

Paternalism vs autonomy: Why watching our words is important

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Two patients were admitted to our unit at the same time: Mr. P, age 27, an architect with unspecified personality disorder, and Mr. D, age 62, a bank manager who has had bipolar disorder for 40 years and was experiencing a moderate depressive episode. Mr. P's discomfort with the treatment team *informing* him of his treatment plan was evident, and he discussed at length his terms and stipulations for management. Mr. D, on the other hand, was loath to shoulder the burden of any decision-making, even in minor matters such as what time he should take his daily walk.

Patient autonomy is a central factor in the present-day doctor-patient equation. In psychiatry, this is sometimes further complicated by a patient's impaired judgment and lowered decision-making capacity (DMC). In our clinical practice, we often notice that younger patients (ie, millennials) prefer to have autonomy rather than being given instructions, which they may find patronising, whereas the older generation relies more on the doctor for decision-making.

What the decision-making process entails

The decision-making process involves 3 steps:

- information gathering
- deliberation
- implementation.

Decision-making preferences fall on a spectrum that ranges from paternalism at one end to autonomy on the other, with many

intervening components, characterized by varying amounts of responsibility shared between doctor and patient.¹ This typically comes into play when there is more than one treatment option with similar outcomes.² Paternalism is defined as an action performed with the intent of promoting another's good but occurring against the other's will, or without consent.³ Here, the patient is not privy to the deliberation process, and no explanations are provided.¹ Hard paternalism focuses on doing good for the patient rather than respecting his or her decision-making, whereas soft paternalism implies trying to raise one final red flag, but ultimately not standing in the way of the patient's choice.⁴

Two other decision-making constructs are shared decision-making (SDM) and informed decision-making (IDM). In SDM, the deliberation process involves participation of both patient and doctor, with active discussion and a final decision after both parties reach an agreement. In IDM, the deliberation is conducted solely by the patient, after he or she receives all information. Shared decision-making and IDM are frequently used interchangeably, but in the latter, the doctor has no role other than to provide information.^{1,5}

continued



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Disclosure

The author reports no financial relationships with any companies whose products are mentioned in this article, or with manufacturers of competing products.



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Clinical Point

It is time for us to adopt these changes and move towards the patient-centered end of the spectrum

Before choosing SDM or IDM, it is necessary to assess the patient's DMC—the ability to understand information about choices, make a judgment that respects personal values, understand potential outcomes, and freely communicate his or her wishes.⁶

Benefits and risks

The progression from paternalism to autonomy began in the mid-20th century as a consequence of the Nuremberg Trials, from which the concept of “informed consent” first came into existence.⁷ The Indian value system has always regarded the medical profession and its practitioners with high esteem, as evidenced by the Sanskrit quote “*Vaidyo Narayano Harihi*,” which translates to “The doctor is God.” A significant chunk of the Indian population still considers the doctor's word to be law, and they hand over health-related decisions to medical professionals. Here, the expectation of a paternalistic attitude is decidedly unequivocal.

Of course, there are pros and cons to every approach. Making patients' independence a priority is the highest virtue of autonomy, but in such cases a patient may have difficulty comprehending medical consequences, and therefore may miss out on the benefits of a sound professional perspective. Paternalism may be superior medically, but the doctor may not be aware of all patient-specific factors, and it would not be prudent to make a

decision for a patient without being privy to the entire picture.

The 21st century has witnessed a change in attitudes regarding medical care. With an increasing interest in patient autonomy, it is time for us to adopt these changes and move towards the patient-centred end of the spectrum. However, this should occur only after the patient improves enough symptomatically to regain DMC; autonomy is unlikely to be appropriate for patients with serious mental illness. Ideally, SDM includes the best of both worlds, and results in optimal outcomes. However, when SDM breaks down, a selective, soft paternalistic attitude would be most beneficial, without impinging on the patient's basic personal rights.

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