Gratitude and Coercion Between Physicians and Patients

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Sometimes, patients are grateful for care that they received only because they were coerced. One of us (WG) recently attended the wedding of a young female physician who had suffered from severe depression and substance abuse. One of the guests, a psychiatrist, had hospitalized her several years ago, telling her, in effect, "You sign or I'll sign." When the psychiatrist greeted her after the ceremony, the bride hugged her and said, "Thank you for saving my life."

Taking this point further, Stone[1] has argued that involuntary commitment can be justified even for patients who resist treatment if they thank the physician later, after their suffering has been relieved. To thank the physician has two possible meanings in this context, and it is not certain which Stone intended. On the one hand, he may have meant that patients may retrospectively understand that they needed hospital care at the time of their commitment. On the other hand, he may have been referring to whether committed patients feel the sentiment of gratitude for that care.

It may be difficult to always generalize from the case of psychiatric commitment to other coercive medical practices. However, clearly the care of all patients is full of various shades of persuasion and coercion, from discouraging treatment of those who maintain high-risk behaviors to subtle biasing of informed consent. Psychiatrists deal more intensely and routinely with these issues, and their experience, in particular empirical study of the "thank you" thesis in psychiatric commitment, offers insights and directions for further research into the problems of coercion in medicine more generally.

In a recent study,[2] we gathered evidence that persuades us that few committed patients are retrospectively grateful for their care, even in those cases where they understand that they had needed care. Most psychiatric patients who are committed to inpatient care are unhappy about the experience, and they remain so even when, in retrospect, they believe that the hospitalization was necessary. In this article, we examine the ethical literature on the sentiment of gratitude and consider whether physicians should expect patients to be grateful for coerced care.

THE EMOTIONS IN PHYSICIAN–PATIENT RELATIONSHIPS

The healing and prevention of illness require good communication and collaborative effort by patients and physicians. These processes flourish in the context of good relationships between physicians and patients.[3] But what is a good physician–patient relationship?

Professional ethical codes and commentaries focus primarily on rights such as adequate information, confidentiality, and continuity of health care. They also prescribe certain attitudes and

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dispositions to physicians, such as courtesy, respect, and responsiveness. The public's expectations of physicians are harder to identify.[4] We can take some guidance, however, from the familiar stereotyped characters of popular movies and fiction: the imperious surgeon; the warm, empathetic primary care physician; and the confused and/or manipulative psychiatrist. The persistence and pervasiveness of these images suggests that patients may be focused less on rights than on the sentiments and personal attitudes that physicians bring to the relationship. Indeed, research on coercion suggests that patients' assessments of whether an admission decision was coercive are strongly related to such issues as their perceptions of physicians' motives and whether they felt listened to and respected during the decision-making process.[5,6]

Physicians' expectations of patients receive less discussion. Clearly, physicians want patients to adhere to prescribed courses of treatment and to take responsibility for their health. The sentiments and attitudes that patients display in their interactions with physicians presumably play an important role in the physician–patient relationship, or so we judge from the complaints of physicians about encounters with demanding and/or ungrateful patients. The expectation that patients will be grateful—or at least not ungrateful—is natural. Physicians perform services for patients that are among the most important and intimate that patients receive. At first glance, the expected response for interventions that relieve suffering or save lives would be gratitude. This article considers the role of patient gratitude in the most strained and difficult aspect of the relationship between psychiatrists and patients—involuntary hospitalization.

THE MORAL PHILOSOPHY OF GRATITUDE

Are there good reasons for an a priori expectation of gratitude? Contemporary moral philosophers have engaged in a detailed analysis of the nature of gratitude, and of the circumstances in which individuals owe gratitude to their benefactors. When we apply this analysis to the coerced psychiatric patient, it seems to us that the situation is not one that leads to an expectation of deep gratitude, even if the patient is well treated. We think that feelings of gratitude are rarely inappropriate. However, the question is, when do individuals have a duty to be grateful? We analyzed the work of several philosophers, including Berger, Card, Fitzgerald, and McConnell,[7-10] in an attempt to answer this question.

Gratitude is a response to someone who has benefited you. Gratitude, at least in the sense considered here, is part of a personal relationship.

The beneficiary must want the benefit, or at least accept it, before he or she would be expected to show gratitude. McConnell goes a step further and states that there is no obligation to gratitude when a benefit is "forced (unjustifiably) on the beneficiary against his will."[10] (It is not clear whether McConnell thinks that individuals ought to be grateful if they believe, in retrospect, that the force was justified.) He believes there should be no argument over this point, but we disagree, especially because a benefit that is forced on the beneficiary infringes his or her autonomy. Thus, the benefactor benefits and injures the beneficiary in the same act, and the beneficiary is not obligated to be grateful for an act that injures him or her.

There are exceptions to the rule that individuals are not grateful for what they do not want. Clearly, individuals often express gratitude to those who give them things that they do not particularly want, and not simply as a matter of courtesy. Individuals may be grateful to others because they recognize that they intended to benefit them, but this exception itself points to another condition.

Obligations of gratitude are created only when a benefactor causes a benefit with an appropriate attitude. The benefactor must specifically intend to produce a benefit for the beneficiary. Deliberate actions by the benefactor may not produce a duty to be grateful if he or she did not intend to benefit the beneficiary. Even if the benefactor's actions cause benefit for the beneficiary, and that effect was intentional, the beneficiary would not necessarily feel inclined to express gratitude toward the benefactor if his or her actions were motivated by self-interest.

Gratitude is required when the benefit requires some sacrifice or concession on the part of the benefactor. If it costs the benefactor absolutely nothing to benefit the beneficiary, it would be

perverse for him or her not to. The beneficiary may express gratitude as a matter of courtesy, but an effusive expression of gratitude would seem odd, even to the benefactor.

According to these philosophers, then, the occasions when an individual has a duty to be grateful are fewer than might have been imagined. Not surprisingly, there are dissenting voices in this literature. Fitzgerald regrets that, "Philosophers generally agree that we ought to be grateful only when a very restrictive set of conditions is met."[7] He notes that this may explain why contemporary philosophers believe that gratitude plays a relatively small role in the moral lives of individuals. However, one might also argue that what the analysis really does is pick out a special form of gratitude—call it deep gratitude—that is unambiguously sincere and authentic and that cannot be mistaken for courtesy or ingratiation. Tepid statements of gratitude for unwanted or unnecessary help are part of every individual's routine experience of daily life. Deep gratitude is a warm sense of appreciation for someone or something, a sense of goodwill toward that person or thing, and a disposition to act that flows from appreciation and goodwill.[7] Deep gratitude may be essential to the sustaining of important, long-term relationships. Berger argues that

> the following are accomplished by sincere, adequate, expressions of gratitude: (a) the recipient shows he recognizes . . . that it was an act benefiting him and done in order to benefit him; (b) the recipient shows that he does not regard the actor as having value only as an instrument of his own welfare; and (c) a relationship of moral community is established, maintained, or recognized, consisting of mutual respect and regard.[8]

COERCION AND GRATITUDE IN PSYCHIATRY

Psychiatry is the only helping profession in which compulsory treatment is a routine part of care. As such, it is in a unique position to inform debate around the ethical meanings and role of gratitude and coercion in physician–patient encounters.

In a recent study as part of the MacArthur Network on Mental Health and the Law,[2] we examined how psychiatric patients view their need for hospitalization. Patients (N = 433) were interviewed about their hospitalization within 2 days of their admission to a psychiatric hospital. We were able to reinterview 270 of them between 4 and 8 weeks following discharge.

During the admission interview, patients were asked, "Do you believe that you need to be in a hospital?" Most patients said that they did need to be hospitalized, but 63 patients said that they did not. When reinterviewed at follow-up, 52% of the patients who had initially said that they did not need hospitalization reported that, in retrospect, they believed that they had needed it. Some of those patients who initially said that they did not need to be hospitalized nevertheless were voluntarily admitted to the hospital. In contrast, only 5% of 198 patients who said at admission that they did need hospitalization shifted to saying that they did not need it. Moreover, those patients who believed that they did not need hospitalization and were committed to the hospital were less likely to change their views than were those patients who had entered voluntarily.

In summary, most patients who initially believed that they did not need treatment changed their *cognitive* appreciation of the need for hospitalization. This change did not appear simply to be random variation because opinions seemed to change almost exclusively in one direction—that of accepting the admission as necessary.

Patients did not, however, change how they *felt* about the experience. At admission and follow-up, we interviewed patients using the MacArthur Perceived Coercion Scale. These questions focus on influence ("What had more influence on your being admitted: what you wanted or what others wanted?"); control ("How much control did you have . . . ?"); choice ("You chose" or "someone made you?"); and freedom ("How free did you feel to do what you wanted . . . ?"). There were no significant changes in perceptions of coercion from admission to follow-up.

We also asked patients about their perceptions of the procedural justice administered to them during their admission.[6] These questions focused on validation ("How seriously did people consider what you had to say?"); process satisfaction

("How satisfied were you with how people treated you when you were coming into the hospital?"); fairness ("How fair was the process of coming into the hospital?"); and voice ("How much chance did you have to say everything you wanted about coming into the hospital?"), motivation ("To what extent did he or she do what he or she did out of concern for you?"), and deception ("Did anyone try to trick you, lie to you, or fool you into coming into the hospital?"). As with perceived coercion, perceptions of procedural justice did not change from admission to follow-up.

Finally, there were almost no changes in the affective attitude of patients toward hospitalization. We asked them to endorse or not endorse a series of emotions concerning their admission. The modal patient was both relieved and sad at the time of hospitalization. Many of the patients were fearful, and some—particularly the coerced patients—were angry. Patients' endorsements of these emotions were almost identical at admission and follow-up.

We did not directly ask patients whether they were grateful for their treatment because this was not a direct goal of the project. However, we believe that if patients had experienced an affective shift to gratitude for hospitalization parallel to the cognitive shift to understanding the need for hospitalization, then we would have seen a shift to more positive statements about the hospitalization. It is our belief, then, that hospitalized psychiatric patients experience a change in their understanding of the need for hospitalization, but that they are often not grateful for hospitalization.

We recognize, however, that many psychiatrists may have firsthand experience of committed or coerced patients who are later grateful, as in the case of the woman described at the beginning of this article. Receiving sincere expressions of gratitude can be a powerful experience, and may lead the psychiatrist to a presumption of gratitude on the part of many committed patients. If we are correct, however, these patients must be relatively rare in relation to the number of patients who are committed.

Some might be tempted to attribute the absence of gratitude to the prevalence of a character disorder among hospitalized patients. Regardless of what role such disorders may play, we believe that there are other explanations. For the coerced patient, any positive sentiment toward the physician may have been overwhelmed by negative feelings associated with having one's will overridden. Similarly, positive feelings may have been blocked by memories of real or perceived disrespect or procedural injustice during the admission: the devaluing of self, the lack of voice in one's fate, dissatisfaction with the way in which the treatment decision was made, or the unfairness of the commitment proceedings. Our interview did not provide us with the kinds of data that could tell us whether these explanations account for the absence of gratitude.

SHOULD PATIENTS BE GRATEFUL FOR COERCIVE CARE?

We believe that the philosophical analysis of gratitude helps explain these findings. In summary, we found that patients who perceived themselves as coerced did not experience a change in their sentiments about hospital treatment, although they did change their beliefs, retrospectively, about their need for hospitalization. The philosophical analysis, for example, suggests a patient may be unlikely to feel grateful when the psychiatrist is perceived to be "just doing his or her job." That is, the patient may view hospitalization as a benefit and recognize that the psychiatrist specifically intended to benefit him or her. However, if the patient believes that the psychiatrist is really just earning a salary, advancing his or her career, satisfying the family, or getting through the day, then he or she may see little need to express gratitude. Berger notes that "contractual relationships are usually thought to be means for advancing the interests of both parties and hence not to be cases of benefits granted in order to help another, and gratitude would be out of place."[8] There is a great ambiguity in physician–patient relationships: are they personal caring relationships, or business relationships? To the degree that physicians become workers who are processing patients, and the time spent per patient decreases, one would expect expressions of gratitude to become increasingly rare.

However, even professional relationships can

provide occasions for sincere expressions of gratitude. Gratitude is likely expressed regularly to surgical and medical specialists and to primary care physicians for what we perceive to be exemplary professionalism in the care they give us. We expect that committed patients rarely feel this. Indeed, to the degree that commitment is based on the need to protect others from harm, patients may feel, with some justification, that their desires have been overridden.

In our view, however, the most likely reason why patients do not feel gratitude is that their cognitive appreciation of the benefits of treatment is paired with the feeling that they have been injured by the denial of autonomy. Berger notes that deep gratitude supports a relationship of moral community between the benefactor and the beneficiary. It may be impossible to feel gratitude toward another for a benefit received when the giving of the benefit occurs in a relationship that lacks moral community. Moral community among peers may require respect for the autonomy of one another. Thus, the process or perception of coercion may be incompatible with gratitude because coercion undermines moral community.

According to our data, patients who perceived themselves as coerced also perceived that the admission process lacked procedural justice. We were unable to determine why they felt that the process was unjust—had they been treated in a way that deprived them of dignity, or are the life circumstances that require commitment just inescapably humiliating? Either way, it seems likely that commitment is inherently demeaning, because the caregiver must believe that the patient cannot order his or her affairs. Thus, the caregiver, however benevolent, must demean the patient and, in this way, invalidate a condition for the patient to feel grateful.

CONCLUSION

Neither our research nor the philosophical analysis of gratitude directly suggest what we should do about commitment procedures. The "thank you" thesis is not the only, or even the primary, justification for involuntary commitment. It is equally plausible that moral community and justice approaches need to be revisited and that the dangerousness model or some other justification may better support the practice of involuntary treatment.

So what is the value of the ethical analysis of sentiments such as gratitude? In our view, it helps us to closely examine the emotional structure and dynamics of the physician–patient relationship. Greater awareness of what patients feel, and why they feel it, may help us to find ways to negotiate difficult processes such as commitment so as to minimize the insult to patients' feelings of autonomy and dignity. Much might be gained if patients who came to retrospectively appreciate their need for treatment also felt grateful toward the physicians who had provided it. These sentiments would likely be a better foundation for a continuing therapeutic relationship than feelings of injured autonomy and mistrust.

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