Ethics in Healthcare 2025

Carver College of Medicine, University of Iowa, Iowa City, IA

May 30, 2025

Should We Sometimes Try to Change a Patient's Mind?

Examining the Ethics of Persuasion in Shared Decision Making in Healthcare

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Conflict of interest disclosures: none

Objectives

1. Discuss the virtue of practical wisdom within the moral dynamic of shared decision making.
2. Differentiate between ‘making a recommendation’ and ‘attempting to persuade’.
3. Illustrate the need for practical wisdom when persuasion is deliberately attempted.

What should we do when a patient refuses a recommendation?

Accept & move on?

Engage and discuss?

Try several times more?

Inform – recommend – persuade – manipulate - coerce

persuasion happens, context matters, clinicians differ …

Purpose: draw from **a framework for practical wisdom** for guidance in responding to challenges posed by the use of persuasion in healthcare

framework for practical wisdom
(phronesis, prudence)

Practical wisdom is expressed when 'clinical judgement' is goal-directed, perceptive, and ethically grounded

Kaldjian LC. Teaching practical wisdom in medicine through clinical judgement, goals of care, and ethical reasoning. *J Med Ethics*. 2010;36(9):558-62.

Definitions

Inform: to impart information or knowledge

Recommend: to suggest an act or course of action as advisable

Persuade: to move by argument to a belief, position, or course of action

Persuasion in healthcare: is attempted when, after having communicated information and a recommendation, a healthcare professional uses reasoning to try to change a patient's thinking toward a decision that is more consistent with the healthcare professional's understanding of what is good for the patient's health.

shared decision making, and its moral dynamic

Shared decision making entails *a moral dynamic* in which two or more people are sharing perspectives about what is best for a patient.

At times, there may be tension between autonomy and beneficence/nonmaleficence.

Models of Decision Making

Analytical stages		Paternalistic model	Intermediate approaches	Shared model	Intermediate approaches	Informed model
Information exchange	Flow	One way (largely)		Two way		One way (largely)
	Direction	Doctor ↓ patient		Doctor ↓ ↑ patient		Doctor ↓ patient
	Type	Medical		Medical and personal		Medical
	Minimum amount	Legal requirement		Anything relevant for decision making		Anything relevant for decision making
Deliberation		Doctor alone or with other doctors		Doctor and patient (plus potential others)		Patient (plus potential others)
Who decides what treatment to implement?		Doctors		Doctor and patient		Patient

Models of decision making about treatment

Charles et al. What do we mean by partnership in making decisions about treatment? *BMJ* 1999;319;780-782

Shared Decision Making (and the healthcare professional's influence)

Shared decision making:

- It is an effort to combine the clinician's guidance with the patient's values and preferences
- This results in "an interpersonal, interdependent process in which the health care provider and the patient relate to and influence each other as they collaborate in making decisions about the patient's health care."

(Légaré & Witteman 2013)

- Charles, C. et al. (1997) Shared decision-making in the medical encounter: What does it mean? (or it takes at least two to tango). Social Science and Medicine 44 (5): 681–692.
- Charles, C. et al. (1999) What do we mean by partnership in making decisions about treatment? British Medical Journal 319:780–782.
- Elwyn G. et al. Shared decision making: a model for clinical practice. J Gen Intern Med. 2012 Oct;27(10):1361-7.
- Elwyn G. et al. Shared decision making and motivational interviewing: achieving patient-centered care across the spectrum of health care problems. Ann Fam Med. 2014;12(3):270-5.
- Berger Z, Galasinski D, Scalia P, Dong K, Blunt HB, Elwyn G. The submissive silence of others: Examining definitions of shared decision making. Patient Educ Couns. 2022;105(7):1980-1987.
- Légaré F, Witteman HO. Shared decision making: examining key elements and barriers to adoption into routine clinical practice. Health Aff (Millwood). 2013 Feb;32(2):276-84.
- Rubinelli S. Rational versus unreasonable persuasion in doctor–patient communication: a normative account. Patient Education and Counseling 2013;92(3):296-301.

A common clinical context involving shared decision making and the possibility of persuasion:
discharges from the hospital against medical advice ('AMA')

Discharging patients against medical advice ('AMA'):

- Approximately 1%-2% of hospitalizations in the United States.
- Highly subjective and variable.
- Associated with physician distress, patient stigma, and adverse outcomes.

Holmes EG, Cooley BS, Fleisch SB, Rosenstein DL. Against Medical Advice Discharge: A Narrative Review and Recommendations for a Systematic Approach. Am J Med. 2021 Jun;134(6):721-726.

These situations are indeed distressing:

- One student's reflection: *"Having a patient leave AMA is such a strong reminder that, at the end of the day, they get to call the shots. I struggled with the ethics of how hard I should push back on trying to convince him to stay…."*

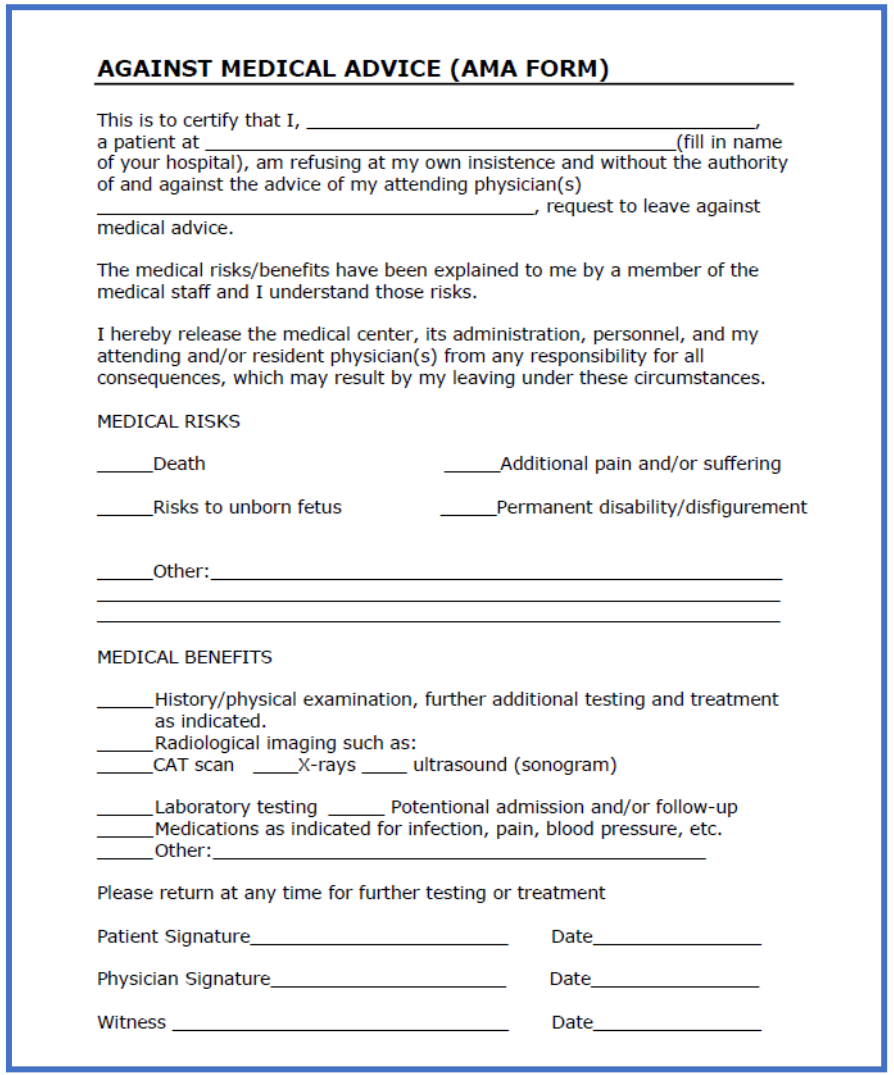
The way **against medical advice** ('AMA') discharges tend to be handled

Typically treated as a matter of informed consent:

> If a competent patient or his or her authorized surrogate declines further inpatient care, physicians should fulfill their legal and ethical obligations to obtain informed consent for the patient's decision and document that decision and the patient's reasons for it in the patient's record.

Alfandre & Schumann. What is wrong with discharges against medical advice. JAMA 2013;310:2393-2394.

- Physicians appear to disagree about the use of **AMA forms** and officially labelling a hospital discharge as being 'against medical advice'.



AGAINST MEDICAL ADVICE (AMA FORM)

This is to certify that I, _____,
a patient at _____(fill in name of your hospital), am refusing at my own insistence and without the authority of and against the advice of my attending physician(s) _____, request to leave against medical advice.

The medical risks/benefits have been explained to me by a member of the medical staff and I understand those risks.

I hereby release the medical center, its administration, personnel, and my attending and/or resident physician(s) from any responsibility for all consequences, which may result by my leaving under these circumstances.

MEDICAL RISKS

_____Death _____Additional pain and/or suffering

_____Risks to unborn fetus _____Permanent disability/disfigurement

_____Other:_____

MEDICAL BENEFITS

_____History/physical examination, further additional testing and treatment as indicated.
_____Radiological imaging such as:
_____CAT scan ____X-rays ____ ultrasound (sonogram)

_____Laboratory testing _____ Potentional admission and/or follow-up
_____Medications as indicated for infection, pain, blood pressure, etc.
_____Other:_____

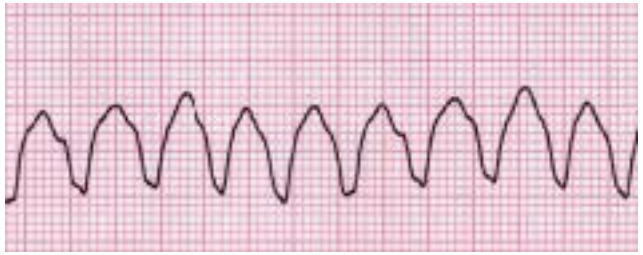
Please return at any time for further testing or treatment

Patient Signature_____ Date_____

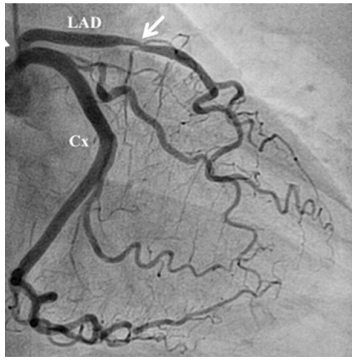
Physician Signature_____ Date_____

Witness _____ Date_____

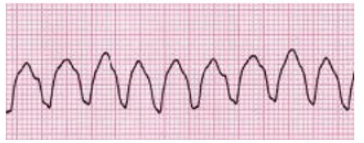
A patient insists on going home

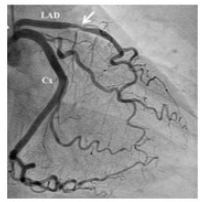


What would a wise physician do?



Responding wisely





Multiple dimensions need to be joined in a single course of action:

Goals

Purpose-directed: what is (or are) the goal(s)?

Perception & Context

Context-engaging: what details (bio-psycho-socio-spiritual) are morally relevant?

Ethics

Ethics-integrating: what virtues and principles need to be integrated?

Deliberation

Deliberative: how is deliberation done, and how is it *shared*?

Motivation

Motivated: what moral reasons and emotions motivate the Cardiologist?

The clinician's influence in shared decision making

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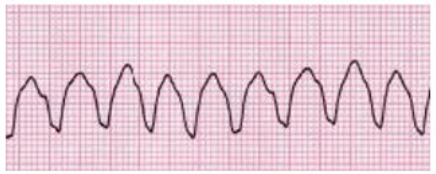
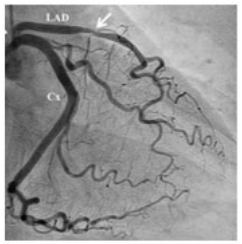




How clinicians influence patients depends on clinicians' beliefs about:

- what health is and healthcare should be
- what goals are worth pursuing
- what probabilities are worth accepting
- what treatment burdens are worth bearing
- what ethical values need to be respected

Viewing shared decision making and persuasion through the lens of autonomy vs. the lens of relational autonomy

Shared decision making in light of principle-based ethical frameworks

Four Principles of Biomedical Ethics

1. Beneficence (do good)
2. Nonmaleficence (avoid harm)
3. Respect for autonomy (self-determination)
4. Justice (fairness, distribution of benefits/burdens)

- Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*, 8th ed. Oxford, 2019.
- Gillon R. Medical ethics: four principles plus attention to scope. BMJ. 1994 Jul 16;309(6948):184-8.

Three Principles of Biomedical Research Ethics

1. Beneficence (avoid harm, maximize good (utilitarian))
2. Respect for persons (self-determination; vulnerabilities)
3. Justice (fairness, distribution of benefits/burdens)

The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research (1979).

The importance of patient autonomy & informed consent

Patient self-determination (and especially the right to refuse treatment)

- *Schloendorff v. New York Hospital* (1914)

"Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his **patient's consent**, commits an assault, for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained…."

https://biotech.law.lsu.edu/cases/consent/Schoendorff.htm

But is autonomy sometimes treated simply as “choice itself”?

A criticism of the standard approach to the concept of autonomy:

> autonomy should not be seen as ‘‘an affirmation of choice itself, where all options are equally worthy, because they are freely chosen, and it is choice that confers worth’’.

(quoting Charles Taylor, *The Ethics of Authenticity*, p. 36-7)

Campbell L. Kant, autonomy and bioethics. *Ethics, Medicine and Public Health* 2017;3(3):381-392.

Sliding threshold for assessment of decision-making capacity (DMC)

(based on beliefs about reasonableness & rationality)

Doctor's assessment of risk/benefit		Patient's decision	doctor & patient	threshold for capacity
Favorable	⇨	consents	agree	LOWER
Unfavorable	⇨	refuses	agree	LOWER
Favorable	⇨	refuses	disagree	HIGHER
Unfavorable	⇨	consents	disagree	HIGHER

Threshold is:

LOWER with agreement

HIGHER with disagreement

- Roth LH, Meisel A, Lidz CW. Tests of competency to consent to treatment. Am J Psychiatry. 1977;134(3):279-84.
- Appelbaum PS. Clinical practice. Assessment of patients' competence to consent to treatment. N Engl J Med. 2007;357(18):1834-40.

Relational autonomy

- Autonomy is a socially constituted capacity; it can be compromised and may need to be assisted.
- A relational view of autonomy requires:
  - Recognition of a person's humanity (dignity).
  - Obligation to try to understand a person's subjective perspective.
  - Obligation to try to shift a person's perspective and promote her capacities for autonomy (enable her to reevaluate and revise her perspective and her reasons for acting).

Mackenzie C. Relational autonomy, normative authority and perfectionism. J Social Philos 2008;39(4):512-533.

Ethics: persuasion is justified by the duty to good and avoid harm

(beneficence & nonmaleficence)

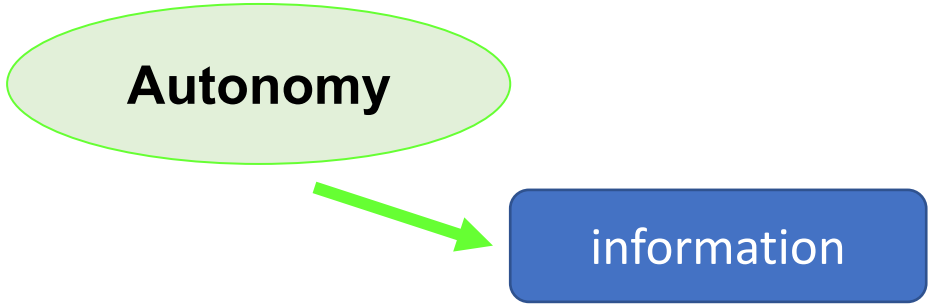
Respect for **autonomy** is very important …

… but the Hippocratic commitment to **beneficence** creates a duty *to try* to persuade patients to pursue the medical course of action that physicians believe is most beneficial and least harmful.

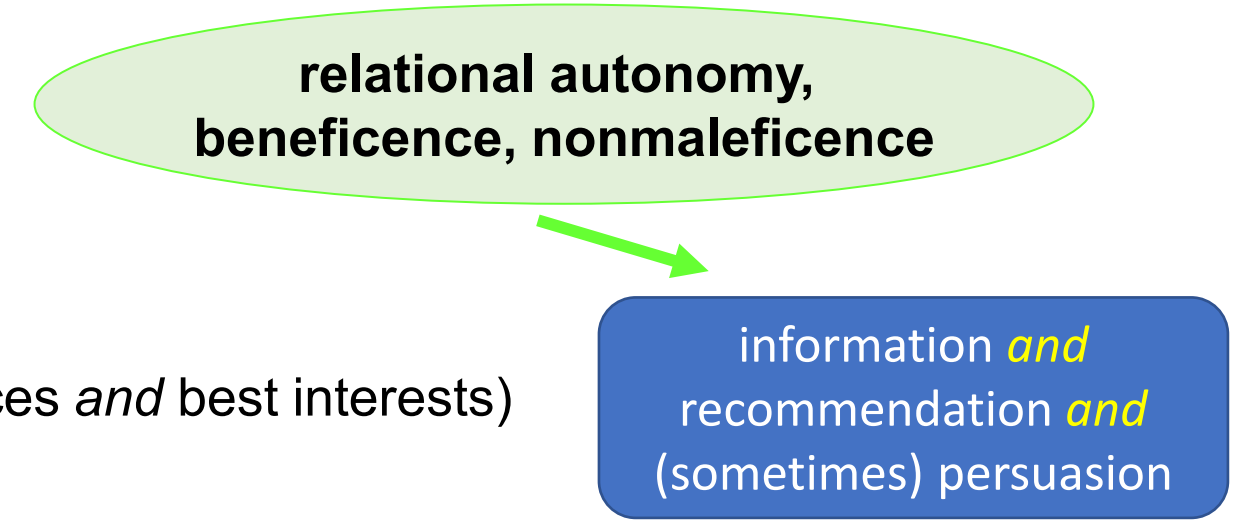
Gillon R. Defending the four principles approach as a good basis for good medical practice and therefore for good medical ethics. J Med Ethics. 2015 Jan;41(1):111-6.

‘autonomy’ vs. ‘relational autonomy’

- Patient: autonomous
  - Respects patient’s preferences & choices (self-determination)



- Patient: interdependent
  - Respects patient’s preferences & choices (self-determination)
  - Recognizes patient’s needs
  - Attends to patient’s overall good (preferences *and* best interests)



Example of relational autonomy and persuasion:

- British Medical Association: Core Ethics Guidance (2.2 Patient autonomy and choice)

Quite categorical

Refusal or rejection of medical advice

- **Can competent adults reject medical advice and treatment?**
  - Competent adult patients are entitled to reject treatment options. Their reasons do not have to be sound or rational; indeed, they do not have to give any reasons at all. Where a competent adult refuses treatment, a healthcare professional is bound to respect that refusal ….

- **Can competent adult patients refuse hospital admission?**
  - Adult patients with mental capacity cannot be hospitalised against their will unless they are sectioned under mental health legislation.
  - In such circumstances it is important to explore the reasons for their refusal, to identify whether they are acting under pressure, and to ensure that their decision is not based on a misunderstanding or incorrect information and that they understand the implications of the decision.
  - Sometimes patients will change their mind if they are provided with additional or more accurate information, support, and encouragement, but, if they continue to refuse, that must be respected.

More nuanced

Persuasion

https://www.bma.org.uk/media/iurldd5z/core-ethics-guidance.pdf

framework of practical wisdom in healthcare

Practical wisdom (drawing from Aristotelian & Thomistic traditions)

- Aims at an end or goal (*telos*)
  - identifies good means to good ends
- Perceptive
- Ethical: interdependent with other virtues and principles (person-centered)
- Deliberative
- Develops through teaching, narrative, role-models, experience, reflection

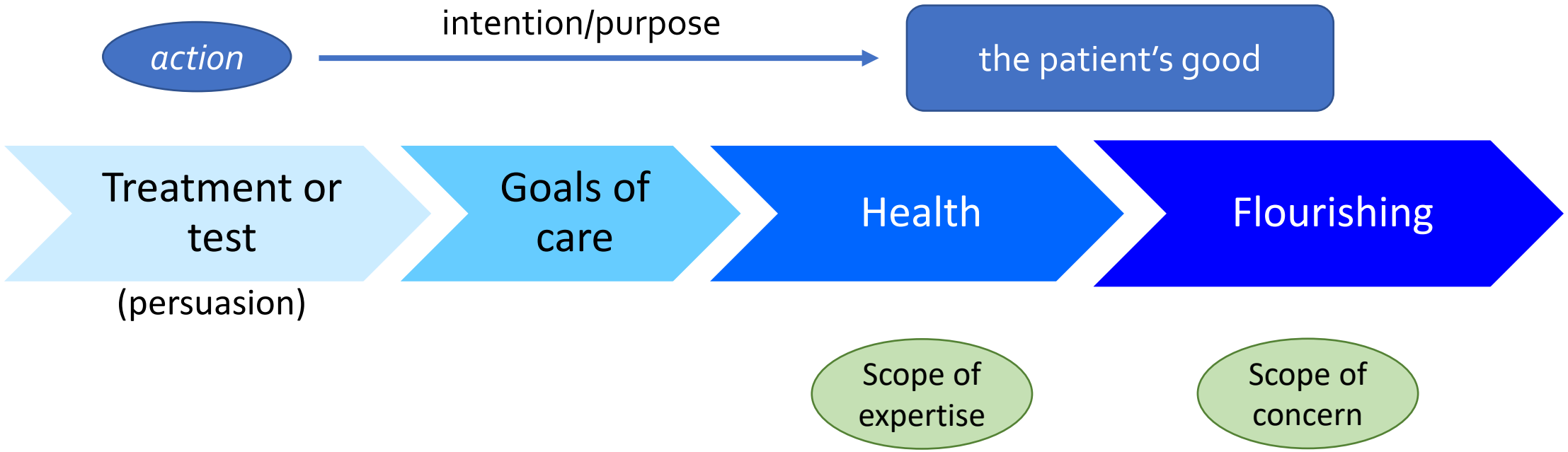
A framework for practical wisdom

(drawing from Aristotelian & Thomistic traditions)

1. Pursuit of worthwhile **ends** derived from a concept of human flourishing — *goals*
2. Accurate **perception of concrete circumstances** detailing the specific practical situation — *perception & context*
3. Commitment to **moral virtues and principles** that are interdependent and form an integrated moral framework — *ethics*
4. **Deliberation** that integrates ends (goals), concrete circumstances, and moral virtues and principles — *deliberation*
5. **Motivation** to act in order to achieve the conclusions reached by such deliberation. — *motivation*

Kaldjian LC. *Practicing Medicine and Ethics: Integrating Wisdom, Conscience, and Goals of Care*. New York, NY: Cambridge Univ Pr, 2014.

Goals: teleology of goal-oriented healthcare



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- Kaldjian LC. Wisdom in medical decision making. In: Sternberg R., Glűck J, editors. *Handbook of Wisdom*, 2nd ed. Cambridge Univ Pr, 2019, pp. 698-720.
- Kaldjian LC. Clarifying core content of goals of care discussions. *J Gen Intern Med* 2020;35(3):913-915.

‘the patient’s good’

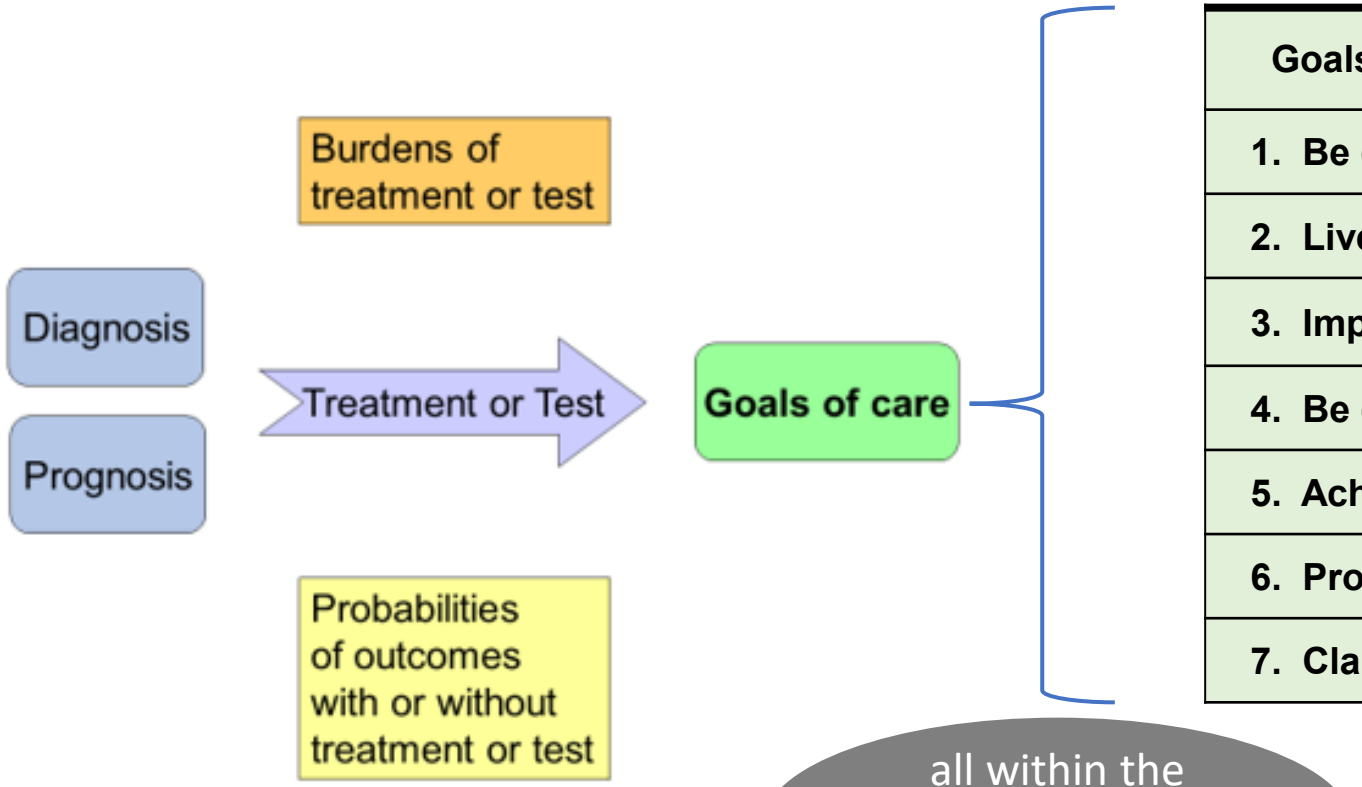
➢ The first principle of medical ethics (its guiding end).

Four components:

- Medical good
  - return of physiological function of mind and body, the relief of pain and suffering
- Personal good
  - what the patient perceives as her own good
- Human good
  - the good for humans as humans (respect for dignity, rationality, wellbeing, etc.)
- Spiritual good
  - the highest good; an ultimate end; beyond material well-being

Pellegrino ED. The internal morality of clinical medicine: a paradigm for the ethics of the helping and healing professions. *J Med Philos* 2001;26(6):559-79.

Context: dimensions of medical decision making and specifying goals of care



Goals of Care
1. Be cured
2. Live longer
3. Improve or maintain function/quality of life/independence
4. Be comfortable
5. Achieve life goals
6. Provide support for family/caregiver
7. Clarify diagnosis or prognosis

- Kaldjian et al. Goals of care toward the end of life: a structured literature review. American Journal of Hospice & Palliative Medicine 2009;25:501-511.
- Haberle et al. Goals of care among hospitalized patients: a validation study. American Journal of Hospice and Palliative Medicine 2011;28:335-341.
- Kaldjian LC. Clarifying core content of goals of care discussions. J Gen Intern Med 2020;35(3):913-915.

Ethics: an integrated framework of virtues and principles

The Moral Event				
Element	**Agent**	Act	Circumstance	Consequence
Theory	**Virtue**	Principles	Particularizing theories	Utilitarianism
Foci	• **Character** • **Caring** • **Intention** • **Accountability**	• Right • Good • Duty • Rule	• Caring for *this* person or group in *this* place, time • Narrative • Culture	• Outcomes • Harms/goods • Pain/pleasure • Utility calculus

Edmund D. Pellegrino. Toward a Virtue-Based Normative Ethics for the Health Professions. *Kennedy Institute of Ethics Journal* 1995;5:253-277 (p. 271 – Figure 1)

Drawing from practical wisdom: a goal-oriented, perceptive, virtue ethics-based, deliberative approach to persuasion in healthcare

Respectful persuasion

- proceeding carefully

Inform – recommend – persuade – manipulate - coerce

To lessen the risk of misunderstanding in this difficult & dangerous terrain:

1. give goal-oriented reasons for the patient to consider.
2. seek to understand the patient's context and perspective.
3. explain the motivation (patient's best interests, conscientious practice).
4. acknowledge the patient's freedom to disagree and refuse.

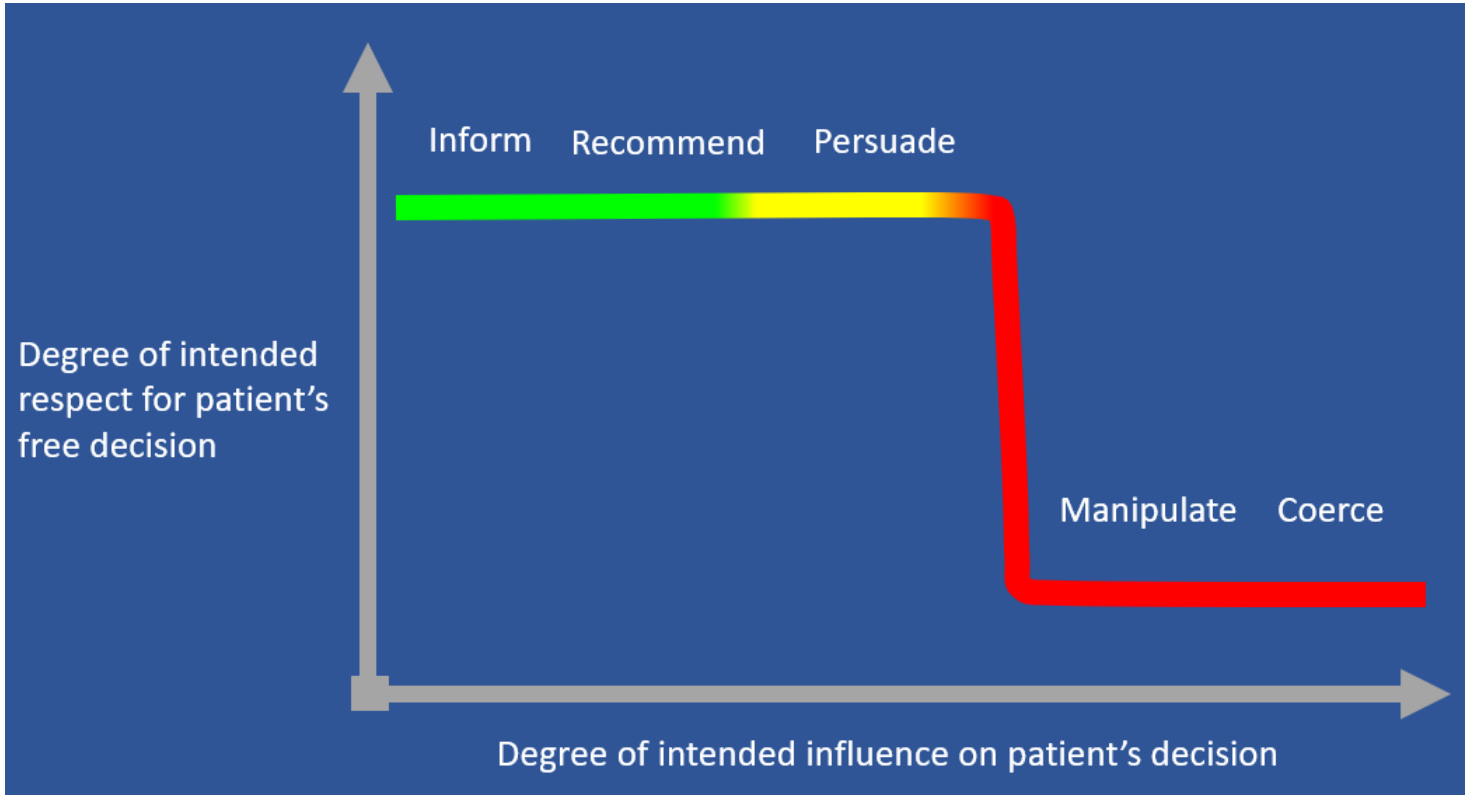
Respectful persuasion can *promotes* autonomy and relationship by giving the patient more opportunity to think about their beliefs, values, and goals with someone who cares.

Practical wisdom

- *goals*
- *perception & context*
- *ethics*
- *deliberation*
- *motivation*

Different degrees of physician influence in shared decision making

- Appropriate
  - Provide information
  - Make a recommendation
  - At times attempt to persuade
- *Inappropriate*
  - Attempt to manipulate
  - Attempt to coerce



Kaldjian LC. To inform, recommend, and sometimes persuade: the ethics of physician influence in shared decision making. *Southern Medical Journal* 2022;115(4):244-246.

If we think we should sometimes try to persuade, we need many virtues to do it ethically

- Benevolence
- Compassion
- Respectfulness
- Humility
- Altruism
- Self-control
- Patience
- Honesty
- Competence
- Trustworthiness
- Practical wisdom
- Integrity

In summary,

- Respectful attempts at persuasion are sometimes ethically appropriate.

- The ethical use of persuasion assumes:
  - relational view of autonomy
  - motivated by a respect for the patient as a person and an objective clinical assessment guided by duties of beneficence and nonmaleficence
  - communicates respect through listening and transparency
  - focused on the patient's good

- Many virtues are needed to make persuasion a positive experience, (regardless of whether or not a patient changes his/her mind).

Discussion