

## ETHICAL MODELS OF PHYSICIAN – PATIENT RELATIONSHIP REVISITED WITH REGARD TO PATIENT AUTONOMY, VALUES AND PATIENT EDUCATION

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ETHICAL MODELS OF PHYSICIAN – PATIENT RELATIONSHIP REVISITED WITH REGARD TO PATIENT AUTONOMY, VALUES AND PATIENT EDUCATION (Abstract): The present paper revisits the ethical models of patient – physician relationship from the perspective of patient autonomy and values. It seems that the four traditional models of physician – patient relationship proposed by Emanuel & Emanuel in 1992 closely link patient values and patient autonomy. On the other hand, their reinterpretation provided by Agarwal & Murinson twenty years later emphasizes the independent expression of values and autonomy in individual patients. Additionally, patient education has been assumed to join patient values and patient autonomy. Moreover, several authors have noted that, over the past few decades, patient autonomy has gradually replaced the paternalistic approach based on the premise that the physician knows what is best for the patient. Neither the paternalistic model of physician – patient relationship, nor the informative model is considered to be satisfactory, as the paternalistic model excludes patient values from decision making, while the informative model excludes physician values from decision making. However, the deliberative model of patient – physician interaction represents an adequate alternative to the two unsatisfactory approaches by promoting shared decision making between the physician and the patient. It has also been suggested that the deliberative model would be ideal for exercising patient autonomy in chronic care and that the ethical role of patient education would be to make the deliberative model applicable to chronic care. In this regard, studies have indicated that the use of decision support interventions might increase the deliberative capacity of chronic patients. **Keywords:** PATIENT AUTONOMY, PHYSICIAN – PATIENT RELATIONSHIP, PATIENT EDUCATION, CHRONIC DISEASES

Autonomy has emerged as a central concept in contemporary health care ethics (1, 2).

In 1981, Miller (3) proposed four senses of autonomy in medical ethics, as follows: autonomy as free action – an action that is

voluntary and intentional; autonomy as authenticity – an action is consistent with the person’s dispositions, values and life plans; autonomy as effective deliberation – the person is aware of and evaluates both the alternatives and their consequences,

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choosing an action based on this evaluation; autonomy as moral reflection – acceptance of the moral values one acts on, as one has reflected on these values and accepts them as his/her own.

Studies have regarded patient autonomy and values to be key variables in the ethical models of patient – physician interaction. Values can be defined as the beliefs or principles of a person, which are used to guide decisions and way of life (4, 5).

It has also been highlighted the importance of good patient – clinician relationships for the ethical principle of respect for autonomy, as supportive relationships can be more facilitative with regard to patient capability for autonomy than concern to allow patient independence (6). Moreover, cancer research has indicated that constructive patient – physician relationships are considered to be essential to minimize disease – related stress and anxiety (7). Additionally, patient education has been increasingly recognized as a method for optimizing treatment of chronic diseases (8).

Thus, the objective of the present paper would be to revisit the ethical models of patient – physician relationship from the perspective of patient autonomy, values and patient education.

### **PATIENT AUTONOMY, VALUES AND PATIENT EDUCATION IN PATIENT – PHYSICIAN INTERACTION**

In 1992, Emanuel & Emanuel (4) outlined the four traditional models of physician – patient relationship. The paternalistic model, where the physician independently decides, assumes that the patient has low health – related values formation, the model being characterized by low pa-

tient autonomy and low information disclosure by the physician. In the interpretive model, the physician provides patients with pertinent information and helps them to elucidate their values, but it is the patient who ultimately decides. The deliberative model allows the physician to guide the patient's decision making and the patient to deliberate on the differences between his or her preferences and the ones of the physician. The informative model, where the patient alone takes on decision making responsibilities, presupposes that the patient possesses well known and fixed values, this model being characterized by high patient autonomy and high medical information delivery to the patient (5, 9).

It has been noticed that the models described by Emanuel & Emanuel tightly link patient values and patient autonomy by assuming that, as patient autonomy increases, the strength and formation of patient values should increase as well. However, twenty years after the publication of the paper of Emanuel & Emanuel on the four models of the physician – patient relationship, Agarwal & Murinson (5) proposed a reinterpretation of these traditional models. The reinterpretation draws attention to the independent expression of values and autonomy in individual patients (e.g. the patient with high autonomy, but low formation of health – related values) and adds patient medical knowledge as a new dimension in the patient – physician interaction. In this regard, while the traditional models of patient – physician relationship involve a unidirectional flow of medical information from physician to patient, the reinterpretation of these models also takes into consideration the growing availability of medical information accessible to the general public via the internet.

In addition, patient medical knowledge is supposed to join patient values and patient autonomy.

Furthermore, several papers underline that, over the past few decades, there has been a shift from a paternalistic approach to patients towards an emphasis on patient autonomy (10, 11, 12, 13).

However, it has been suggested that good patient care might involve a closer look at some remaining aspects of paternalism (11). In this regard, it has been revealed that paternalism should still have a role in decision making, if we consider that there are physicians who avoid making difficult medical decisions by hiding behind the respect for patient autonomy (14). On the other hand, studies indicate that the number of physicians who believe in paternalism as a form of beneficence is still significant (15). Moreover, even though patient expectations and desire to be implicated in treatment decisions are increasing, some patients still prefer to leave decision making to their physician (7). Another study has also noted that there are many patients who would prefer a paternalistic approach (16). In addition, there has been outlined that the so-called modern paternalism takes into account patient values and interests, but considers these values as only one factor among others, whereas autonomy refers to patient values as decisive (17). In any case, several authors indicate that the balance between autonomy and paternalism needs reassessment in such a way that beneficence and autonomy would be mutually reinforcing rather than competing (14, 18, 19, 20).

If the four traditional models of the physician – patient relationship would be represented as a single linear axis, the paternalistic model and the informative one

would be the two extremes of the axis, neither of the two being satisfactory with regard to decision making approach (4, 5, 10, 21). The informative model, also known in the literature as the independent choice model, reflects a defective understanding of patient autonomy, as it sacrifices physician competence for patient control. In this model, physicians withhold their recommendations and experience and carry out patients' decisions. Such a model presumes that if the patient is to gain power to make autonomous choices, the physician has to lose power (4, 10). Nevertheless, it is suggested that such overemphasis on patient autonomy may suppress beneficent intervention (19).

Therefore, the paternalistic model leaves the patient outside the decision making process, while the informative model leaves the physician outside by reducing the role of the physician to that of a technician providing the chosen service (2, 4, 22).

The deliberative model offers a better alternative to these unsatisfactory approaches, because, in this model, both physician and patient engage in moral deliberation and the patient considers through open dialogue alternative health – related values. Thus, the deliberative model promotes shared decision making and negotiation between the physician, who has a caring attitude, and the patient, being recommended as the best model for the physician – patient relationship and for exercising patient autonomy (2, 4, 9). Shared decision making has also been increasingly regarded as an ideal model of physician – patient interaction, in which both the patient and the physician make active and essential contributions through open dialogue, joint deliberation and mutual understanding (4, 22, 23). An analogous model based on

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mutual understanding, described in the scientific literature as an authentic interaction between physician and patient, is the dynamic and genuine dialogue – based model of autonomy, which also reflects a care giving relationship and overcomes the imbalance of power that is present in both paternalistic and informative models with regard to decision making (11). Additionally, the enhanced autonomy model underlines that the physician guides the decisions of the patients in a way that allows patients to exercise autonomy more powerfully if they make decisions that integrate the experience of the physician with their own. Hence, this model promotes, similarly to the deliberative model, to the shared decision making model and to the dialogue – based model, a physician – patient relationship characterized by open dialogue and mutual influence and understanding, where patient and physician share power, negotiate differences and actively exchange ideas (10).

Moreover, in 2014, by revisiting the four traditional models of patient – physician relationship, Reach (9) proposes a model of care in chronic diseases based on patient education, pointing out that the ethical role of patient education would be to make the deliberative model applicable to chronic care and, thus, to give patients the opportunity to exercise autonomy in an ideal situation. In this regard, patient education is referred to as an ethical pathway that links three of the four models of physician – patient relationship, as follows: the physician first gives the facts (the informative model), helps the patients to elucidate their preferences (the interpretive model) and finally gives them the opportunity to choose between their preferences and the ones of the physician, so that the deliberative model can be reached at the end of this

pathway.

Studies on decision making in cancer patients have emphasized that the distress experienced during the time of diagnosis might diminish the deliberative capacity of a patient (24). In this regard, it has been pointed out the contribution of decision aids in cancer care, as decision aids are described to be decision support interventions designed to teach patients the deliberative skills needed to negotiate their way through relevant information, to clarify their values and to guide them in the steps of decision making and communicating with others (25, 26).

In order to promote respect for autonomy of patients with chronic life-threatening diseases, it has been revealed that such patients should be encouraged to have a values discussion with their physician and to document the values and goals that should guide future decisions. As values can change, values discussions should be revisited occasionally, especially when patient condition changes significantly. In this regard, it has been emphasized that the physician should recommend the medical means to honor those values and achieve those goals (27).

### **CONCLUSIONS**

To conclude, patient autonomy, patient values and patient education are referred to as central variables in the models of physician – patient interaction.

The deliberative model, the shared decision making model, the dialogue – based model of autonomy and the enhanced autonomy model are recommended to be the best for the physician – patient relationship and for exercising patient autonomy, and, in our opinion, they appear to express, under different names, the same model of

physician – patient relationship. Such a model, which is based on open dialogue, joint deliberation and mutual understanding, would be the balanced alternative between the two extremes represented by the paternalism and the informative model, as it overcomes the imbalance of decision making power between patient and physician.

Moreover, the deliberative model has been suggested to be ideal for exercising patient autonomy in chronic care. Studies have indicated that the use of decision aids could increase the deliberative capacity of chronic patients. In addition, it has been pointed out that, in order to promote re-

spect for autonomy of chronic patients, discussions that elucidate patient values should be occasionally revisited.

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#### REFERENCES

1. Woods S. Respect for persons, autonomy and palliative care. *Med. Health Care Philos.* 2005; 8(2): 243-253.
2. Warren R. Paternalism in medical ethics: a critique. *Dialectic* 2010; Issue 06.
3. Miller BL. Autonomy & the refusal of lifesaving treatment. *Hastings Cent. Rep.* 1981; 11(4): 22-28.
4. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. *JAMA* 1992; 267(16): 2221-2226.
5. Agarwal AK, Murinson BB. New dimensions in patient-physician interaction: values, autonomy, and medical information in the patient-centered clinical encounter. *Rambam Maimonides Med. J.* 2012; 3(3): e0017.
6. Entwistle VA et al. Supporting patient autonomy: the importance of clinician-patient relationships. *J. Gen. Intern. Med.* 2010; 25(7): 741-745.
7. Fallowfield LJ. Treatment decision-making in breast cancer: the patient-doctor relationship. *Breast Cancer Res. Treat.* 2008; 112 Suppl 1: 5-13.
8. Vulpoi C et al. Therapeutic patient education--method of optimizing treatment in chronic diseases. *Rev. Med. Chir. Soc. Med. Nat. Iasi* 2007; 111(1): 13-18.
9. Reach G. Patient autonomy in chronic care: solving a paradox. *Patient Prefer. Adherence* 2014; 8: 15-24.
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. Nessa J, Malterud K. Tell me what's wrong with me: a discourse analysis approach to the concept of patient autonomy. *J. Med. Ethics* 1998; 24(6): 394-400.
12. Rosner F. Informing the patient about a fatal disease: from paternalism to autonomy--the Jewish view. *Cancer Invest.* 2004; 22(6): 949-953.
13. Brom L et al. Patients' preferences for participation in treatment decision-making at the end of life: qualitative interviews with advanced cancer patients. *PLoS One* 2014; 9(6): e100435.
14. Roeland E et al. When open-ended questions don't work: the role of palliative paternalism in difficult medical decisions. *J. Palliat. Med.* 2014; 17(4): 415-420.

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15. de Souza Trindade E et al. The physician when facing diagnosis and prognosis of advanced cancer. *Rev. Assoc. Med. Bras.* 2007; 53(1): 68-74.
16. Stiggelbout AM et al. Ideals of patient autonomy in clinical decision making: a study on the development of a scale to assess patients' and physicians' views. *J. Med. Ethics* 2004; 30(3): 268-274.
17. Weiss GB. Paternalism modernized. *J. Med. Ethics* 1985; 11(4): 184-187.
18. Pellegrino ED. Patient and physician autonomy: conflicting rights and obligations in the physician-patient relationship. *J. Contemp. Health Law Policy* 1994; 10: 47-68.
19. Woodward VM. Caring, patient autonomy and the stigma of paternalism. *J. Adv. Nurs.* 1998; 28(5): 1046-1052.
20. Gessert CE. The problem with autonomy. *Minn. Med.* 2008; 91(4): 40-42.
21. Chin JJ. Doctor-patient relationship: from medical paternalism to enhanced autonomy. *Singapore Med. J.* 2002; 43(3): 152-155.
22. Charles C et al. Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango). *Soc. Sci. Med.* 1997; 44(5): 681-692.
23. Almyroudi A et al. Decision-making preferences and information needs among Greek breast cancer patients. *Psychooncology* 2011; 20(8): 871-879.
24. Peters E et al. Age differences in dual information-processing modes: implications for cancer decision making. *Cancer* 2008; 113(12 Suppl): 3556-3567.
25. O'Connor AM et al. Risk communication in practice: the contribution of decision aids. *BMJ* 2003; 327(7417): 736-740.
26. Barnato AE et al. Communication and decision making in cancer care: setting research priorities for decision support/patients' decision aids. *Med. Decis. Making* 2007; 27(5): 626-634.
27. Billings JA, Krakauer EL. On patient autonomy and physician responsibility in end-of-life care. *Arch. Intern. Med.* 2011; 171(9): 849-853.

### NEWS

#### FIBROMUSCULAR DYSPLASIA OF CARDIAC CONDUCTION SYSTEM ARTERIES IN TRAUMATIC AND NONNATURAL SUDDEN DEATH VICTIMS

In several reports, luminal narrowing by fibromuscular dysplasia of the sinus and/or AV-node artery was found in examinations of unexplained deaths and, in many cases, was considered as the cause of death. These reported cases were aged between 0 and 49 years; both sexes were affected. However, there are no data on the frequency of fibromuscular proliferations of arterial walls in heart healthy control groups. But, the exact cause of these fibromuscular vessel alterations is still unclear. Possible hypotheses might be either the consequence of the impact of the bloodstream on small vessel branches or a protective mechanism against luminal extension. Since fibromuscular proliferations of arteries of the cardiac conduction system and small coronary arteries occur in 84% in an obviously heart-healthy control group, these findings should be known to every (forensic) pathologist and anatomist. This might reduce the risk of misdiagnosis. In the same time, the reported results demonstrate that microscopically detectable findings of the cardiac conduction system arteries similar to fibromuscular dysplasia do not indicate a defined disease and should not be considered as a cause of death when there are no macroscopic findings in the coronary arteries (Zack F, Kutter G, Blaas V, et al. Fibromuscular dysplasia of cardiac conduction system arteries in traumatic and non-natural sudden death victims aged 0 to 40 years: a histological analysis of 100 cases. *Cardiovascular Pathology* 2014, 23: 12–16).

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