General practice ethics: Overdiagnosis, harm and paternalism

Wendy Rogers, Yishai Mintzker

This is the fourth in a six-part series on general practice ethics. Cases from practice are used to trigger reflection on common ethical issues where the best course of action may not immediately be apparent. The case presented in this article is an illustrative compilation and is not based on specific individuals. In the first article, the authors provided a suggested framework for considering the ethical issues to assist practitioners in reaching an ethically justifiable decision.

Case

James Trantor, 45 years of age, is a generally anxious man and has chronic conditions including type 2 diabetes and ischaemic heart disease. Recently, he had an episode of right facial numbness. Dr Kim, his general practitioner (GP), sent him for a thorough work-up. No specific cause was found for the numbness, which resolved over a period of weeks. However, duplex sonography of the carotid arteries revealed a 6 mm nodule in the left thyroid lobe. There were no ultrasound features suggestive of thyroid cancer. What, if anything, should Dr Kim tell Mr Trantor regarding the nodule?

Identifying the ethical problem

Thyroid nodules, most of which are benign, are found in up to 67% of people on ultrasound.[1] Only some of these small nodules are cancerous. Even if cancer is confirmed, many of the most common types (papillary cancer) do not follow an aggressive course and are unlikely to cause harm to the patient if left untreated. Detection and treatment of thyroid nodules raises concerns about overdiagnosis.[1] If there are no other risk factors for malignancy, biopsy is recommended only for nodules >10 mm in size.[2] Thus, according to guidelines, Dr Kim can advise Mr Trantor against further investigation of the lesion. However, Dr Kim knows that once Mr Trantor hears about the possibility of cancer, no matter how remote, he will be extremely anxious and want further investigation.

Dr Kim is unsure of the right thing to do. This case raises tensions between respecting the patient's autonomy and acting in the patient's best interests, as well as questions about resource allocation. As with previous cases, we start with the patient's perspective, followed by a discussion of the practitioner's obligations and duties.[3]

The patient's perspective

Mr Trantor is very anxious about his health. He prefers to be safe rather than sorry, and to undertake any actions that might prevent the risk of future illness, especially cancer. He has looked at the ultrasound report and knows there is something abnormal. In Mr Trantor's view, Dr Kim is a very valuable adviser, but he himself should make decisions about his healthcare, taking into account Dr Kim's advice. Mr Trantor's thinking is influenced by the example of his neighbour, who was diagnosed with thyroid cancer a few years ago. She made a full recovery after surgery and is free of the disease; her example makes him hope for a similar cancer-free outcome.

The practitioner's duties and obligations

Dr Kim's primary duty is to act in the best interests of his patient. He also aims to avoid preventable harm, respect Mr Trantor's decisions regarding his own healthcare, foster the relationship with his patient and be responsible in his use of healthcare resources. The challenge in this case lies in the divergence between what Dr Kim thinks is in Mr Trantor's best interests, in terms of likely benefits and harms, and Mr Trantor's own views. Dr Kim is worried about a number of potential harms if he tells Mr Trantor there is even a very low risk of cancer. Mr Trantor will be extremely anxious and wish to have the nodule investigated. This investigation may entail physical harm, as well as the time and cost of attending for diagnostic procedures, anxiety while waiting for results, and any side effects or complications from treatment. In Dr Kim's view, although it is possible that further investigation may reveal a potentially malignant cancer, the risk of harm associated with Mr Trantor's anxiety and comorbidities, the very low chance of benefit, and the high likelihood of overdiagnosis do not justify further work-up in this case.[2] Dr Kim calls an endocrinologist to verify that a conservative action (yearly ultrasound without biopsy) would be the recommended practice.

Despite the potential for harm, Dr Kim feels uncomfortable at the thought of acting paternalistically by taking the decision away from Mr Trantor. It is widely accepted that individuals are the best judge of their own interests, and should be allowed to make decisions that affect their own welfare, as long as others are not harmed. However, even with a general commitment to respecting a patient's autonomy, general practice often involves degrees of paternalism,[4] for example, when GPs suggest a single course of action rather than offering patients a comprehensive list of options. Decisions such as these may be driven by time pressures or considerations of cost, and may be justifiable, but whenever GPs withhold information or make decisions for patients without consulting them, on the grounds of the patient's best interest, they are acting paternalistically. Appealing to patients' best interests rarely, if ever, justifies overriding the decisions of autonomous patients, unless the patient has clearly indicated they prefer the doctor to make the decision for them.

In some circumstances, extreme anxiety may make a person unable to make autonomous decisions. Dr Kim usually supports Mr Trantor in making his own decisions by providing him with information about healthcare options, discussing these options and offering advice. He knows Mr Trantor expects him to be honest and would be upset at the thought of his GP intentionally concealing information from him.

While Dr Kim's primary obligation is to his patient, he also has a duty to not waste healthcare resources. Using resources such as his own time, specialist consultations, imaging and surgical treatment in cases of likely overdiagnosis diverts these resources away from potentially more urgent and more effective healthcare.

Potential actions and their consequences

One option is for Dr Kim to withhold information from Mr Trantor about the malignant potential of the lesion. This would spare Mr Trantor from anxiety, and avoid costs and burdens of investigation and treatment. But, as Mr Trantor is capable of making autonomous decisions, this would be unjustifiably paternalistic. Hiding information would also be a serious breach of trust in the GP–patient relationship. Patients trust doctors to be honest and open in their communication. Violating this trust can compromise the relationship and undermine the perceived reliability of any future advice from the GP.

The alternative is to tell the patient of the lesion and its possible consequences. This option preserves trust, respects the patient's right to make his own decisions and is consistent with patient-centred care. However, Dr Kim may wish to consider how he frames this information. For example, he may wish to start with the advice from the endocrinologist for annual examinations, or suggest a second opinion prior to making a decision regarding the biopsy. He may wish to explain overdiagnosis and its harms, perhaps using prostate cancer as an example. He may wish to refer to previous decisions where Mr Trantor accepted his advice, or where they reached a negotiated decision.

Conclusion

Dr Kim elected to respect Mr Trantor's autonomy and preserve the trust in their relationship rather than act paternalistically. This was despite his concerns about the likely harms to Mr Trantor and the potentially biasing effect of anxiety on his decision making. In general, it is not justifiable to override a patient's autonomy to prevent harm to them. The situation is less clear when trying to balance the welfare of individual patients against population-level costs. Overdiagnosis creates considerable challenges in managing these issues. The harms of testing are less clear to patients[5] than to physicians.[6] This imbalance is aggravated by social, systemic and legal factors that tolerate overdiagnosis but not underdiagnosis.[7,8] In our view, addressing these problems requires social, systemic and legal responses. Systemic responses, such as public debate about overdiagnosis or limits on Medicare rebates for certain tests, have the potential to set the parameters within which GPs help individual patients to understand the potential harms and benefits of diagnostic interventions.

Authors

Wendy Rogers BMBS, BA (Hons), PhD, MRCGP, FRACGP, Professor of Clinical Ethics, and ARC Future Fellow, Department of Philosophy and Department of Clinical Medicine, Macquarie University, Sydney, NSW. wendy.rogers@mq.edu

Yishai Mintzker MD, Clinical Instructor, Sackler Faculty of Medicine, Tel Aviv University, Tel Aviv, Israel

Competing interests: None.

Provenance and peer review: Commissioned, externally peer reviewed.

References

1. Brito JP, Davies L, Zeballos-Palacios C, Morris JC, Montori VM. Papillary lesions of indolent course: Reducing the overdiagnosis of indolent papillary thyroid cancer and unnecessary treatment. Future Oncol 2014;10:1–4.
2. Gharib H, Papini E, Paschke R, et al. American Association of Clinical Endocrinologists, Associazione Medici Endocrinologi, and European Thyroid Association Medical guidelines for clinical practice for the diagnosis and management of thyroid nodules: Executive summary of recommendations. Endocr Pract 2010;16:468–75.
3. Rogers WA, Braunack-Mayer AJ. General practice ethics: Inter-professional responsibilities. Aust Fam Physician 2015;44:519–22.
4. McKinstry B. Paternalism and the doctor–patient relationship in general practice. Br J Gen Pract 1992;42:340–42.
5. Waller J, Douglas E, Whitaker KL, Wardle J. Women's responses to information about overdiagnosis in the UK breast cancer screening programme: A qualitative study. BMJ Open 2013;3:e002703.
6. Gøtzsche PC, Jørgensen KJ. Screening for breast cancer with mammography. Cochrane Database Syst Rev 2013;6:CD001877.
7. Woloshin S, Schwartz LM. How a charity oversells mammography. BMJ 2012;345:e5132.
8. Hoffman JR, Kanzaria HK. Intolerance of error and culture of blame drive medical excess. BMJ 2014;349:g5702.

correspondence **afp@racgp.org.au**