Medical Paternalism vs Patient Autonomy

Nathan Alexander, BSRS, R.T.(R)
Kenya Haugen, DM, R.T.(R), FAEIRS

Patient-provider relationships in medicine have been changing constantly since medical treatment began and have been embodied by paternalism for decades.[1] Historically, medical paternalism was expected in practice; however, today the paternalistic model has shifted to a balanced, shared decision-making model between the health care professional and patient. Patient autonomy is encouraged to ensure patients are well informed about their conditions and possible treatment options; however, an imbalance between paternalism and patient autonomy can still exist in the current health care environment whereby the patient takes a passive role as opposed to an active role in their care.[1] Medical paternalism happens when medical decisions are made for patients without explicit consent. Conversely, patient autonomy occurs when a patient who has decision-making capacity makes decisions regarding their care, even if the decision contradicts the clinician's guidance.[1] Patients and physicians can have different perspectives on how to respond to a diagnosis or to treatment options. Medical paternalism is occasionally necessary, such as when routine blood tests are prescribed without patient input, but the approach to decision-making has evolved from a paternalistic model to one that prioritizes greater respect for the patient's autonomy.

In the 18th century, medical paternalism was a necessary component of health care.[2] Patients were uneducated and were viewed as passive recipients of health care. Not until the late 1800s did Sigmund Freud suggest the importance of communication with patients, thus proposing a new, alternative model to the traditional paternalistic patient-provider relationship model.[3] According to Freud, patients should be active participants in their medical decisions. Freud's ideas sparked an ongoing search for an optimum patient-provider model that best serves patients while allowing them to be active decision-makers in their care.[2,4]

Beginning in the 1970s, there was a marked shift in the patient-provider relationship, acknowledging the importance of patient autonomy in decision-making.[5] Although paternalism has been investigated and theorized for hundreds of years, new insight into its ethical implications within the patient-provider relationship now is being explored. Medical ethicists and researchers have long theorized about what the relationship should look like, including the 3 basic models of paternalism, shared decision-making, and patient autonomy.[1,4,5]

Methods

Databases searched for this review included PubMed and Google Scholar. The authors sought to develop an exhaustive review of patient-provider relationship models and their ethical justifications, and medical paternalism and its effects on patient autonomy. Articles were limited to peer-reviewed studies published between 2010 and 2022; however, exceptions were made for seminal research or analysis. Searches included these key words and phrases: *medical paternalism, patient autonomy, patient autonomy preferences,*

disclosure of diagnosis, patient-provider relationship, physician-provider relationship, and *medical paternalism and imaging.* Studies were selected based on their contribution to supporting an existing patient-provider relationship model or development of a new model. A total of 19 articles were selected for review.

Results and Discussion

Traditionally, paternalism has been the standard in medicine, with physicians acting on behalf of the patient with minimal input from the patient. In this traditional model, the physician decides what to tell the patient about the diagnosis, which treatment plans to present, and which treatment plans are preferable for the patient.[1,5] Historically, the medical profession has had a prevalence of paternalism in the decision-making process, but this model of the patient-provider relationship has been criticized due to its tendency to devalue patients' autonomy in their health care choices.[1] However, a patient-provider relationship that exists without paternalism completely is not a reasonable expectation. A surgeon who proceeds with a surgical procedure without consulting the patient regarding the choice of surgical techniques or a physician who recommends a specific imaging examination for a patient after an injury without seeking their input is acceptable. Although the patient is not completely autonomous in deciding how their surgery will progress or which imaging examination they will receive, these paternalistic actions are innocuous.

Controversy about paternalism in the patient-provider relationship does not include matters, such as choice of surgical techniques or specific imaging methods, but rather physicians not being forthright in their conversations with patients about their treatment options, diagnoses, and other aspects of their health care. Many studies have investigated the moral permissibility of paternalism in medicine.[1,5-7] Clinicians and nonclinicians disapprove of paternalism; however, a clinician is more likely to deem paternalism in health care as acceptable because they hold the position of authority and the ability to share decisions.[1]

There are scenarios in which a decision on treatment involves broader contexts such as legal and public policy matters.[8] The physician might be aware of population data that reveal the percentage of patients in a similar clinical situation who consented or refused the proposed treatment, which might influence the options presented to the patient, and patients who are unaware of population data cannot factor that information into their decision-making process.[8] Most patients value a collaborative relationship in which they are informed thoroughly and work together with health care professionals to decide on the best treatment plan.[1,6-9] However, studies have been conducted that support a need for the paternalistic, antipaternalistic, and shared decision-making models of the patient-provider relationship.[6-10]

Paternalistic Model

In the traditional, paternalistic model, the control of patient care is in the purview of the health care professional rather than the patient.[1,6-10] In this model, the health care professional commonly makes decisions for the patient, withholds information about the diagnosis and treatment options, or encourages a patient toward a certain choice by making it seem preferable to alternative treatments. The most common argument for the traditional paternalistic model is that health care professionals have superior knowledge to their patients about medicine and are in the best position to make decisions about their patients' health care. Proponents of this model argue that the decision-making process for health care decisions should be objective.[11] A patient might be incapable of making objective decisions about their care because of a lack of knowledge or understanding when compared with the health care professional. Therefore, according to proponents of the paternalistic beneficence model, the health care professional has an ethical responsibility to ensure the patient receives adequate care when necessary.

Patient-provider relationship models encompassing medical paternalism make 2 assumptions. First, a health care professional making decisions for a patient is morally and ethically permissible. Second, the health care professional knows what is best for the patient. Recent studies demonstrate cases in which a moral basis for paternalism can be argued.[7,8]

One article provided a scenario in which a patient who was diagnosed with recurrent laryngeal carcinoma was presented with the option of a total laryngectomy

without alternative treatment options.[12] The patient subsequently refused the procedure, but the clinician worked with the patient's caregivers to arrange a meeting with a patient who had successfully completed the total laryngectomy procedure.[12] The physician's actions might be perceived as overstepping the patient's autonomy by persistently presenting a particular treatment option, known in practice as *nudging*, and emphasizing the importance of meeting with a previous patient. The patient decided to have the surgery after meeting with the previous patient.

When engaging with patients who are making decisions about their medical care, health care professionals possess a comprehensive understanding of the entire scope of a procedure, including the recovery process, and have gained insight from the experiences of previous patients. In an older study specific to imaging, Kovacs et al investigated the correlation between radiographic vertebral endplate changes and lower back pain.[13] The study found no correlation between the 2 variables, and vertebral endplate changes are more likely to signify the absence of lower back pain.[13] At the time, despite the increasing awareness that radiographic vertebral endplate changes hold no clinical significance, numerous surgical societies persisted in recommending spinal surgery based on these findings.[13] In the study, the omission of this finding in radiology reports or the failure to clarify its lack of clinical relevance had been suggested as a potential strategy to safeguard patients from receiving unnecessarily aggressive treatment.[13] The act of withholding this information from the radiologist's report, and consequently from the patient, can be considered paternalistic. An autonomous patient would need to be aware of all anatomic findings in their imaging studies, yet in this case, doing so could put the patient at risk for aggressive and potentially unnecessary surgery. The moral justification for excluding this finding from the report, thereby preventing the patient from being recommended an unnecessary and aggressive form of treatment, can be grounded in the principle of do no harm, as stated in the Hippocratic oath. In both cases, by using the traditional, paternalistic model of the patient-provider relationship, physicians undermined their patients' autonomy to provide the best possible treatment.

In a different study, Bain et al investigated the process of testing mothers for HIV in sub-Saharan African countries.[14] An opt-in approach, in which mothers were counseled about HIV and HIV testing and then could choose whether to receive the test, had become an opt-out approach.[14] In the opt-out approach, mothers were informed that the test would be included in the standard group of prenatal tests and that they could decline the test if requested. Researchers argued that many mothers take the HIV test under some degree of coercion, whether implied or involuntary.[14] Many of the clients were unaware that the test was voluntary and that they could decline it if they wished.[14] If the mother's HIV status is known, transmissibility to the fetus can be decreased to less than 2%, compared with 75% if the mother's status is unknown.[14] The opt-out approach increased the prevalence of HIV testing by 17% compared with the opt-in approach.[14] This situation in sub-Saharan Africa highlights an interesting dilemma between informed consent and beneficence. Although the HIV testing policy precludes the possibility of truly informed consent from the mothers, it decreases the likelihood that previously undiagnosed HIV could be transmitted to the fetus. The researchers indicated that the approach was acceptable morally to protect the interests of public health.[14]

The studies by Kovacs et al and Bain et al supported a moral basis for a paternalistic model for the patient-provider relationship.[13,14] In both studies, the ethical justification for paternalism stems from the implausibility of informed consent. Bain stated that some scholars consider the requirements for obtaining informed consent unrealistic.[14] If patients were informed fully about the implications of radiographic vertebral endplate changes, there arguably would be no moral dilemma for radiologists in including these findings in their report because the patient would decide for themselves the importance of the radiologist's findings. If mothers in sub-Saharan Africa were informed fully about the risks, transmissibility, and treatment of HIV, there might not be a need for a paternalistic approach to providing HIV testing because most mothers might decide to be tested on their own.

For health care professionals, the notion of advocating for what is morally right and beneficial for patients is inherent to the practice of medicine, as is the

recognition that patients might make choices occasionally that are not aligned with their best interests or their values. The key lies in determining how health care professionals can ethically influence these decisions by striking a balance between promoting beneficence and respecting patient autonomy.[10] One approach that addresses this delicate balance is the implementation of the shared decision-making model.

Shared Decision-Making Models

Several other models of the patient-provider relationship aim to do what is best for the patient as well as respect the patient's autonomy.[12,15,16] Some scholars argue for a technical model, in which the health care professional is there to provide medical expertise to the patient.[1] This model requires that the physician disclose all information to the patient about their health. For example, the physician diagnoses the disease or injury, explains the possible treatment options to the patient along with the risks and benefits of each, and discusses the probability of a favorable outcome with each treatment and the popularity of decisions among patients with similar pathologies.[1] The patient is free to decide what to do without discussion regarding the patient's life, values, or future health goals. Many critics of this model see this as an extreme reaction to the paternalistic model.[1] A reasonable expectation is that patients would want some sort of discourse with their physician about their life goals and how to best achieve them.

Amiddi Naeini et al conducted a study in which they interviewed psychiatrists to identify common themes in their decisions about how to disclose information to their patients.[17] Findings showed that psychiatrists often act paternalistically when disclosing information about their patients' diagnoses. One psychiatrist said, "First, I need to see if it helps the patient to know the diagnosis. If the disclosure of the diagnosis is good for him, I will disclose the name of the disease."[17] This is an instance of paternalism in which patients are not informed about the nature of their health care because they are not told the name of the disease unless the health care professional decides it is appropriate. The researchers stated that doing so creates the image that psychiatric patients lack the ability to manage their disease-related knowledge.[17] Paternalism in this case is unethical and calls for psychiatry to take a step closer to the technical model in terms of patient-provider relationships.[17] Participants in this study (psychiatrists) should move toward the technical model in their patient-provider relationships and disclose the name of the disease when speaking with patients about their diagnosis and treatment plans.

Another model of the patient-provider relationship is the shared decision-making model, in which the health care professional helps the patient identify their values and health goals and explores which treatment options fit best.[15,16,18] This model incorporates the concept of beneficence in trust, meaning that beneficence should guide the health care professional's discussion with the patient, with the patient's autonomy as a necessary constraint.[15,16,18] In this model, the relationship should feature discussions about the patient's disease and treatment options without attempts at persuasion by the health care professional. Controversy arises when these discussions turn paternalistic because the patient is ill-informed and places their trust in the health care professional.[8]

A study by Berlin investigated the ethical implications of informed consent before an imaging study involving ionizing radiation.[15] According to the study, informed consent is required for an imaging procedure that likely will expose the patient to increased risks or potential complications, but an issue arises in regard to computed tomography (CT) studies because the data are inconclusive as to whether CT scans and other imaging studies predispose a person to cancer.[15] Berlin stated there is no consensus in the radiology community as to whether informed consent should be obtained before studies such as CT.[15] By mentioning the possibility of developing cancer from a CT scan, albeit remote or nonexistent, health care professionals might scare patients from obtaining medically necessary imaging studies for fear of something that is inconclusive.[15] However, a study by Busey et al found that 90% of the patients surveyed indicated that they wished to be informed of potential increased risk of cancer before proceeding with the CT scan.[16] For this reason, Berlin called for informed decision-making in which the decision to proceed with the imaging study involving ionizing radiation is an inclusive process between the autonomous patient and the health care professional.[15]

The professional must take part in an honest discussion with the patient about the risks of malignancy, the lack of conclusive data, and the potential benefits of the procedure.[16] Although the patient cannot be informed of the risks of these imaging studies because the data are inconclusive, a shared decision-making model could help the patient make a decision that is best for them.

Regardless of their expertise and proficiency, health care professionals must recognize the importance of viewing the patient as a unique individual and understanding their personal values and life aspirations. By considering the patient's specific existential context, health care professionals can offer the most appropriate medical treatment.[18] The professional is meant to provide expertise, consult, and advise, but the patient makes the final decision.

Although health care professionals have an important role in the shared decision-making process, a certain level of paternalism can still be observed in these models. Although not as popular in practice or among health care professionals, some medical ethicists argue that paternalism to any degree in the patient-provider relationship is unethical, and patients should have complete autonomy in health care decisions, especially those involving prescription medications.[11] Moral philosopher Jessica Flanigan makes the argument that "people are generally sufficiently capable of judging what treatments are in their interest, and they have a presumptive advantage over other potential decision-makers," therefore, health care professionals should concur with patients' decisions about what treatment they will receive.[11] This has enormous implications for health care, specifically in pharmaceutical autonomy. Flanigan argued that a patient is best suited to know how a medication will affect their overall well-being, and so must be allowed to self-medicate or choose which medications to receive as a form of treatment, regardless of potential adverse effects or inefficacy.[11] This model, a clear form of antipaternalism, implies that patient autonomy is paramount in the health care setting.[11]

Although this model prioritizes patient autonomy, there is a possibility that it might not be implemented effectively in practice, despite its strong commitment to respecting patient autonomy. Unfettered access to pharmaceuticals could cause more harm than good when people can use powerful narcotics for a minor headache. From an ethical standpoint, a patient has the right to abuse a drug or die from drug use so long as they are exercising autonomy.[11] This conclusion is dangerous and does not need to be implemented with a balanced, shared decision-making model between patient and health care professional. In the case of self-medication, a discussion between the health care professional and the patient about the medications applicable to the illness, the risks and benefits of each medication, and the popular choice among patients in similar situations would produce better results than would unregulated access to all medications.

Conclusion

All models discussed consider what is best for the patient but feature varying degrees of medical paternalism and respect for patient autonomy. When a patient seeks medical care, they have the right to be an active member in the decision-making process regarding effective and safe treatment; however, patients lack the knowledge and expertise of health care professionals and are seeking the best, fastest way to be treated from a trusted health care professional. Preserving patient autonomy does not have to contradict the pursuit of what is best for the patient if health care professionals invest sufficient time and effort in thoroughly educating their patients.

Nathan Alexander, BSRS, R.T.(R), is a cardiovascular invasive specialist for WakeMed Health and Hospitals in Raleigh, North Carolina.

Kenya Haugen, DM, R.T.(R), FAEIRS, is associate professor of radiologic sciences for the University of North Carolina at Chapel Hill.

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