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A PATIENT'S TRUST IN THEIR DOCTOR ON THE FRAMEWORK OF MILLER'S FOUR SENSES OF AUTONOMY

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REZUMAT. **Încrederea pacientului în medic din perspectiva celor patru sensuri ale autonomiei (Miller, 1981).** Atât încrederea cât şi autonomia sunt principii de bază pentru o practică medicală etică. Încrederea este îndeosebi importantă în depăşirea distanţei dintre dovezi ştiinţifice şi practică. Articolul de faţă argumentează faptul că, deşi centrală îngrijirii medicale moderne, autonomia nu poate fi păstrată întotdeauna în situaţii care presupun încredere. Oamenii au sau nu au încredere fără ca ei să fie în mod necesar autonomi. Acest fapt are loc chiar şi în situaţia în care nicio regulă morală nu este violată de medic sau pacient.

Cuvinte cheie: *încredere, autonomie, etică medicală*

ABSTRACT. **A Patient's Trust in Their Doctor on the Framework of Miller's Four Senses of Autonomy.** Both trust in the doctor-patient relationship and respect for patient autonomy are basic principles for an ethical medical practice. Trust is particularly important in filling in the gap between scientific evidence and clinical practice. This is so because patient trust is associated with patient compliance with therapeutic recommendations. This paper argues that although central to modern medical care, autonomy cannot always be preserved in situations dealing with trust. People trust or distrust without being necessarily autonomous. This happens even if no moral rule is violated by either the doctor or patient.

Keywords: *trust, autonomy, medical ethics*

Introduction

The evidence-practice gap in the treatment of chronic illnesses has been attributed to broad socio-economic factors as well as to individual doctor and patient factors.[1, 2] Amongst various factors that are responsible for this gap, mutual trust in the doctor-patient relationship plays an important role [3-5].

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This is so because mutual trust is at the core of the doctor-patient relationship, which in turn, is the vehicle for medical care that may improve or maintain the patients' health. The significance of a patient's trust in their doctor is well recognized and is associated with the patients' willingness to seek care, to disclose symptoms and to be compliant with therapeutic recommendations. [6-8] Although a doctor'strust in their patients is less discussed and studied in the literature [8, 9] it plays a significant role in chronic care, because in chronic care doctors have to transfer significant responsibilities associated with self-care to their patients. In addition, a willingness to trust patients is a significant ethical step in recognizing the patient as a person with agency rather than merely a passive recipient of care. [8] This recognition of the patients' agency is partial respect for patient autonomy as well as for a patient's capacity to assume responsibility for their health.

Autonomy is regarded as one of the key concepts in the doctor-patient relationship and in the ethical standard of care. Many philosophers have insisted that the concept of a person as an autonomous agent must play a key role in ethical theory. From this position there are ways to resist coercion and its softer variations like manipulation and undue influence. In biomedical ethics, the concept of a person as an autonomous agent makes it mandatory for health professionals to consider the values of patients and to not let their own values influence decisions about treatment [10].

However, despite the fact that all parties agree that trust and autonomy are important, there is little knowledge over the relationship between the two. Aspects of autonomy as a conscientious choice seem problematic in light of implicit trust because trust does not rely on rationally considering alternatives [11]. Taking into account the basic structure of trusting as a four key elements (e.g. I trust you to do X) gives more insight into where autonomy lies in this process [12]. Trust is defined in many ways, and researchers agree that it's a complex construct. Most of them agree that trust is the optimistic acceptance of a vulnerable situation in which the truster believes the trustee will care for the truster's interests [13]. Therefore, there is no need for trust in the absence of vulnerability [14, 15]. This brings us to the discussion about what trust does to patient autonomy. Is trust an exercise of autonomy, a way of expressing one's willingness to choose, or does it mean renounce to one's autonomy in the favor of another who is supposed to see one's best interests?

A patient's trust in their doctors

Patient trust is important for a good doctor-patient relationship. Patient trust can ensure a feeling of safety for the patient and give them the opportunity to openly speak of their problems, even if they are not usually shared with

others. Trust can be also understood as a prerequisite necessary for the patient to give consent for physical examinations, samples to be taken or willingly get treatment. In the past years patient trust has become a research interest of a number of studies on the doctor-patient relationship in health care. When one trusts, they become vulnerable and too some extent dependent on the good will of others. Patients need, one way or another, to trust doctors if they want to benefit from doctors' skills and knowledge. In medical ethics, maintaining and further cultivating trust is consequently a defining feature of the patient-doctor relationship [11].

From a psychological point of view, trust might be considered the most important feature for the development and maintenance of well-functioning relationships. Several major psychological theories, like the attachment theory [16] and Erikson's theory of psychosocial development [17], start from the premise that higher levels of trust in early significant relationships (e.g. parents or other attachment figures) lead to better functioning relationships in adulthood. Taking into account the importance of trust in relationships across the lifespan, little is known about how and why interpersonal trust is built, maintained and changes when betrayed.

Historically, interpersonal trust has been conceptualized in two ways. The person-centered view states that trust entails general beliefs about the degree to which other people are likely to be reliable or helpful. According to the dyadic (interpersonal) perspective, trust is a psychological state of a truster toward a specific trustee. The truster needs the trustee's cooperation in order to attain important outcomes or resources. Trust involves three components (e.g., ''I trust you to do X'') [18] which encompasses an interaction particularly difficult to study. A person can be trustful in some situations, but not in others, towards some doctors but not others, and so on. Thus, trust is a function of the self (I, the truster), the specific partner (you, the trustee) and the specific stake in the given situation (to do X). Trust-relevant situations typically activate two main processes: feelings of vulnerability and expectations about how the trustee is likely to behave [12].

Previous research on trust has been conducted in dispositional and interpersonal frameworks. This work has revealed that insecure individuals, with lower self-esteem and poor differentiated self-concepts, (i.e. poorly tied together) trust their relationship partners less [19]. Interpersonally oriented research has indicated that trust tends to be higher when individuals believe their partners have more benevolent intentions. Other research has also suggested that the building of trust involves a process of reduction in uncertainty [12]. Four core principles of interpersonal trust get revealed from a review of the interpersonal trust literature[19]. First, individuals appraise the degree to which they can trust

their partners by observing a partner's decision that goes against their personal interest and support the best interests of the trustor or the relationship. Second, situations when trust is appraised often occur naturally and unintentionally during day to day life. According to the situational circumstances, however, individuals may enter or create such situations to test whether their current level of confidence in a partner is secured. Third, individual differences in attachment styles or self-esteem influence fluctuations in trust over time in interpersonal relationships. Those who are more securely attached, have better self-esteem and are generally more likely to experience trust as well as improvements in trust across time. Fourth, neither the degree nor the fluctuations of trust in relationships can be thoroughly understood without considering the dispositions and actions of both truster and trustee, especially in situations where trust gets diagnosed [19].

From a normative point of view, seven observations with widespread agreement about trust can be found in the literature [20]: (1) Trust encompasses some degree of risk (those who trust, run the risk of allowing those they trust near things that they care about). (2) The truster give the trustees some discretion as to how their trust should be fulfilled and are willing to give up immediate control of whether and how this has been done. (3) Trust makes co-operation easier and allows people to inhabit a safer world in which they need not plan for every possibility. (4) Trust and distrust are self-confirming (those who have trust tend to favorably interpret the behaviors of those they trust and may also encourage trustworthy behavior). (5) The absence of trust does not necessarily imply distrust (there can be a neutral stance of neither trust nor distrust). (6) Trust cannot be willed (although people are sometimes able to make themselves act as though they trust someone). (7) The value of trust is not depleted by its instrumentality for cooperative relations[20].

In health care contexts, interpersonal trust is now usually conceptualized as some sort of positive expectation about the intentions and actions of the trustee. In particular, those who trust expect the trusted person(s) to behave with goodwill towards them and with competence in the domain(s) in which they are trusted. The placing of trust may involve a "leap of faith," but people who trust somehow decide to do so. The expectations held by the people in trust may sometimes prove unrealistic and may not be always welcome by the trustees. People who trust make themselves somehow vulnerable to those they trust. Their expectations of good intentions and competence and the discretion that they offer to those whom they trust, set up or exacerbate a difference in power that makes them vulnerable to abuse by opportunistic behavior [20].

It is commonly accepted that one individual may trust another in some respects but not others. For instance, a patient who judges a general practitioner to be excellent from a technical point of view but cold in his/her way of communicating,

might tend to trust him/her with respect to the treatment administered for thierillness than with respect to the care of their psychological well-being. Trust is especially valued, particularly as a way of allowing people to get on and cooperate in a world without any guarantees.

However, trust isn't inevitably "a good thing" [20]. While trust may enable valued things to thrive, it may also support immoral activities such as exploitation and conspiracy to harm, in which case it should not be encouraged [21]. It's difficult to provide a definitive set of criteria in order to appraise when trust is justified and how much "good judgment" is needed to place trust wisely in the context of health care. However, a number of ways in which we might distinguish justified from unjustified trust might be considered. As a possible test for the moral decency of trust relationships is the consideration of the ability of these relationships "to survive awareness by each party to the relationship of what the other relies on in the first place to ensure their continued trustworthiness or trustingness"(p. 259) [21]. A trustworthy relationship is morally wrong if "either party relies on qualities in the other which would be weakened by the knowledge that the other relies on them" (p. 256) [21]. Wrong handling of trust includes the misuse of discretionary powers by the trustee, either by taking too much risk or by failing to use discretion at all. It also includes excessive verifications of the actions of the trustee by the truster or the truster's failed to check at all because of an exaggerated fear that any such verification would insult the trustee [22]. Threats to trust include inflexible unforgiving on the part of the truster and exaggerated sensitivity to criticism on the part of the trustee [21]. The notion of informed or conditional trust have received more attention lately, which emphasizes the distinction between trust as well as both enforced dependency and vague hope [23].

Autonomy and trust

The notion of autonomy in bioethics relies on the individual capacity for self-determination. It results in a principle of respect for autonomy for each person. Some authors draw a distinction between autonomy as a capacity of individuals and autonomy as a feature of actions or decisions. It follows that a person who has the capacity for autonomy may act in a nonautonomous manner on certain occasions, like those encompassing coercion. Autonomy is a basic right of liberal individualism. In social philosophy, individual autonomy might, at some level, conflict with the community's values, like the good of society as a whole, caring for others. In medical bioethics, a patient's right to autonomy might come in conflict with physician's obligation to benefit his/her patients [24].

In medical ethics, considering the person as an autonomous agent makes it mandatory for health professionals to respect a patient's value and not to decide about treatments according to a physician's own values. Using the notion of medical judgment is not always clear, and it may only be an excuse for the paternalistic attitude of "what the doctor thinks is best." This has made some authors speak about conflict between autonomy and medical judgment, although this opposition might not be as radical as it seems [10].

Because trust is a crucial feature of the interpersonal doctor-patient relationship, it's useful to analyze how trust is built and maintained with respect to the patient's autonomy. However, there is more than one conception of patient autonomy. The relationship between trust and autonomy might become clearer when taking into account the four senses of the concept proposed by Miller: autonomy as free action, autonomy as authenticity, autonomy as effective deliberation and autonomy as moral reflection [10].

Autonomy as free action encompasses an action that is voluntary and intentional [10, 24]. An action is considered voluntary if it's not the result of coercion, duress or undue influence. On the other hand, an action is intentional if it is the conscious choice of the individual. For instance, to submit or refuse to submit to medical treatment is an action. If the patient agrees to pain relief medication but is given an antibiotic, without their knowledge, the patient has voluntarily submitted to treatment, but his/her action was not at their own free will because they had no intention of receiving an antibiotic. This is the reason why the whole normative framework of informed consent strives to maintain the right to autonomy as free action. Permission given for a medical action makes the intervention voluntary. Knowledge of what treatment will be given makes it intentional [10].

From the point of view of trust, both voluntariness and intentionality become very interesting topics of discussion. For example, we can admit the existence of implicit trust, the one that relies on automatic unconscious processes,which is not the result of rationally weighting the alternatives [11]. If someone trusts his/her doctor more because that doctor is more physically attractive, one can easily argue that this kind of choice is based more on irrelevant cues, pertaining rather to expectancy-based suggestion than reason [25]. It's difficult to state that the individual is really autonomous if his/her choice is based on unconscious influence. If permission to be treated by a certain doctor makes that action voluntary, the individual might not be really autonomous, having chosen that doctor based on irrelevant cues.

If a patient finds out from a certain source that a doctor has vast experience with hip replacement, we can argue that his choice is informed and, therefore, intentional. Knowledge about the doctor makes choosing that doctor

intentional. On the other hand, if a patient chooses the doctor to do a hip replacement because that doctor is famous for having written many books about hip prosthetics, it's more difficult to separate the knowledge the patient really has about that doctor. Based on an irrelevant cue (e.g. being famous in scientific literature makes one a good orthopedic surgeon), the patient makes a choice which is neither coerced, or under duress. We might consider the suggestive influence the patient succumbed to as being an undue influence. However, we cannot argue that the doctor him/herself is to blame about consciously exercising an undue influence over their patient. Is the patient autonomous when he/she makes choices based on irrelevant cues? One way of looking at the dilemma is to see the implicit trust the patient comes forward with as the result of a conflict of interests [26]. One the one hand, it is in the interest of the doctor to pursue his/her academic career and good scientific reputation. On the other hand, there is the interest of the doctor to pursue their medical career. The reputation gained scientifically, although irrelevant for some situations, might influence patients. It's difficult to separate the degree in which a patient's autonomy, in this case, remains intact.

In the sense of authenticity, autonomy means that an action is in harmony with the person's attitudes, values, dispositions and life goals or in other words, the person is acting in his/her character [10]. In order to consider an action as "inauthentic", it should be unusual or unexpected, although important for the individual and with no apparent explanation. According to Miller's four senses of autonomy, an action or a choice is unusual for a given actor if it is different from what they would commonly do in the circumstances. If no explanation appears for an important action or the one given is highly unconvincing, then it is possible to wonder if the action is really the one that the individual wants to take. Usually, disturbances in the person's life are taken into account in order to explain inauthenticity. On the other hand, most people have mood swings that can conflict in some situations. There are still many questions about this sense of autonomy that can't really be explored here, for instance, whether there can be an authentic and sudden change of values and life plans [10].

But what if Mrs. X trusted her general practitioner GP for twenty years and, all of a sudden and with no apparent reason, she decides to switch to another male GP, far younger and inexperienced. Of course, one can argue that this is the patient's right, but is it autonomous? What if the patient started to distrust her old GP because her GP is a woman and she is angry with women in general because of her failed marriage and unfaithful husband? It's difficult to call this a rational decision and in Miller's framework about autonomy, it doesn't seem to be an autonomous one either. The feeling of distrust is brought up, again, by external circumstances to the relationship, and we can argue that

Mrs. X is not being herself. Her distrust is not related to her previous satisfaction, and she seems to have been acting under the previous disturbance of her personal life.

Autonomy as an effective deliberation happens when a person believes that he/she is in a situation that requires a decision, is fully aware of the alternatives and the consequences of each alternative, evaluates them all and makes a choice based on this evaluation. It has been suggested, for instance, that teenagers' trust in health care providers concerning mental problems is low due to fear of losing autonomy and confidentiality [27]. Even if it's, after all, a matter of degree (one can be more or less aware and careful in taking decisions), effective deliberation is distinct from authenticity and free action. A person's action can be impulsive, therefore being voluntary and intentional but not effectively deliberated. Further, a person might act authentically using of a rigid pattern of life but without effective deliberation really taking place. In medicine, there is no effective deliberation if a patient believes that the physician makes all the decisions[10]. We can add that there is no effective choice in trust if the patient believes that there is no way out but to trust that particular doctor.

In the clinical practice, the following must be kept in mind in order to do the best possible to protect a patient's active deliberation. First, the knowledge a patient needs to reach a decision about treatment or intervention is not equivalent to the doctor's information on the matter. Secondly, what makes a patient's decision nonrational, is the fragrant inconsistency with the other values of the patient or the good evidence that the patient will not persist in the decision he/she made. Third, it is true that having not experienced all the aspects of the alternatives makes effective deliberation difficult.

But what about trust and effective deliberation? When deliberating in order to reach negotiated trust, the patient needs all the alternatives [11]. If someone is to choose what private dental practice they should trust more in order to start a complicated treatment, that individual might want to deliberate on the alternatives. This means the patient should be aware of all important aspects needed in order to make that choice. For instance, the patient might not know that a relevant performance indicator exists, as in the total number of solved cases or a patient's satisfaction index that has been measured. Without knowing about the existence of such potential criteria, if the criteria are, indeed, important, there cannot be effective deliberation. It's also true that the patient might not know that some other dental practices exist in the city, so again, autonomy is not fully exerted if there isn't satisfactory knowledge of the alternatives.

Autonomy as a moral reflection encompasses a fully aware acceptance of the values one considers his/her own. In order to reach this moral awareness, one is considered to have reflected on this set of values. This makes this sense

of autonomy the most profound. It comes from a process of self-analysis, an awareness of alternative values one can choose from and the capacity to act according to them. Autonomy as moral reflection and effective deliberation are different notions. One can effectively deliberate without an explicit questioning of the values at the base of that particular choice [10].

It is likely that we trust people who share similar values [28]. This means that some people build trust by knowing that the doctor shares similar values. For instance, it's highly probable that a very religious person trusts a doctor more who is also very religious than a doctor who is an open atheist. This further complicates the matter. Should it be a moral duty for doctors to openly state their personal values, in order to preserve their patient's autonomy as a moral reflection or not? It might be possible that a person strongly believes that the doctor has more chances to cure them if that doctor is a believer, because God would surely help the medical act. In order for the patient to exert his/her autonomy in this sense, a doctor's values concerning that particular faith should be, at least in theory, known to the patient. There is a dilemma if there's a duty for the doctor to disclose these particulars in such cases. One can ask if it would it be morally wrong for the doctor to let their patient believe they share the same religious faith, if not asked otherwise. But in all this, there is doctor's autonomy as well, so these questions are not easy to answer.

Conclusion

Trust is a key element in order to fill-in the gap between evidence and practice in chronic care and medicine in general. Doctors want their patients to trust them and patients want to be able to trust their doctors and preserve their autonomy in the same time. We rely on the four basic elements of a trusting attitude: I trust you to do this [12]. In order for the person as a moral agent to be fully autonomous in Miller's framework, all the four criteria should be met: voluntariness-intentionality, authenticity, effective deliberation and moral reflection [10]. We have giving some arguments that trust is often implicit and, therefore, automatic, suggested or taken for granted [11, 25]. We don't necessarily choose to trust someone, so we are not necessarily autonomous by way of intentionality or voluntariness. We also argued that trustful and distrustful situations can arise from the loss of authenticity, creating more circumstances when someone is not necessarily autonomous when trusting the doctor. There are situations when trust is negotiated [11]. In order for an effective deliberation to take place, a patient should be aware of alternatives, but not all of alternatives or criteria for separating alternatives might be available to the patient. Again,

this might lead to negotiated trust which is not, effectively, deliberated, so it is not autonomous. Finally, moral reflection might conflict with a physician's own autonomy. If some particulars of the doctor-patient relationship make it desirable for the patient to be aware of similarities or dissimilarities in values, the patient might trust or distrust based on a moral choice which is not, in fact, autonomous per se. We conclude that although trust and autonomy are two important principles in medical practice, trust is impossible to limits on in a full autonomy framework. People often trust or distrust without being autonomous, and this situation doesn't seem to necessarily reside in a moral choice the doctor or the patient makes .

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