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Physician Autonomy, Paternalism, and Professionalism: Finding Our Voice Amid Conflicting Duties

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The American Board of Internal Medicine and other leading medical organizations recently articulated "A Physician Charter" based on 3 principles: (1) the primacy of patient welfare; (2) patient autonomy; and (3) social justice.¹ The charter is intended to establish a system of core values for everyone working in the medical profession, and for physicians in particular. These 3 principles function as the proverbial 3-legged stool. Overall, patients will be better served, and physicians will feel more satisfied with their work, if all 3 principles are fully integrated by medical professionals in support of the medical encounter.

The writers of the charter believe it is needed because changes in the health care delivery system and the conditions of medical practice in the industrialized world are tempting physicians to abandon their commitment to the primacy of patient welfare. Physicians are now subject to powerful adverse forces, which may contribute to their loss of voice in the medical encounter.^{2, 3, 4} This paper describes some of these forces, shows how they can undermine the patient-physician relationship, and explores these 3 principles of medical professionalism can help physicians regain their voice.

Challenges to Medical Decision Making

Medical practice is becoming more challenging because its evidence bases and guidelines are in constant evolution. For example, the Centers for Disease Control and Prevention (CDC) has identified 12 risk factors for average adult patient that require more than 24 preventive services.⁵ The CDC has made recommendations concerning which preventive services provide the greatest health benefit for the resources invested. Comparing health benefits across treatments for chronic diseases and preventive services, Woolf argues that we need a national evidence base that will inform policymakers about improvements in the population's health and that will also inform practitioners about health improvements expected for the individual patient.⁶

The practice of medicine is further complicated by new epidemics (eg, SARS, obesity), and new evidence regarding established treatments (eg, hormone replacement therapy) that change the standards of care. Physicians must actively participate in discussions about new epidemics and treatment standards to help patients interpret the distorted media coverage that surrounds them and understand

how the information relates to them. Patients also need physician help in interpreting the direct-to-consumer advertising of costly medications, fad diets, and "health" supplements.

Both physicians and patients are inundated with arbitrary treatment regulations and financial punishments for "out-of-system treatments." Physicians have added pressures from pharmaceutical industry inducements that encourage the use of expensive treatments of marginal efficacy. They are penalized for low productivity, which threatens their willingness to discuss complex patient problems, even those that are most likely to affect the patient's health.² Patterns of physician reimbursement encourage procedure-oriented interventions and minimize counseling, in spite of the greater benefit of brief counseling for patient health.^{5, 6, 7} On their side of the encounter, patients may pay more for maintaining established relationships with out-of-system clinicians and are charged copayments for preventive treatments, which reduces their utilization of these proven, effective services.⁸

Undermining the Patient-Physician Relationship

As a result of all these complex, sometimes contradictory, often covert and self-interested inducements from third parties, physicians often are confronted with resistance when they explain their treatment decisions to patients. The case of antibiotic treatment for viral infections is a prime example. Antibiotics have not been shown to improve medical outcomes for otherwise healthy patients with early symptoms of upper respiratory infections. In fact, patients incur the risk of side effects (allergic reactions, GI disturbance, and cost) without the potential for benefit. From the social justice point of view, prescribing antibiotics for URIs in otherwise healthy people wastes resources and could contribute to resistant bacteria in the population. Yet, patients frequently request, and sometimes demand, these antibiotics and interpret physicians' withholding them as undermining their autonomy. Patients feel further dissatisfied if they have been charged a copayment for the visit without getting what they perceive to be an effective treatment in return.

In cases such as this, the value the patient places on having access to prescribed medication on demand appears to be in conflict with the physician's obligation to put patient welfare first and to consider social justice in allocation of medical resources. An approach that would enhance patient autonomy would require the physician to: (1) elicit the patients' concerns and perceptions about their illnesses and their medications, (2) provide the patient with information about the risk of side effects, and (3) explore and understand differences in his or her perceptions and values and those of the patient.

Unfortunately, pressure on the physician to be productive may limit the extent to which he is willing to have this in-depth discussion, especially when the discussion tends to be filled with conflict and is time-consuming. It is easier to write the prescription in the name of supporting "patient autonomy."

Patient Autonomy—Mistaken and Real

There are important difficulties with this simplistic notion of autonomy defined as the patient's right to make treatment decisions independently. First, without being reasonably informed about benefits and burdens, the patient cannot possibly be autonomous. An autonomous decision is one in which the decision maker has adequate information about his or her options, their probable outcomes, and the risks and benefits associated with each. Hence, a physician who allows a patient to dictate treatment decisions without adequate information has misunderstood autonomy as independence rather than as volition. Allowing the patient to make an uninformed decision in the name of patient autonomy actually violates all 3 elements of professionalism defined above.

How well are physicians doing in offering "informed" consent in the current environment? In a study that examined audiotapes of more than 3500 clinical decisions in 1000 patient-physician encounters, Braddock and colleagues rated how fully informed patients were about the decisions they were making.² They found that only 9 percent of the decisions were fully informed, and none of the intermediate level decisions, such as accepting a prescribed medication, met criteria for being fully informed. Among the researchers' criteria were discussions of the nature of the decision, the patient's preferences, the treatment alternatives and uncertainties, and an assessment of the patient's understanding. Certainly, this method of assessing the informed decision-making process was rigorous, inasmuch as it required meeting all criteria in each category of decision making. However, the data are symptomatic of the difficulties physicians have in supporting the principles articulated in the Charter. Braddock concluded that informed decision making among his group of primary care physicians and surgeons was "often incomplete."⁹

This decision making conflict could be resolved with external controls. For example, with the prescribing of antibiotics, a physician might say, "I would love to prescribe antibiotics for you, but the system will not allow it." This might, however, leave both sides feeling unsatisfied and manipulated. An alternative resolution would entail the physician's engaging the patient in an active discussion of the risks and benefits of the antibiotic, trying to inform the patient rather than simply controlling him or her. Patients who are engaged in active discussions and informed decision making have a chance to understand that their welfare may be mildly threatened rather than improved by inappropriately taking antibiotics. Since personal health and autonomy are basic, shared values, this frank discussion is more likely to result in the patients' internalizing the physician's message and stopping their pursuit of inappropriate prescriptions.

Enhancing Real Patient—and Physician—Autonomy

By avoiding the discussion and prescribing the antibiotic, the physician has undermined all 3 principles of patient welfare, social justice, and patient autonomy. By controlling the patient, and refusing to prescribe the antibiotic without an extensive, mutually informing discussion, the physician has undermined patient autonomy but may have supported patient welfare and social justice. Thus, it is only

by using their knowledge, expertise, and communication skills in a mutually informative process that physicians can support all 3 principles of professional care—including promotion of patient autonomy.

In the 8 years since Quill and Brody published their study on the balance between physician power and patient choice,¹⁰ a considerable amount of empirical work has been done to assess patient autonomy and discover methods of intervening to increase it.¹¹ The effectiveness of an "enhanced autonomy intervention" by practitioners has been demonstrated in a randomized clinical trial of tobacco dependence treatment.¹² The results indicate that patient autonomy is enhanced when practitioners make the effort to:

- elicit patient values,
- acknowledge patient affect,
- provide a clear rationale for cessation and use of medications,
- support patient initiations (ie, to support patient preference for the use of pharmacotherapy),
- and minimize external control.

These efforts more than doubled the 6-month prolonged abstinence from tobacco achieved by patients in community care. Patients in community care were provided self-help materials, contact and cost information on all active smoking cessation programs in the community, and encouraged to meet with their physicians about quitting. Patients in the intervention group were twice as likely to take medications for cessation and to use them for a longer period of time than those in community care. The enhanced autonomy intervention had this effect on abstinence whether the patient initially wanted to quit smoking or not. Patient quality of life, assessed by measurements of depressive symptoms and vitality, was also enhanced in patients who stopped smoking. This study illustrates how an important health outcome is enhanced when medical intervention actively advocates for patient welfare and patient autonomy. Since tobacco companies disproportionately prey upon people of lower socioeconomic status and on those with mental illness, medical intervention also serves social justice.

An Active Voice, Not a Controlling Voice

Most medical encounters involve decisions that are far less clear-cut than the effectiveness of antibiotics in upper respiratory infections and treating patients for tobacco dependence. If physicians have difficulty fully informing patients about treatment options in cases where the evidence of benefits and harms is clear, doing so is likely to be more difficult in complicated circumstances, such as cases where the therapeutic recommendations have not been tested in a randomized controlled trial and are based on physician experience and judgment. Potential conflicts between physician and patient values are more likely to occur.

At the other end of the spectrum, some patients tend to rely too much on physician opinion. Several studies have identified that as many as two-thirds of patients prefer

that the physician make the decisions,¹³ probably because they believe they lack competence. It is easier for the physician to simply make the decision, but this leaves the patient uninformed about treatment options and unable to evaluate the physician's treatment decision and how it may conflict with the best interest of the patient.

All 3 principles of care direct physicians to inform patients about adverse external forces that can influence their recommendations. This includes disclosing anything that the physician would be embarrassed to have the patient discover later (eg, recruitment incentives for enrolling patients in clinical trials, personal profit from tests ordered, or reimbursement incentives from insurers for withholding expensive tests of marginal effectiveness). Respect for patient autonomy requires that physicians provide this information freely and explore its meaning and implications with the patient. Physicians must support patients' seeking second opinions when conflicts of interest exist that could influence the physicians' recommendations or when the patient chooses alternative sources of care and testing. Perhaps, a more time efficient way to address this issue might be to post physician conflict-of-interest statements in waiting rooms and examination rooms.

In the long run, well-informed patients are the most effective force for protecting the primacy of patient welfare, enhancing their autonomy, and avoiding social injustice. These core principles of care imply that physicians need an active voice in the relationship, using their expertise and experience to enhance patient welfare rather than keeping quiet in a misguided effort to protect independent patient decision making. The enhanced autonomy approach has been demonstrated to be more motivational for patients when practitioners maintain a clear active voice that is not controlling. Following an enhanced autonomy model of care will almost certainly result in physicians' voices being heard again in the practice of medicine.

References

1. ABIM Foundation. Medical professionalism in the new millennium: a physician charter. *Ann Intern Med.* 2002;136:243-246.
2. Braddock CH, Edwards KA, Hasenberg NM, Laidley TL, Levinson W. Informed decision making in outpatient practice: time to get back to basics. *JAMA* 1999;282(24):2313-2320.
3. McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Engl J Med* 2003;348(26):2635-2645.
4. Williams GC. Policy forum 2. "You can pay me now, or you can pay me later." *Virtual Mentor.* November 2003. Accessed November 3, 2003.
5. Coffield AB, Maciosek MV, McGinnis M, et al. Priorities among recommended clinical preventive services. *Am J Prevent Med* 2001;21(1):1-9.
6. Woolf SH. The need for perspective in evidence-based medicine. *JAMA* 1999;282(24):2358-2365.

7. Whitlock EP, Orleans CT, Pender N, Allan J. Evaluating primary care behavioral counseling interventions: an evidence-based approach. *Am J Prevent Med* 2002;22(4):267-284.
8. Solanki G, Schauffler HH. Cost-sharing and the utilization of clinical preventive services. *Am J Prevent Med* 1999;17(2):127-133.
9. Braddock CH, Edwards KA, Hasenberg NM, Laidley TL, Levinson W, 2313.
10. Quill TE, Brody H. Physician recommendations and patient autonomy: finding a balance between physician power and patient choice. *Ann Intern Med* 1996;125(9):763-769.
11. Williams GC. Improving patients' health through supporting the autonomy of patients and providers. In: Deci EL, Ryan RM, eds. *Handbook of Self-Determination Research*. Rochester, NY: University of Rochester Press; 2002:233-254.
12. Williams GC, McGregor HA, Sharp D, et al. Testing a self-determination theory intervention for motivating tobacco cessation: supporting autonomy and competence in a clinical trial. Unpublished manuscript, University of Rochester, 2003.
13. Schneider C. *The Practice of Autonomy*. New York, NY: Oxford Press; 1998.

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