

Open Peer Commentary on:

“Empowerment Failure: How Shortcomings in Physician Communication Unwittingly Undermine Patient Autonomy”

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Abstract

While this paper does not explicitly define the concept of autonomy, the way Ubel et al describe clinicians’ failures to enhance their patients’ autonomy reflects a broader understanding of autonomy than the default account as free and informed choice. In this OPC I would demonstrate that the communication strategies the authors recommend reflects a more sophisticated conception of autonomy than the understanding that typically prevails in bioethics. I will also distinguish between weak and strong forms of paternalism, and argue that a weak paternalistic approach is not only defensible but also aligns with the strategies the authors propose. Thus, by clarifying the concept of autonomy we can show how it can be enhanced in practice.

Keywords

Bioethics, clinical ethics, personal autonomy

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Autonomy, information and paternalism in clinical communication

In their paper “Empowerment Failure: How Shortcomings in Physician Communication Unwittingly Undermine Patient Autonomy”, authors Ubel, Scherr and Fagerlin demonstrate that physicians often fail to support patients’ autonomy in their clinical interactions.

Although they do not explicitly define how they understand autonomy, in their discussion of how physicians fail to enhance patients’ autonomy, the authors presuppose a broader, more sophisticated understanding of autonomy than the default conception in medical ethics.

Furthermore, the improvements to physician communication that they recommend can be understood as a weak form of paternalism, which can enhance rather than undermine patients’ autonomy.

This paper initially reflects a common feature of medical ethics, which is to assume a “default account” of autonomy as free, informed choice. In their influential *Principles of Biomedical Ethics*, Beauchamp and Childress (2013) establish three conditions for autonomy: intentionality, understanding, and noncontrol.¹ This prevailing understanding of autonomy is reflected in Ubel et al’s introduction to their paper which illustrates the prevalence of “empowerment failure” in clinical practice. The authors seem to understand autonomy to be a patient’s right to make their own decisions, or to participate in genuinely shared decision-making processes. The features of clinical encounters which fail to empower patients fall into two categories: failures of information provision, and failed attempts to share decision-making with patients in a meaningful way. In other words, clinicians failed to empower patients because they undermined Beauchamp and Childress’

¹ Intentionality means that the decision is made purposefully, not by accident; understanding means that the patient has sufficient information and can make sense of it in a way that supports their decision making; and noncontrol refers to the absence of manipulation, coercion, or undue influence.

second criterion for autonomy, which is to ensure the patient has sufficient understanding to make their decision. The authors also reflect the default conception of autonomy in their recommendations, in which they suggest that autonomy is about patients having “a say about their healthcare choices” (p. 21).

However, Ubel et al’s explanations of clinicians’ failures to communicate information in a way that empowered patients reflects a more sophisticated understanding of autonomy.

The authors criticized clinicians’ “ethic of information”, their a tendency to provide large amounts of information – often according to a “standard ‘spiel’” – which was not tailored and responsive to the individual patient. Clinicians were observed to exhibit a need to convey a large amount of information to the patient, whether or not the patient desired to receive it, and often in a manner that was indifferent to the patient’s emotional state.

This criticism reflects the misconceptions about communication and the role of information that Manson and O’Neill identify in their discussion of informed consent (Manson and O’Neill 2007). They argue that the emphasis on providing information in order to respect patients’ autonomy via informed consent processes has led to unhelpful ways of thinking about information. They describe a “container/ conduit” metaphor which considers information to be ‘stuff’ that can be contained in a person or document, and transferred to another person. Such a metaphor is misleading, because it obscures the norms that underpin communicative exchanges between people. Effective communication is flexible and responsive to each participant.

Some of the communicative interchanges described by Ubel et al are instances of clinicians’ failure to adapt their communication style in response to feedback from the patient. For example they deliver large quantities of information with little regard to the patient’s requirements, they persist in their verbose “standard ‘spiel.’” This reflects a desire to

transmit a quantity of information to the patient, instead of a meaningful engagement with the patient. The authors identify further failures of communication which include neglecting questions for clarification, and ignoring patients' emotional distress. In these instances the emphasis on providing information, rather than responsively adapting communication to the situation, undermines patient autonomy. These failures represent a lack of adherence to the communicative norms which underpin effective communication, suggesting that the authors tacitly subscribe to a broader understanding of autonomy such as I have articulated more fully in a forthcoming paper (Dive & Newson, forthcoming). This concept of autonomy moves away from a focus on providing maximum information, and emphasizes critical reflection on patient values.

Importantly, the prevailing conception of autonomy as explicated by Beauchamp and Childress takes autonomy to be a property of decisions, not of persons (Beauchamp and Childress 2013). Focusing on the autonomy of individual decisions leads to undue emphasis on informed consent and thereby on the provision of information to patients. However, if autonomy is construed more broadly as a property of persons, this allows a more pragmatic focus on how clinicians can enhance patient's capacity to be autonomous (Dive & Newson, forthcoming). Dworkin (1988) considers autonomy to be a capacity that involves reflecting critically on one's desires and preferences, and adjusting them in light of their higher-order preferences. Ubel et al's recommendations about "activating patients" and diagnosing their preferences support precisely this kind of understanding of autonomy.

Ubel et al also observe that clinicians fail to recognize the nuances of their interpersonal relationships with patients. Donchin emphasizes various relational dimensions of autonomy, and of particular relevance here is the interpersonal dimension of the patient-clinician relationship, and its inherent power dynamics (Donchin, 2000). Ubel et al illustrate how

failures to recognize these dynamics compromise patients' autonomy, understood as a capacity to make decisions that align with their own values. The authors' recommendations consist of strategies that seek to enhance the autonomy capacity of patients, and reflect Manson and O'Neill's account of adaptive and responsive communicative interchanges. For example, the recommendations to assess patients' baseline understanding of the disease and engage interactive teaching techniques to ensure understanding describe exactly this kind of exchange, which is inherently interpersonal. Furthermore, the recommendation to "diagnose" patient's preferences – rather than merely asking – reflects the requirement to engage the patient in a process of critical reflection on what matters to them.

Ubel et al observed that clinicians often exerted undue influence on patients, in "a clinical encounter that... at its core, is not very different from old fashioned paternalism" (p. 5). The accusation of paternalism – that is, interfering with the liberty of another person for their own good – is clearly intended to be a criticism, but the discussion that follows does not support a rejection of paternalism entirely.

Paternalism² usually has negative connotations, but as Conly argues, it can have overall beneficial effects on people's lives by helping them to achieve the kind of life they wish to live (Conly 2012). By appealing to findings which are well accepted in the fields of psychology and behavioral economics, she shows that we are all prone to errors of reasoning due to cognitive failures. These errors cause us to make choices that do not support us to achieve our long-term goals. They include (among others) a tendency to

² For the purposes of considering the relationship between autonomy and paternalism, a distinction between strong and weak paternalism is useful. Strong paternalism is intervening to override someone's autonomously-chosen goals for the kind of life they wish for themselves; by contrast, weak paternalism is overturning a person's (first order) choices in order to help them achieve their autonomously-chosen life goals.

discount the future at a rate that is not rational, and a belief that we are less likely than others to suffer future misfortune. These known cognitive failures justify (soft) paternalistic interventions to help us achieve the goals we value. Levy also argues that given evidence of such cognitive errors, a degree of paternalism which constrains the choices available to us is justified (Levy 2012).

One kind of cognitive limitation that Conly describes is a susceptibility to be swayed by the way that information is presented to us, particularly in a medical context. An example of this is when medical professionals describe treatment options in ways characterized by Ubel et al as unreasonably paternalistic, for instance when descriptions of different treatment alternatives incorporate the *clinician's* value judgements. Ubel et al argue that the challenge for clinicians is to present different treatment options as impartially as possible. However if the emphasis is on enhancing patients' autonomy, then the challenge is rather to elucidate each individual patient's preferences and goals, and to present the information about treatment options in relation to those goals.

In the case of urologists' discussions with patients, this is an area where treatment choices are highly dependent on patient preferences – particularly the relative value they place on sexual function, incontinence, and likely survival timeframes. Clearly it is essential in such situations to ensure that guidance in relation to treatment options is presented with reference to the patient's values and preferences. When the authors say that physicians have a role in guiding patients' decisions but should do so in accordance with the individual patient's values and preferences (p. 19), they are advocating a weakly paternalistic intervention. In this way, clinicians should seek to present information that is not value-neutral, but which makes reference to the specific patient's values.

While Ubel et al do not explicitly define how they understand patient autonomy and appear at first to equate the concept with the freedom to make one's own choices, their discussion and recommendations reflect a more sophisticated understanding of autonomy that moves away from a focus on information provision, such as that for which we have recently argued (Dive & Newson, forthcoming). Their critique of strongly paternalistic communication techniques combined with recommendations to engage with patients' values and preferences support weakly paternalistic approaches as a way of enhancing patients' capacity for autonomy.

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