other, and there was an outlet for an artificial kidney in his leg. Suddenly he released his arms with a tug and tore off his breathing mask, saying, just before slipping into his final coma, “They are cheating me of my death” (1).

Let us consider the experience of one of the present authors as a patient. At the age of 47 he contracted craniopharyngioma, a very serious disease. When he was taken into hospital he felt despair, rather as he had done on being detained by his country’s security service; he did not know when or how he would get out. This uncertainty about the future was brutally painful. No one could explain in simple terms what would happen to him in the operating theatre, and he was unable to find out, even from an expert, what the risks were of the surgery he was to undergo. Everything was left to the imagination of himself and his partner, the co-author of this article. In a nightmare of contradictions he saw a dark future and she told him she saw a bright one, although she secretly believed it to be black.

This is our first criticism about the way patients are treated: there is a lack of information for them, not only indicating contempt for their intellectual capacity but also, significantly, enabling doctors to keep for themselves what it has cost them so much to achieve, a position of importance in the dialectic of life and death.
tance in the dialectic of life and death. Knowledge, it seems, is not counted as something to be shared, but a costly asset to be kept hidden from the gaze of the uninitiated. Doctors certify our births at a given date and time, preserve us from death for as long as possible, and eventually issue death certificates in our names. The legitimizers of life, they are with us from its beginning to its end.

**Dependence**

Doctors tend to adopt a defensive attitude in coping with the anxiety produced by working against death. This easily develops into an attitude of omnipotence, of magical power over disease and life, and to a breakdown in communication with colleagues and patients. The excessive degree of dependence thus generated in patients is exacerbated by the weakness caused by disease. Patients are implicitly required to behave themselves, in other words to be totally dependent.

However, as dependence grows so do patients’ needs and the misunderstandings that result in frustration for both patients and health professionals. Therapists feel that their efforts are not appreciated by patients, and this is associated with feelings of persecution. Patients commonly suspect that their needs are not being given due attention by the people to whom they have completely surrendered themselves.

**Pain**

Our second criticism concerns the management of pain. When one arrives on the therapeutic scene one gets the impression, however unfairly, that pain is a tool that carers have for achieving their aims. It is as if the value of treatment is considered to increase with the degree of physical suffering associated with it. Historically, pain supposedly had a therapeutic function: after all, one way of curing infections and preventing gangrene was to apply a red-hot iron. Less harshly, perhaps, yet probably indicative of a similar mindset, it has often been considered that a medicine with an unpleasant taste is likely to be particularly effective. Such baggage from the past could surely be discarded if a little imagination and more respect for patients were brought into the picture.

Until the beginning of the 19th century, pain was seen as unavoidable. Doctors did not feel compelled to try and alleviate it,

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and patients tried to bear it as bravely as possible. Later in the same century the manifestation of pain came to be regarded as something indecent that should be kept private, because of the undesirable evidence it gave of the presence of disease.

The sensation of pain, of physical injury, is probably the most difficult to express in words. It is internalized partly as an interplay of love and hatred for the carers: on the one hand there is love, often not so much present love as imagined love in the future, and on the other hand there is hatred, which cannot be expressed. The patient sees any public demonstration of this hatred as extremely dangerous because it might lead to reprisals or abandonment. So the patient tries to complain as little as possible.
The protestations of some hospital doctors about the complaints they receive from inpatients suggest a complete failure to realize how much emotion people bottle up inside themselves. The doctors turn to psychiatrists or psychologists with a view to calming the patients down and making them less of a nuisance. In theory it is possible for inpatients to change their doctor, but they know, or at least vaguely feel, that this would be regarded unfavourably by the other doctors in the hospital and could consequently be counter-productive. In urban settings it is different for outpatients, who, if they do not like the way a doctor is treating them, can change to a different one without fear of repercussions.

There is sometimes an element of sadism in the way pain is used and abused by health professionals. It is often said in jest that a butcher is a frustrated surgeon, and there might be a modicum of truth in this. In any case, surgeons have the opportunity to manifest sadistic tendencies quite legitimately every day. Pain can be used to punish and reward patients and it helps in the establishment of implicit rules about who holds power in the relationship between the cared-for and the carer.

What about ethics? The Greek origin of the word refers to the morals, character and behaviour of people. Curiously, the Spanish word ético, as well as meaning "ethics", also means "consumptive" or "wasted", although this derives from a different root. Allowing ourselves a little play on words, we could say that today, more than ever before, the concept of ethics is represented by the second meaning.

Reference