PERSUASION AT THE BEDSIDE

What can clinicians do to help patients make decisions?

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What ethical principles govern clinical encounters?

1. Beneficence
2. Autonomy

(There are two others, but we’re not going to worry about them:
3. Justice
4. Non-maleficence)
The Principles of Beneficence and Autonomy

The principle of beneficence
Clinicians must act with the aim of benefiting their patients.

The principle of autonomy
Competent patients have the right to make decisions about their own care (and in particular to refuse treatments).
Beneficence and Autonomy: the possibility of conflict?

Joan is 35 years old and has a one cm cancer of the breast without clinical evidence of lymph node metastasis. Her mother and sisters had cancer of the breast. Her surgeon argues, based on her history and the cytology of the tumour, that she has a very high chance of developing a second carcinoma. He recommends a bilateral mastectomy. This, he argues, will give her the best chance of survival. Joan replies that this will be very disfiguring. She would prefer to have a lumpectomy followed by yearly mammography. This, she argues, will give her a better quality of life.*

Question: Assuming there is a conflict between autonomy and beneficence here, what should the clinician do?

The standard view

When autonomy and beneficence conflict, autonomy (defeasibly) wins.

- The clinician’s pursuit of what is good for the patient is constrained by the principle of autonomy.

The takeaway: At the end of the day, competent patients have the right to make decisions, even if those decisions are bad for them.

Question: What can clinicians do to influence a patient’s choice while respecting the patient’s autonomy?
Influencing patients while respecting autonomy: two questions

1. What *methods* of influence are consistent with respecting patient autonomy?
   - In other words: what can we do in order to influence the patient while respecting her autonomy?

2. What *ends* of influence are consistent with respecting patient autonomy?
   - In other words: for *what purpose* can we try to influence the patient while respecting her autonomy?
A list of methods of influence

- Physical compulsion
- Coercion
- Lying
- Omitting
- Framing
- Non-rational emotional appeals
- Non-rational situational methods
- Rational persuasion
- Explicitly correcting well-known biases

Two ways to categorize forms of influence:
- Rational v non-rational
- Transparent v non-transparent
Possible ends of influence

- Getting the patient to change her choice of means.
  - Helping the patient achieve his own conception of the good.
  - Taking the patient’s values as given.

- Getting the patient to change her ends.
  - Trying to get the patient to change or modify her conception of the good.
  - Not taking the patient’s values as given.
Combining methods and ends

The claim: what you think about the permissibility of using certain methods of influence might depend on the purpose of the influence.

For example, you might think one or some of the following:

- It is never permissible for clinicians to try to change patients’ ends, no matter how they do it.
- It is only permissible to try to change patients’ ends by way of transparent, rational methods of influence.
- It is never permissible to try to change patients’ means by omitting certain information.
- It is sometimes permissible to try change a patients’ means by non-transparent or non-rational methods of influence, but not permissible to try to change a patient’s ends by non-transparent or non-rational methods of influence.
Why the point of trying to influence the patient might matter so much

Why you might think it is never permissible to influence ends.

- Concerns about expertise.
- Liberal considerations.

Why you might think it is sometimes permissible to influence ends.

- Principle of beneficence.
- Clinicians can be wise!

Intermediate suggestion: exploring ends v influencing ends
Back to Joan: what can the clinician permissibly do to influence her decision?

Key questions

1. Why is she refusing the treatment?
2. If we want to try to get Joan to change her mind, are we doing so to help her achieve her own goals or to get her to change her goals?
3. If we’re trying to get her to change her goals, are we carefully distinguishing between a) our role as a medical expert and b) our role as someone who cares about the patient, has a view about what is best, but doesn’t have any special expertise?
4. Should the clinician have even recommended a treatment before talking to Joan about her goals and values?
Further Reading

Here is a link to a Dropbox folder where you can access some papers on this issue.

- It will only be accessible for the next week or so, so grab the papers soon!