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Overdiagnosis, harm and paternalism

In this month's case we engage with the problem of overdiagnosis in looking at the challenges of managing anxious patients who have incidental findings of uncertain importance.

James Trantor is a generally anxious 45 year old man with chronic conditions including type II diabetes and ischaemic heart disease. Recently he had an episode of right facial numbness. Dr Kim, his general practitioner, sends him for a thorough work up. No specific cause is found for the numbness, which resolves over a period of weeks. However, duplex sonography of the carotid arteries revealed a 6 mm nodule in the left thyroid lobe. There are no ultrasound features suggestive of thyroid cancer.

What, if anything, should Dr Kim tell Mr Trantor about the nodule?

Identifying the ethical problem

Thyroid nodules, most of which are benign, are found in up to 50% of people on ultrasound. Only some of these small nodules are cancerous, and even if cancer is confirmed, many of the most common type, 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 over 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 about the right thing to do. This case raises tensions between respecting patient 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 practitioner 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 that there is something abnormal. In his view, Dr Kim is a very valuable adviser, but it is he himself who should make decisions about his health care, taking account of Dr Kim's advice. His thinking is influenced by the example of his neighbor, 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, to respect Mr Trantor's decisions about his healthcare, foster the relationship with the 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, which 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, while it is possible that further investigation will reveal a potentially malignant cancer, the risk of harms 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 Mr. Trantor's case.(2) He calls

an endocrinologist to verify that conservative action (yearly ultrasound without a biopsy) is 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 a person is the best judge of his or her own interests, and should be allowed to make decisions that affect their own welfare, so long as others are not harmed. But even with a general commitment to respecting patients' 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 like 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 interests, they act paternalistically. Appealing to patients' best interests rarely if ever justifies overriding the decisions of autonomous patients, unless the patient has clearly indicated that they prefer the doctor to make the decision for them.

In some circumstances, extreme anxiety may make a person unable to make autonomous decisions. But Dr Kim usually supports Mr Trantor to make his own decisions, by providing him with information about healthcare options, discussing these, and offering advice. He knows that Mr Trantor expects him to be honest and would be upset at the thought that his GP intentionally concealed 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 other, potentially more urgent and more effective healthcare.

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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 anxiety and avoid the 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 their 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 about 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 about 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 in which Mr Trantor accepted his advice, or where they reached a negotiated decision.

Conclusion

Dr Kim elected to respect Mr Trantor's autonomy and preserve 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 justified to override a patient's autonomy to prevent harm to that patient. The situation is less clear when we try 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, legal and systemic factors that tolerate overdiagnosis but not underdiagnosis.(7),(8) In our view, addressing these problems requires social, legal and systemic 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 understand the potential harms and benefits of diagnostic interventions.

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