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Editorial

Paternalism *v.* autonomy – are we barking up the wrong tree?

Peter Lepping, Tom Palmstierna and Bevinahalli N. Raveesh

Summary
We explore whether we can reduce paternalism by increasing patient autonomy. We argue that autonomy should not have any automatic priority over other ethical values. Thus, balancing autonomy *v.* other ethical pillars and finding the optimal balance between the patient's wishes and those of other relevant stakeholders such as the patient's family has to be dynamic over time.

Declaration of interest
None.

Peter Lepping (pictured) works as a consultant psychiatrist for Betsi Cadwaladr University Health Board in Wrexham, North Wales. He is an honorary professor at the Centre for Mental Health and Society, Bangor University and at Mysore Medical College and Research Institute in India. Tom Palmstierna works as a senior psychiatrist at the forensic psychiatric out-patient unit at the Stockholm Addiction Centre. He is a professor of psychiatry at the Norwegian University of Science and Technology, Trondheim, Norway and associate professor at Karolinska Institutet in Stockholm, Sweden. Bevinahalli N. Raveesh is professor of psychiatry and works as director of the Dharwad Institute of Mental Health & Neurosciences in India.

Many attempts have been made across the world to reduce paternalism in medicine. In psychiatry these attempts have arguably been most pronounced because psychiatry has traditionally used legislation to sanction coercion and detention, thus reducing patient autonomy.[1] For England and Wales the Mental Capacity Act 2005 explicitly sanctions the use of coercion in order to facilitate investigations and treatment that is in the patient's best interest while the patient lacks capacity. Traditionally the argument has been that doctors and nurses have made too many decisions for patients, which has compromised patient autonomy, and recent court interpretations of the Mental Capacity Act have reinforced the importance of patient autonomy.[2]

Pillars of medical ethics

The question that arises from these developments is primarily whether we will actually be able to reduce medical paternalism by increasing patient autonomy and whether the legislation route is the best way forward in this regard. Patient autonomy is an ethical value that is important and has developed over decades. There is, however, no *a priori* reason to focus on any one particular ethical value above others. Beauchamp & Childress first defined the four pillars of medical ethics and included beneficence (do good), non-maleficence (do no harm), autonomy and justice.[3] In medical ethics it is very clear that patient autonomy should be seen as a value of equal status to the others, not prioritised as a value of higher order. Beauchamp & Childress point out that society has a legitimate interest in good outcome and 'doing good'. Simply put, in medical ethics doing the right thing for the patient has equal value to patient autonomy.

Other medical ethics theories such as the ethics of care focus on the dilemmas patients have to navigate within complex relationships and environments.[4,5] They consider care and empathy to be primary objectives of medical and nursing input. Again, they particularly recognise the complexity of human relationships that people live in and the fact that relatives and friends may well play an important role for the patient's decision-making and continuous treatment. An example of this different focus is seen in many societies in the developing world where more collegial decision-making processes within the family are preferred, and beneficence for the family as a whole may be seen as more important than the immediate autonomy of the individual at a particular point in time.[6] It should be emphasised that any overruling of the patient's autonomy is not necessarily permanent. By a temporary overruling of this principle, for example in psychotic states, the patient can regain capacity to exercise 'true' autonomous decisions once recovered. By focusing on patient autonomy to the detriment of beneficence, non-maleficence and justice, we create the potential for services to become unjust as a whole and for individual decisions to regularly not turn out to be in the patient's interest. Some may argue that this is a legitimate price to pay if it overcomes paternalism but this implies the fundamental assumption that by strengthening patients' expressed wishes, autonomy will in fact overcome medical paternalism.

Shifting the balance in doctor–patient relationships

However, this assumption has a number of serious flaws. Paternalism is a description of a particular type of doctor–patient or nurse–patient relationship that implies that the doctor or nurse knows what is best for the patient and enforces that opinion on the patient.[7] The patient in this type of relationship is not equal but in a subordinate position. Modern medicine has rightly argued that this has to change and that the patient not only has to be in an equal position to the doctor but he or she is also the ultimate decision-maker. Many attempts have been made to facilitate the change in the doctor relationship by educating doctors and nurses as well as patients and, in the UK, the General Medical Council has played a major role in this. Other countries have had similar drives to alter the balance towards the patient. Recent court cases about consent and autonomy in England and Wales have established the principle that even the consent process and the choice of side-effects mentioned has to be individualised towards each patient. The argument used by the judges who passed those judgments was always to reinforce autonomy in

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order to overcome paternalistic behaviours by doctors and nurses.[8]

However, the fundamental problem with this approach of using a legalistic focus on autonomy to battle paternalism is that paternalism is about the doctor–patient relationship whereas autonomy is an ethical value. These relationships in healthcare exist in parallel to principles of ethics.[5] Fundamental relationships can and need to change over time if we want to improve healthcare and the way we treat patients, but are we barking up the wrong tree if we think we will achieve this by compromising fundamental ethical values such as beneficence, non-maleficence and justice?

Although there is always a tendency to use legislation when desired developments do not happen quickly enough there is little evidence to suggest that this approach works to change behaviours. Furthermore, by meddling with important ethical values we run the serious risk of jeopardising good outcomes and justice within the healthcare system. This is because a constant rather than a dynamic focus on autonomy is likely to increase the number of poor outcomes, especially as clinicians regularly overestimate patients' capacity to make decisions.[6,9] In addition it requires additional resources to facilitate individual healthcare wishes that may then have an impact on the overall ability of the system to deliver just healthcare, especially in times of austerity and limited resources. If we create an imbalance between fundamental medical ethical values, we are likely to jeopardise outcomes without addressing the fundamental problems of paternalism. Paternalism can only be changed by changes to the doctor–patient relationship that are fundamentally about equality and communication and not autonomy.[7] Balancing autonomy *v.* other ethical pillars and finding the optimal balance between the patient's wishes and those of other relevant stakeholders such as the patient's family has to be dynamic over time, depending on the course of the patient's mental condition. However, a reasonable first starting point to finding solutions would be an acceptance that the primacy of the immediate expressed wish of autonomy can cause potential problems for the patient's recovery.

If we accept that there is no *prima facie* case that any ethical principle should trump any other in all cases, re-balancing the different interests and ethical principles in psychiatric practice could focus on outcomes that are important for the patient and his or her immediate environment. This would have to be done with a clear knowledge of important ethical principles other than autonomy and what they mean in current practice in different socioeconomic contexts.[10] Different countries, different socioeconomic contexts and different cultures need to develop ways to optimise this re-balancing process so that any limitations to patient autonomy are for the shortest possible time and in the least restrictive way.

Peter Lepping, MSc, MD, MRCPsych, Wrexham Community Mental Health Team, Betsi Cadwaladr University Health Board, Ty Derbyn, Wrexham Maelor Hospital, Wrexham, Centre for Mental Health and Society, Bangor University, and Mysore Medical College and Research Institute, India; **Tom Palmstierna**, MD, PhD, Forensic Psychiatric Outpatient Unit, Stockholm Addiction Centre, Karolinska Institutet, Stockholm, Sweden, and Norwegian University of Science and Technology, Trondheim, Norway; **Bevinahalli N. Raveesh**, MSc, MD, MBA, LLB, LLM, Dharwad Institute of Mental Health and Neurosciences, India

Correspondence: Peter Lepping, Wrexham Community Mental Health Team, Betsi Cadwaladr University Health Board, Ty Derbyn, Wrexham Maelor Hospital, Croesnewydd Road, Wrexham LL13 7TD, Wales. Email: peter.lepping@wales.nhs.uk

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