

Communication patterns in the doctor–patient relationship: evaluating determinants associated with low paternalism in Mexico

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Abstract

Background Paternalism/overprotection limits communication between the healthcare professionals and patients and does not promote shared therapeutic decisions. In developed countries, communication patterns have been regulated to promote autonomy, whereas in developing countries, they reflect the physician's personal choice. The goal of this work was contribute to knowledge of communication patterns used in the clinical practice in Mexico, and identify the determinants that favor a low paternalist/autonomist doctor-patient relationship.

Methods A self-report study of communication patterns within a sample of 761 mental healthcare professionals in Central and Western Mexico was conducted. Multiple ordinal logistic regression models were performed to analyze paternalism and associated factors.

Results A high prevalence (68.7% [95% CI 60.0-70.5]) of paternalism was observed among mental healthcare professionals in Mexico. The main determinants of low paternalism/autonomism were the medical specialty (OR 1.67 [95% CI 1.16-2.40]) and the sex, whereby female physicians were more likely to explicitly share diagnoses and therapeutic strategies with patients and their families (OR 1.57 [95% CI 1.11-2.22]). A pattern of highly explicit communication was strongly associated with low paternalism/autonomism (OR 12.13 [95% CI 7.71-19.05]). Finally, a modification effect of age strata on association between communication pattern or speciality and low paternalism/autonomism was observed.

Conclusions Among mental healthcare professionals in Mexico, an elevated paternalism prevailed. Sex, medical specialty, and a pattern of open communication were closely associated with low paternalism/autonomism. Strengthening the competencies of health professionals and promoting explicit communication could contribute to achieving a transition towards a more autonomist communication in clinical practice in Mexico. The ethical implications will need to be resolved in the near future.

Background

The autonomy that clinicians must offer their patients entails the ability to judge a clinical condition without being influenced by external factors that may affect said assessment [1], thus allowing people the capacity to make a decision consistent with their values and with a critical perception of the environment in which they are developed [2]. In contrast, the pattern of communication and antagonistic attitudes toward self-determination are defined as paternalism, which is interpreted as the imposition—not coercion and even less so insult [3]—regarding diagnoses and therapeutic options under the implicit assumption that it is not possible to make shared and rational decisions with patients [4].

In this respect, an early form of self-determination and individual rights concerning healthcare were established by Kant in the seventeenth century [5]. Recently, it has been reported that the autonomy in the patient-doctor relationship is a cultural value and a cornerstone of Anglo-Saxon bioethics [6] but one that has not been implemented efficiently in poorly educated populations [7] or those with a background of social marginalization [8]. In many circumstances, offering a choice of treatment to patients accelerates emotional stress and anxiety among patients who have a particularly passive personality [9]. There are

trends that establish the benefits of elevated paternalism in populations that traditionally do not participate in clinical decisions, with the assumption that healthcare professionals can provide medical services of high ethical quality and establish greater intimacy with the family [10]. There are also positions that recognize that, in some social and clinical conditions, the autonomy of patients may be compromised [11]. In this type of situation, the belief is that the power of families and patients should be respected in terms of their autonomy, more than that of the physician and the laws that regulate this relationship [12, 13]. In this regard, we must also recognize the inequitable relationship that is established and the over-practice of power when a communication pattern is set by healthcare professionals with patients and their families who are vulnerable either because of their social status or because of their complex morbid condition [14]. Moreover, this is influenced by implicit assumptions and stereotypes [15], which determine the relationship between physician and patients.

Among patterns of ambiguous communication are inadequate responses to patients, prevalence of paternalism and dehumanization [16]. The strategies that have been proposed to eradicate them include incorporating professional skills to promote self-determination through specific training in service [17] and emphasizing competencies, the predominance of beneficence, equity in care and respect for patient's autonomy [18]. Likewise, the patients' point of view regarding their own disease is the primary approach of patient-centered medicine [19]. In this sense, healthcare professionals must take into account the perspective of their patients, including their feelings, ideas, concerns, impact and expectations [20] about their morbid condition. In all of these situations, the self-determination principle of individuals, regardless of their specific ideas must be analyzed in a globalized and plural world [21].

At the end of the day, the main goals of communication between physicians and their patients are to establish a good interpersonal relationship to facilitate the exchange of information and to allow the involvement of patients in the decision-making process [22]. In this context, we show the results of a survey on perception of communication patterns used by a selection of mental and neurological healthcare professionals in Central and Western Mexico. Although some efforts to improve the physician-patient communication have been implemented, the paternalism is still a constant in the clinical practice. This information will be useful to propose regional strategies that contribute to improving patient-centered medical care considering that self-determination must exist according to the principles of social justice.

Materials And Methods

Participants

We conducted a survey in a convenience selection of 761 mental healthcare professionals assisting children with Autism Spectrum Disorder (ASD), Intellectual Development Disorder (IDD) and Attention Deficit Hyperactivity Disorder (ADHD), in order to explore their personal and professional characteristics about communication patterns with parents of children with these disorders. We invited Psychiatrists, Psychologists, Nurses, Social Workers, as well as Residents of the Psychiatry specialty and related-healthcare areas to participate. Healthcare professionals were working in Mental, Neurological and Children's hospitals located in Mexico City (Psychiatric Hospital Fray Bernardino, National Institute of

Neurology and Neurosurgery, National Institute of Psychiatry Ramón de la Fuente Muñiz, Children's Psychiatric Hospital Dr. Juan N. Navarro). In addition, we include residents from the Medicine School at the National Autonomous University of Mexico, pediatricians from the Children's Hospital (central state of Morelos), and psychiatrists from the Psychiatric healthcare services of Mexico City and the Jalisco Institute of Mental Health. From each participating institution, an interviewer verbally invited mental healthcare professionals to participate. Once the healthcare professionals accepted to participate, we provide a questionnaire to fill out which was collected in the following two hours or the next day. The study was carried out from June 2018 to January 2019.

Questionnaire

The questionnaire included items related to the mental healthcare professional's educational level, medical specialization, questions about patient care and, a series of questions aimed at recording the participant's personal and professional characteristics. These last two sections corresponded to questions that explore personal situations of professionals, both in medical care and in their daily lives, which were used to construct the following indicators: paternalism, the attitude towards death, the communication pattern, the bioethics training courses, and religion, among others. The questions had a Likert-type response option, which allow the understanding of the level of agreement on the mental healthcare professionals with the proposed statements (strongly disagree, disagree, agree, and strongly agree). The questionnaire has been previously used in other studies within the Mexican population, under adequate internal consistency (0.76) through the Kuder-Richardson test [23].

Primary outcome

Paternalism (dependent variable) was constructed based on the following questions:

a.

The confidence that you want to inspire in your patients diagnosed with a chronic disease is: 1- Confidence and calm, 2- A combative spirit, 3- An active participation, 4- I do not intervene in the mood of my patients.

b.

The best hope we can give to a parent with a child diagnosed with IDD/ASD is to make him/her feel that life continues as normal as possible.

c.

Emotional distress does very little; therefore, I try to assist the children's parents as much as possible by avoiding feelings such as sadness, grief or anguish.

d.

Enthusiasm should be given to encourage parents, even if it means telling a lie.

e.

We create reality to others. For example, if a parent with a son diagnosed with an incurable disease sees me in calm, the parent would think, "If the physician is in calm, the situation might not be so bad".

f.

When I see someone "crestfallen", my first reaction is to try to distract that person to encourage him/her, even when the subject changes.

- g. Talking about painful topics only makes the pain worse.
- h. When I have a problem, I try to conceal it from my loved ones.
- i. I was always taught to avoid causing someone's distress.

Paternalism was defined as the attitude and behavior of the mental healthcare professional that imposes their outlooks and decisions on their patients, limiting their autonomy under the statement that they do so for the benefit of their patients or themselves. Based on their distribution (tertiles), the categories of the paternalism were high paternalism/overprotection (T1, reference category), moderate paternalism (T2) and low paternalism/autonomism (T3). Paternalism [24, 25] has been associated with attitudes of overprotection that are commonly understood as an infringement of the freedom and autonomy of a person with a beneficent or protective purpose. In the field of healthcare, paternalism includes the confrontation between individual personal needs and human rights (autonomism) on one hand, and the social overprotection and medical care, on the other. Family members also usually approach their sons or daughters from their perspective, wanting the best for their loved ones but sometimes they underestimate their capacity and desires [26].

Independent variables

Predictors analyzed of paternalism were: a) communication pattern, which was defined in relation to its communication with the parents of children diagnosed with ASD, IDD and ADHD, regarding their diagnosis, prognosis and treatment; b) Value to the truth, it refers to the value provided by the healthcare professional in the communication held with the parents, that is, the correspondence between what the healthcare professional knows about the situation of the parents and what the healthcare professional tells them; c) Attitude towards death, it refers to the willingness of the healthcare professional to adapt, react and act in situations related to death; d) Training in bioethics, which refers to courses related to medical ethics that the healthcare professional has received throughout his/her professional training and; e) religion (believer and not believer).

This study included also knowledge indicators on ASD, IDD, and ADHD as predictors of the paternalism. To construct these indicators, three clinical vignettes were presented in the last section of the questionnaire. Clinical vignettes were presented as cases or scenarios of people with a specific age and any of the previously mentioned disorders, and accompanied by different questions about diagnosis, prognosis and treatment. Once the case was presented, the qualification of the answers was carried out, taking into account those that were adequately answered, considering that the battery of vignettes was developed by a group of experts in paidopsychiatry. Positive attitude and high knowledge about ADHD and IDD were considered with three or four correct answers; intermediate knowledge with 2 correct questions; and low knowledge when they had one or no correct answer. In the case of ASD, the cut-off points were: Positive attitude and high knowledge if they had 3 correct answers; middle knowledge with 2 correct questions; and low knowledge when they had one or no correct answer.

Statistical analysis

A descriptive analysis of the study population was carried out. For comparisons, we used chi-square tests. To evaluate the association between the attributes of communication and a low paternalism/autonomism, a logistic ordinal multivariate model was constructed. Odds Ratio (OR) and 95% Confidence Interval (CI) were obtained. The following variables were considered as possible predictors of a low paternalism/autonomism: a) age (categorized as 43–76 years as the reference category, 30–42 years and 19–29 years), b) sex, c) specialty (no, yes), d) value to the truth (low, moderate, high), e) communication pattern (hide, partial communication, open communication), f) religion (not believer, believer), g) attitude towards death (low, moderate, high), h) family member diagnosed with some type of IDD/ASD (yes, no), i) bioethics courses (none, ≥ 1), and j) knowledge about ASD, IDD and ADHD (low knowledge, middle knowledge, and positive attitude and high knowledge).

To assess the joint effects of age and communication patterns or speciality on the possibility to have a low paternalism/autonomism, we created the following interaction terms: a) age (tertiles) and communication patterns (hide, partial communication and open communication); b) age (tertiles) and speciality (yes, no). The reference category for each interaction was when there was an open communication and young age and when professionals have specialty and young age. Ordinal regression models were also adjusted by sex, religion, value to the truth, participant institutions (medical facilities/universities), and bioethics courses. Finally, the Stata 14 program was used for all statistical analyses.

Results

The paternalism prevailed in the context of mental healthcare professionals in Mexico. That is, 68.7% (95% CI 60.1–70.5) of the evaluated population presented a considerable degree of paternalism (moderate and high). This fact was accompanied with 66.5% (95% CI 63.0–69.8) of mental healthcare professionals reporting that they hid some information from their patients. Consistently, the perceived value to the truth was low at 50.3% of the participants (95% CI 46.7–53.9), as seen in Table 1. Likewise, among mental healthcare professionals in Central and Western Mexico, there was low knowledge regarding IDD (41.7% [95% CI 38.1–45.3]) and ADHD (38.9% [95% CI 35.4–42.5]). Table 1 shows the frequency of communication attributes by strata of paternalism.

Table 1

Socio-demographic characteristics and communication attributes of health professionals stratified by paternalism¹, Mexico, 2018.

	Overall n = 761	High paternalism /Overprotection (T1) n = 364 (47.8%)		Moderate Paternalism (T2) n = 159 (20.9%)		Low paternalism /Autonomism (T3) n = 223 (29.3%)		
Variables	n (%) ²	n	% ²	n	% ²	n	% ²	p value ³
Age								
43–76 years	229 (30.1)	117	32.1	38	23.9	68	30.5	
30–42 years	234 (30.8)	103	28.3	53	33.3	75	33.6	
19–29 years	280 (36.8)	134	36.8	65	40.9	77	34.5	0.27
Gender								
Men	310 (40.7)	168	46.2	64	40.3	74	33.2	
Women	440 (57.8)	192	52.8	91	57.2	147	65.9	0.007
Speciality								
No	328 (43.1)	191	52.5	56	35.2	76	34.1	
Yes	425 (55.9)	172	47.3	97	61.0	146	65.5	< 0.001
Familiar with some IDD/ASD								
Yes	132 (17.4)	65	17.9	27	17.0	40	17.9	
No	630 (81.1)	296	81.3	129	81.1	179	80.3	0.97
Communication pattern								

¹ Paternalist care is an attitude in which the caregiver is considered above the care recipient, that is, a traditional “institutional” approach. The care recipients are considered to play a passive role. Based on their distribution paternalism was categorized in tertiles (T1, T2, T3). ² Not all percentages add up to 100%, due to missing values. ³ Chi2 test.

	Overall n = 761	High paternalism /Overprotection (T1) n = 364 (47.8%)	Moderate Paternalism (T2) n = 159 (20.9%)	Low paternalism /Autonomism (T3) n = 223 (29.3%)				
Hide	315 (41.4)	233	64.0	49	30.8	31	13.9	
Partial communication	191 (25.1)	74	20.3	59	37.1	58	26.0	
Open communication	230 (30.2)	52	14.3	48	30.2	129	57.9	< 0.001
Value to the truth (Truthful communication from the professional to the patient)								
Low	383 (50.3)	205	56.3	81	50.9	91	40.8	
Moderate	198 (26.0)	90	24.7	43	27.0	62	27.8	
High	163 (21.4)	65	17.9	32	20.1	66	29.6	0.003
Attitude towards death								
Low acceptance	321 (42.2)	157	43.1	65	40.9	95	42.6	
Moderate acceptance	237 (31.1)	120	33.0	46	28.9	69	30.9	
High acceptance	177 (23.3)	78	21.4	45	28.3	51	22.9	0.56
Bioethics courses								
None	235 (31.4)	114	31.3	45	28.3	70	31.4	
≥ 1	514 (68.6)	246	67.6	110	69.2	150	67.3	0.81
Religion								

¹ Paternalist care is an attitude in which the caregiver is considered above the care recipient, that is, a traditional “institutional” approach. The care recipients are considered to play a passive role. Based on their distribution paternalism was categorized in tertiles (T1, T2, T3). ² Not all percentages add up to 100%, due to missing values. ³ Chi2 test.

	Overall n = 761	High paternalism /Overprotection (T1) n = 364 (47.8%)	Moderate Paternalism (T2) n = 159 (20.9%)	Low paternalism /Autonomism (T3) n = 223 (29.3%)					
Believer	519 (68.2)	271	74.5	103	64.8	137	61.4		
Not believer	237 (31.1)	93	25.6	55	34.6	86	38.6	0.003	
Knowledge of IDD									
Low	317 (41.7)	147	40.4	67	42.1	100	44.8		
Middle	288 (37.8)	140	38.5	61	38.4	83	37.2		
Positive attitude and high knowledge	118 (15.5)	62	17.0	22	13.8	32	14.4	0.79	
Knowledge of ASD									
Low	191 (25.1)	86	23.6	40	25.2	62	27.8		
Middle	303 (39.8)	161	44.2	65	40.9	75	33.6		
Positive attitude and high knowledge	224 (29.4)	98	26.9	45	28.3	77	34.5	0.11	
Knowledge of ADHD									
Low	296 (38.9)	162	44.5	54	34.0	77	34.5		
Middle	247 (32.5)	100	27.5	56	35.2	87	39.0		
Positive attitude and high knowledge	173 (22.7)	87	23.9	40	25.2	44	19.7	0.01	
<p>¹ Paternalist care is an attitude in which the caregiver is considered above the care recipient, that is, a traditional “institutional” approach. The care recipients are considered to play a passive role. Based on their distribution paternalism was categorized in tertiles (T1, T2, T3). ² Not all percentages add up to 100%, due to missing values. ³ Chi2 test.</p>									

When we explored the predictors of low paternalism/autonomism, women were more likely to explicitly share diagnoses and therapeutic strategies with patients and their families (OR 1.57 [95% CI 1.11–2.22]) (Table 2). Likewise, another determinant of sharing-based autonomy (low paternalism) was having a

medical specialty background (OR 1.67 [95% CI 1.16–2.40]). A pattern of open communication was strongly associated with low paternalism/autonomism (OR 12.13 [95% CI 7.71–19.05]). In the case of middle knowledge of ASD, the odds of low paternalism/autonomism were 0.60 (95% CI 0.40–0.91) when compared with low knowledge about this disorder. Table 3 shows the association between attributes of communication and medical speciality background, with the low paternalism/autonomism in Mexico by age strata.

Table 2

Factors associated with low paternalism/autonomism of health professionals in Mexico, 2018.

Variables	n (%)	OR ¹	Multiple ²	
			95% CI	
Age				
43–76 years	229 (30.1)	1.0		
30–42 years	234 (30.8)	0.79	0.51	1.24
19–29 years	280 (36.8)	0.72	0.46	1.13
Gender				
Men	310 (40.7)	1.0		
Women	440 (57.8)	1.57	1.11	2.22
Speciality				
No	328 (43.1)	1.0		
Yes	425 (55.9)	1.67	1.16	2.40
Familiar with some IDD/ASD				
Yes	132 (17.4)	1.0		
No	630 (81.1)	0.98	0.64	1.50
Value to the truth (Truthful communication from the professional to the patient)				
Low	383 (50.3)	1.0		
Moderate	198 (26.0)	0.86	0.58	1.29
High	163 (21.4)	0.98	0.63	1.53

¹ Odds Ratio, ordinal logistic regression. ² Odds Ratio, adjusted by all variables included in table and participant institutions (medical facilities/universities) and religion.

		Multiple ²		
Communication pattern				
Hide	315 (41.4)	1.0		
Partial communication	191 (25.1)	4.52	2.98	6.87
Open communication	230 (30.2)	12.13	7.71	19.05
Bioethics courses				
None	235 (31.4)	1.0		
≥ 1	514 (68.6)	0.76	0.53	1.11
Knowledge of ASD				
Low	191 (25.1)	1.0		
Middle	303 (39.8)	0.60	0.40	0.91
Positive attitude and high knowledge	224 (29.4)	1.04	0.67	1.63
Knowledge of ADHD				
Low	296 (38.9)	1.0		
Middle	247 (32.5)	1.27	0.85	1.89
Positive attitude and high knowledge	173 (22.7)	0.93	0.61	1.43
Knowledge of IDD				
Low	317 (41.7)	1.0		
Middle	288 (37.8)	0.75	0.52	1.08
Positive attitude and high knowledge	118 (15.5)	0.62	0.39	1.01

¹ Odds Ratio, ordinal logistic regression. ² Odds Ratio, adjusted by all variables included in table and participant institutions (medical facilities/universities) and religion.

Table 3

Association of communication attributes and speciality with low paternalism/autonomism in health professionals: age modifying effect in Mexico, 2018.

	19–29 years			30–42 years			43–76 years			
	OR ¹	95% CI		OR ¹	95% CI		OR ¹	95% CI		p value
Variables										
Communication pattern										
Hide	1.0			1.0			1.0			
Partial communication	2.73	1.40	5.32	10.23	4.46	23.51	5.57	2.49	12.49	
Open communication	11.10	5.31	23.10	26.26	10.43	66.10	11.48	4.68	28.15	
Interaction term										
Speciality										
No	1.0			1.0			1.0			
Yes	0.94	0.54	1.63	2.87	1.24	6.64	2.03	0.98	4.21	
Interaction term										
¹ Odds Ratio adjusted by gender, familiar with some IDD/ASD, value to the truth, bioethics courses, religion, participant institutions (medical facilities/universities), and knowledge about ASD, ADHD and IDD.										

Discussion

In Mexico, physicians' self-reported patterns of communication with their patients, reflected a highly paternalistic/overprotective attitude among more than a half of the healthcare professionals studied, with a communication strategy characterized by hiding diagnostic information from patients and not promoting shared therapeutic decision-making process. That is, paternalism has been implemented for decades as a tradition in the doctor-patient relationship in Mexico and other Hispanic countries, and a patient's right to self-determination does not exist as a key principle of social justice due to this traditional hierarchical relationship. In this regard, social justice is an intrinsic value that promotes equal respect for the rights and obligations of each human being, and this must be promoted in an inter sector manner as public policy [27] in various social and economic fields, including health care field. Although paternalism is perceived negatively, an action can be paternalistic only if there is an expectation that it generates a benefit [28]. Population-wise, paternalism is a common public health practice, and the critics of interventions aimed describe them as undermining the autonomy and freedom of people [29].

In this study, women had a more autonomist attitude/low paternalism compared with men. Hamman et al. did not find significant associations between psychiatrists' attitudes toward shared decision-making process in relation to sex [30]. Other studies that have assessed the psychiatrists' sharing-based decision behaviors into practice, have reported no sex-based differences [31, 32] or higher scores for women [33]. In addition, previous research on patient-physician communication has revealed that women physicians engage in more partnership behaviors and discussion about social aspects of patients and their families and communicate a higher degree of empathy [34, 35]. Female physicians engage in communication that broadly relates to the larger life context of patients' conditions by addressing psychosocial issues through related questioning and counseling, greater use of emotional dialogue, a more positive dialogue, and a more active recruitment of patients input. When taken together, these elements comprise a pattern that can be broadly considered "patient-centered" interview [36]. Behavioral differences within the communication styles among male and female physicians would be especially important if they produce corresponding gender differences in patients' behavior directed back at them. Indeed, a separate meta-analysis which investigates the effects of physician's gender on communication with patient suggested that patient behavior largely reciprocates the gender-linked physician behavior reported in the study [36]. A growing pressure to do more in limited time may act to further amplify the communication differences among physicians of different genders. While male physicians may respond to time pressures by dispensing with socioemotional and psychosocial tasks, as suggested by Mechanic [37], female physicians may find this more difficult to do [38]. Female physicians currently record proportionately more diagnoses of a psychosocial nature than their male colleagues do [39], and the demand for diagnosis and treatment of mental healthcare problems in primary care is expected to grow. Female physicians facilitate partnership and patient participation in the medical exchange more effectively than do male physicians. Roter and Hall proposed in 1998 that the quality of the interactive process is critical to the establishment of a therapeutic relationship and that this process is related to physician gender [38].

We also found that having a medical speciality was associated with low paternalist/autonomism communication patter, however, other studies have shown that even when doctors have a specialty, the paternalistic attitude persists. A qualitative study compared the perspectives of parents and physicians with pediatric speciality regarding shared decision-making in ADHD. Results indicated that although parents and doctors share favorable opinions about the childcare process, they understand the decisions taken in a different manner. Instead of familiarizing families with all the options first, the pediatricians provide information to persuade families to accept the treatment of their choice [40]. On the contrary, and according to the findings in other settings involving physicians with speciality, families claim for exhaustive and impartial information before making decisions, even if they finally delegate the decision's responsibility to the clinician [41]. These different scenarios could be explained, in part by the quality of communication between the physician and the patient/parent, the technical language and probably by the cultural context of both [42].

Regarding the communication patterns in Mexico, the attention approach is on the self-reported relationships of mental healthcare professionals with their patients. It should be borne in mind that the pattern of physician-patient communication is influenced by the physician's knowledge on the disease and their awareness of various therapeutic strategies. Beyond those aspects, the values associated with

promoting autonomy and academic competencies to practice patient-based medicine are discussed under the assumption that healthcare professionals receive the necessary training that allows them to have an adequate management and control of unhealthy conditions. However, even in developed countries, insufficient training, for example, in the management of IDD has been reported [43, 44]. In our study, the percentage of neurologists and mental healthcare professionals with positive attitude and high knowledge about IDD was low (15.5%) while for ADHD and ASD was slightly higher (22.7% and 29.4%, respectively); this could be explained because IDD is not clearly perceived as pathological condition and, to an even lesser degree, as a public health problem.

The pattern of communication that physicians establish with their patients influences patient compliance and follow-up of the proposed therapeutic recommendations. Thus, if there is a failure in this process, it cannot be attributed exclusively to patients [45]. In patterns of open communication, the main determinant factor is the value that the doctor lays on truth, which is an acquired quality and constitutes a cultural pattern. In this context, the principle of respect for autonomy requires instructed patients adequately and appropriately about diagnoses, treatments and prognoses. However, there are extreme precedents that suggest that the value of life and primary survival nullify the value of truth [46], but this clearly does not constitute a generality in medical practice and is a function of other ethical values. However, in an environment of conservative conscience, with deeply rooted cultural values, paternalism is accentuated, whereas the possibility of autonomy and empowerment of patients [47] is not a consideration. In the psychiatry field, paternalism emphasizes that staff members must ensure the patient's best interest in daily care and treatment, but that decisions are to be taken by the professionals only [48, 49]. The patient is expected to comply with decisions despite the fact that the professionals may not have fully taken into account their specific needs and preferences [50]. On the contrary, the idea of autonomy has been clearly expressed in the first version of the WMA International Code of Medical ethics-1949 [51]. The code states that the physician is bound to respect a competent and well-informed patient's right to accept or refuse treatments. In this regard, in the context of Mexico and Latin American, the self-perception that an individual values truth is associated with explicit communication patterns. Truth constitutes an ethical value linked to honesty, which implies the attitude that an individual must keep a consistent and continuous truthfulness in words and actions with impartiality and objectiveness, at all times. Although in our study we did not identify the value to the truth as a determinant associated statistically with low paternalism/autonomism, we found a strongly association between an open communication pattern and low paternalism/autonomism.

In our study, we found that the association between the communication patterns and speciality with paternalism was modified by age of the health professionals, and this effect was greater in those professionals aged 30 to 42 years. A study with Israeli doctors was conducted to explore the attitudes of these doctors face to two dilemmas: to reveal the truth to patients about a poor prognosis and to help patients with terminal illnesses to end up their lives; as part of the results, it was observed that those younger doctors had a better communication compared to the older ones [52]. Similar effects were observed in a survey that evaluated the attitudes of doctors from seven countries, which indicates that doctors under 40 have a more proactive attitude to discuss, for example, an unfavorable prognosis [53]. It could be explained, in part, because less experienced young doctors are more dogmatic towards the truth and more participatory with parents [54], while more experienced doctors are more skeptical about the truth and tend

to adopt paternalistic attitudes in their interactions with patients [55]. Young doctors are more active to practice a more open communication. This could be related to the greater emphasis given to autonomy, less paternalism and informed consent in health care [56].

Limitations

Due to the nature of the design, we faced associations and did not consider causal relationships. On the other hand, it is a convenience sampling, which can compromise the generalization of the results. Although it does not represent all health professionals, the result may represent a first situational diagnosis about the determinants of paternalism from the perspective of the communication patterns between the health professionals and parents of patients diagnosed with any neurodevelopmental disorder or other diseases.

Conclusions And Recommendations

A considerable paternalistic/overprotective pattern prevailed among mental healthcare professionals in Mexico. Sex, medical specialty, and a pattern of open communication were closely associated with low paternalism/autonomism. A discussion on the communication patterns that doctors hold with their patients in Mexico, aims to establish without judgment, the pertinence of create a relationship between physicians and their patients more effective by a) strengthening the practice of patient-centered medicine, b) ensuring the best medical competencies, including ethical values, and c) promoting autonomy in the physician-patient relationship, as we strive for a society where self-determination does not constitute a gift but is derived from a social right, this is, social justice. It is also necessary for health professionals to develop strategies that can facilitate a shared decision-making, such as how to provide clear and simple explanations, verify understanding, favor listening of concerns and patient needs, reach a consensus on a treatment plan and establish a follow-up plan that is convenient for both parties [57]. More research is needed to provide evidence regarding which mode of care is more beneficial and fitting in each context, particularly in the relationship with parents of patients diagnosed with some neurodevelopmental disorders.

Abbreviations

OR

Odds ratios; CI:Confidence intervals; ASD:Autism Spectrum Disorder; IDD:Intellectual Development Disorder; ADHD:Attention Deficit Hyperactivity Disorder

Declarations

Ethics approval and consent to participate

The protocol was approved by the Research Ethics Committee of the National Institute of Public Health in Mexico and the other participant institutions. From each participating institution, an interviewer verbally invited mental healthcare professionals to participate. Once the healthcare professionals accepted to participate, we provide a questionnaire to fill out which was collected in the following two hours or the next day. E-consent was voluntary and was obtained prior to the interview.

Consent for publication

Not applicable.

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Author' contributions

ALA, LPE and KG designed the study. ALA and DER, AGCI and MLE carried out the data collection and data analysis. ALA, RVR carried out interpretation of data. ALA, LPE and RVR drafted the manuscript and ALA, DER, SCL and RVR made major revisions. All authors read and approved the final manuscript.

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References

1. Kristinsson S. Autonomy and informed consent: a mistaken association? *Med Health Care Philos.* 2007;10(3):253–64.
2. Dworkin G. Autonomy and behavior control. *Hastings Cent Rep.* 1976;6(1):23–8.
3. Dworkin G. Against autonomy response. *J Med Ethics.* 2014;40(5):352–3.
4. Shapiro M, Ward F. Autonomy Means Having to Make a Choice. *Am J Bioeth.* 2016;16(11):19–20.
5. Tepper JE. Ethics in Clinical Care. *Int J Radiat Oncol Biol Phys.* 2017;99(2):250–4.
6. Saad TC. The history of autonomy in medicine from antiquity to principlism. *Med Health Care Philos.* 2018;21(1):125–37.
7. Luna F. Paternalism and the argument from illiteracy. *Bioethics.* 1995;9(3–4):283–90.
- 8.

- Gracia D. The historical setting of Latin American bioethics. *J Med Philos.* 1996;21(6):593–609.
- 9.
- Levy SM, Herberman RB, Lee JK, Lippman ME, d'Angelo T. Breast conservation versus mastectomy: distress sequelae as a function of choice. *J Clin Oncol.* 1989;7(3):367–75.
- 10.
- Thompson GA, Whiffen LH. Can Physicians Demonstrate High Quality Care Using Paternalistic Practices? A Case Study of Paternalism in Latino Physician-Patient Interactions. *Qual Health Res.* 2018;28(12):1910–22.
- 11.
- Muller S. Respect for Autonomy in Light of Neuropsychiatry. *Bioethics.* 2017;31(5):360–7.
- 12.
- Wade DT. Commentary on Charles Foster's 'The rebirth of medical paternalism: an NHS Trust v Y'. *J Med Ethics.* 2019;45(1):8–9.
- 13.
- Foster C. The rebirth of medical paternalism: An NHS Trust v Y. *J Med Ethics.* 2019;45(1):3–7.
- 14.
- Eliassen AH. Power Relations and Health Care Communication in Older Adulthood: Educating Recipients and Providers. *Gerontologist.* 2016;56(6):990–6.
- 15.
- Allen JO. Ageism as a Risk Factor for Chronic Disease. *Gerontologist.* 2016;56(4):610–4.
- 16.
- Branson CF, Houseworth J, Chipman JG. Communication Deficits Among Surgical Residents During Difficult Patient Family Conversations. *J Surg Educ.* 2019;76(1):158–64.
- 17.
- Falcone JL, Claxton RN, Marshall GT. Communication skills training in surgical residency: a needs assessment and metacognition analysis of a difficult conversation objective structured clinical examination. *J Surg Educ.* 2014;71(3):309–15.
- 18.
- De Roubaix JA. Beneficence, non-maleficence, distributive justice and respect for patient autonomy—reconcilable ends in aesthetic surgery? *J Plast Reconstr Aesthet Surg.* 2011;64(1):11–6.
- 19.
- Hanyok LA, Hellmann DB, Rand C, Ziegelstein RC. Practicing patient-centered care: the questions clinically excellent physicians use to get to know their patients as individuals. *Patient.* 2012;5(3):141–5.
- 20.
- Hashim MJ. Patient-Centered Communication: Basic Skills. *Am Fam Physician.* 2017;95(1):29–34.
- 21.
- Padela AI, Malik AY, Curlin F, De Vries R. [Re]considering Respect for Persons in a Globalizing World. *Dev World Bioeth.* 2015;15(2):98–106.
- 22.
- Ong LM, de Haes JC, Hoos AM, Lammes FB. Doctor-patient communication: a review of the literature. *Soc Sci Med.* 1995;40(7):903–18.
- 23.

Lazcano-Ponce E, Angeles-Llerenas A, Alvarez-del Rio A, Salazar-Martinez E, Allen B, Hernandez-Avila M, et al. Ethics and communication between physicians and their patients with cancer, HIV/AIDS, and rheumatoid arthritis in Mexico. *Arch Med Res.* 2004;35(1):66–75.

24.

Fernández-Ballesteros R, Sánchez-Izquierdo M, Olmos R, Huici C, Ribera Casado JM, Cruz Jentoft A. Paternalism vs. Autonomy: Are They Alternative Types of Formal Care? *Front Psychol.* 2019;10:1460-.

25.

Fernández-Ballesteros R, Sánchez-Izquierdo M, Olmos R, Huici C, Caprara MG, Santacreu M, et al. Development and validation of a paternalism and autonomist care assessment. *J Adv Nurs.* 2019. 10.1111/jan.14154.

26.

Sánchez-Izquierdo M, Santacreu M, Olmos R, Fernández-Ballesteros R. A training intervention to reduce paternalistic care and promote autonomy: a preliminary study. *Clin Interv Aging.* 2019;14:1515–25.

27.

Toumi R. Globalization and health care: global justice and the role of physicians. *Med Health Care Philos.* 2014;17(1):71–80.

28.

Carter SM, Entwistle VA, Little M. Relational conceptions of paternalism: a way to rebut nanny-state accusations and evaluate public health interventions. *Public Health.* 2015;129(8):1021–9.

29.

Newdick C. Health equality, social justice and the poverty of autonomy. *Health Econ Policy Law.* 2017;12(4):411–33.

30.

Hamann J, Mendel R, Cohen R, Heres S, Ziegler M, Bühner M, et al. Psychiatrists' use of shared decision making in the treatment of schizophrenia: patient characteristics and decision topics. *Psychiatr Serv.* 2009;60(8):1107–12.

31.

Goossensen A, Zijlstra P, Koopmanschap M. Measuring shared decision making processes in psychiatry: skills versus patient satisfaction. *Patient Educ Couns.* 2007;67(1–2):50–6.

32.

Young HN, Bell RA, Epstein RM, Feldman MD, Kravitz RL. Physicians' shared decision-making behaviors in depression care. *Arch Intern Med.* 2008;168(13):1404–8.

33.

Goss C, Moretti F, Mazzi MA, Del Piccolo L, Rimondini M, Zimmermann C. Involving patients in decisions during psychiatric consultations. *Br J Psychiatry.* 2008;193(5):416–21.

34.

Roter DL, Hall JA, Aoki Y. Physician gender effects in medical communication: a meta-analytic review. *JAMA.* 2002;288(6):756–64.

35.

Bylund CL, Makoul G. Empathic communication and gender in the physician-patient encounter. *Patient Educ Couns.* 2002;48(3):207–16.

36.
Roter D. The enduring and evolving nature of the patient-physician relationship. *Patient Educ Couns*. 2000;39(1):5–15.
37.
Mechanic D. Changing medical organization and the erosion of trust. *Milbank Q*. 1996;74(2):171–89.
38.
Roter DL, Hall JA. Why physician gender matters in shaping the physician-patient relationship. *J Womens Health*. 1998;7(9):1093–7.
39.
Bensing JM, van den Brink-Muinen A, de Bakker DH. Gender differences in practice style: a Dutch study of general practitioners. *Med Care*. 1993;31(3):219–29.
40.
Fiks AG, Hughes CC, Gafen A, Guevara JP, Barg FK. Contrasting parents' and pediatricians' perspectives on shared decision-making in ADHD. *Pediatrics*. 2011;127(1):e188-96.
41.
Jackson C, Cheater FM, Reid I. A systematic review of decision support needs of parents making child health decisions. *Health Expect*. 2008;11(3):232–51.
42.
Derrington SF, Paquette E, Johnson KA. Cross-cultural Interactions and Shared Decision-making. *Pediatrics*. 2018;142(Suppl 3):187-S92.
43.
Salvador-Carulla L, Martinez-Leal R, Heyler C, Alvarez-Galvez J, Veenstra MY, Garcia-Ibanez J, et al. Training on intellectual disability in health sciences: the European perspective. *Int J Dev Disabil*. 2015;61(1):20–31.
44.
Caux C, Lecomte J. Consent to care of persons with intellectual disability in Quebec: from vulnerability to capability. *Salud Publica Mex*. 2017;59(4):462–7.
45.
Hansson SO. The Ethics of Making Patients Responsible. *Camb Q Healthc Ethics*. 2018;27(1):87–92.
46.
Avci E. Should physicians tell the truth without taking social complications into account? A striking case. *Med Health Care Philos*. 2018;21(1):23–30.
47.
Muaygil RA. From Paternalistic to Patronizing: How Cultural Competence Can Be Ethically Problematic. *HEC Forum*. 2018;30(1):13–29.
48.
Charles C, Gafni A, Whelan T. Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model. *Social science & medicine (1982)*. 1999;49(5):651 – 61.
49.
Beauchamp TL, Childress JF. *Principles of biomedical ethics*: Oxford University Press, USA; 2001.
- 50.

Sandman L, Granger BB, Ekman I, Munthe C. Adherence, shared decision-making and patient autonomy. *Med Healthc Philos.* 2012;15(2):115–27.

51.

WMA. International Code of Medical Ethics-1949. <https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/>. Accessed 13 December 2019.

52.

Velan B, Ziv A, Kaplan G, Rubin C, Connelly Y, Karni T, et al. Truth-telling and doctor-assisted death as perceived by Israeli physicians. *BMC Med Ethics.* 2019;20(1):13.

53.

Voorhees J, Rietjens J, Onwuteaka-Philipsen B, Deliens L, Cartwright C, Faisst K, et al. Discussing prognosis with terminally ill cancer patients and relatives: a survey of physicians' intentions in seven countries. *Patient Educ Couns.* 2009;77(3):430–6.

54.

Honeycutt C, Sleath B, Bush PJ, Campbell W, Tudor G. Physician use of a participatory decision-making style with children with ADHD and their parents. *Patient Educ Couns.* 2005;57(3):327–32.

55.

Falkum E, Forde R. Paternalism, patient autonomy, and moral deliberation in the physician-patient relationship. Attitudes among Norwegian physicians. *Soc Sci Med.* 2001;52(2):239–48.

56.

O'Neill O. Accountability, trust and informed consent in medical practice and research. *Clin Med (Lond).* 2004;4(3):269–76.

57.

Politi MC, Street RL Jr. The importance of communication in collaborative decision making: facilitating shared mind and the management of uncertainty. *J Eval Clin Pract.* 2011;17(4):579–84.