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Physicians as choice architects: paternalism and respect for autonomy

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Update

Abstract

The doctor-patient relationship differs significantly from other social interactions, and in the last years studies on this subject have grown significantly. The concept of autonomy now also encompasses patients, with notable expansion of their sphere of participation and influence in decision-making in treatments and clinical procedures, mitigating that overly paternalistic role of the physician. But this change poses a serious question: what are the limits of this autonomy? This article believes in the solution of libertarian paternalism, an idea proposed by Richard Thaler and Cass Sunstein, in which the doctor acts as a choice architect for the patient. Based on the hypothetico-deductive method, this study verifies the possibility of adapting libertarian paternalism to current medical practices, mainly in hard cases, establishing the scope and limits of patient autonomy.

Keywords: Doctor-patient relations. Personal autonomy. Paternalism. Treatment refusal .

Resumo

Médico como arquiteto da escolha: paternalismo e respeito à autonomia

A relação médico-paciente difere significativamente das demais interações sociais. Não por acaso, cresce expressivamente o número de estudos voltados exclusivamente à referida área. O fortalecimento da concepção de autonomia passou também a abranger a figura do paciente, com notória ampliação de sua esfera de participação e de influência na tomada de decisão em tratamentos e em procedimentos clínicos, mitigando aquela concepção exacerbadamente paternalista que recaía sobre a figura do profissional médico. Porém, daí insurge grave problemática: quais são os limites dessa autonomia? Acredita-se que a solução se encontra na ideia do paternalismo libertário, tese de Richard Thaler e Cass Sunstein, em que o médico atua como arquiteto da escolha do paciente. A partir do método hipotético-dedutivo, o objetivo do presente ensaio é verificar a possibilidade de adequar o método do paternalismo libertário à prática médica, mormente em relação aos hard cases, estabelecendo o alcance e os limites da autonomia do paciente.

Palavras-chave: Relações médico-paciente. Autonomia pessoal. Paternalismo. Recusa do paciente ao tratamento.

Resumen

El médico como arquitecto de elección: paternalismo y respeto por la autonomia

La relación médico-paciente difiere significativamente de otras interacciones sociales. No es coincidencia que haya un aumento expresivo de estudios centrados exclusivamente en esta área. El fortalecimiento del concepto de autonomía ha abarcado también la figura del paciente, con una notable ampliación de su esfera de participación y influencia en las decisiones sobre tratamientos y procedimientos clínicos, mitigando la concepción extremadamente paternalista que recae en la figura del profesional médico. Sin embargo, esto plantea un problema grave: ¿dónde están los límites de esta autonomía? El artículo argumenta que la solución radica en la idea de paternalismo libertario propuesta por Richard Thaler y Cass Sunstein, según la cual el médico actuaría como el arquitecto de elección del paciente. Con base en el método hipotético-deductivo, el objetivo de este estudio fue verificar la posibilidad de adaptar la metodología del paternalismo libertario a la práctica médica, especialmente con relación a los casos difíciles (hard cases), para establecer el alcance y los límites de la autonomía del paciente.

Palabras clave: Relaciones médico-paciente. Autonomía personal. Paternalismo. Negativa del paciente al tratamiento.

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Should patients be allowed to choose a treatment that, within the given spectrum of choices, represents the least effective alternative according to the state of the art? Should they be allowed to refuse treatment even when this could result in death? How can a person who lacks the necessary scientific knowledge be responsible for a decision that relies on such knowledge?

The answers proposed by this article are not based on the concept of patient autonomy as an absolute value, nor do they seek to reestablish an excessively paternalistic doctor-patient relationship in which the physician holds exclusive power over decision-making. Rather, we propose to solve this impasse by analyzing the concept of "choice architecture," presented by economist Richard H. Thaler and philosopher Cass R. Sunstein [1] in the book *Nudge: improving decisions about health, wealth, and happiness*. According to the authors, *if you are a doctor and must describe the alternative treatments available to a patient, you are a choice architect* [2].

In short, the authors' "libertarian paternalism" is based on maintaining people's freedoms of choice while optimizing them, so they are instigated – but never coerced – into making the best decisions according to the scientific knowledge on the topic in question. In the doctor-patient relationship, for example, medical science performs this role.

However, when it comes to human relations, technical knowledge certainly cannot prevail in all circumstances. Numerous other aspects of a personal, social and even legal nature must also be considered. In this sense, this article discusses the concept of "choice architecture" within medical practice, its reflexes and legal limits, while analyzing it in light of the Code of Medical Ethics (CEM) [3] and the following Resolutions of the Federal Council of Medicine (CFM): 1,805/2006 [4], 1,995/2012 [5] and 2,232/2019 [6].

Before beginning, it is important to assert that this essay does not pertain to cases involving legally incapacitated patients or people with diseases that limit cognitive capacity. These cases require the intervention of parents or legal guardians and involve a whole different system of action, with *a priori* differences to the concept of libertarian paternalism – since, in these cases, decisions are necessarily taken by a third party. Therefore, the article limits itself to relationships in which patients are legally capable and able to exercise their autonomy in a free and informed manner.

Using the scientific method, our proposal is to apply the concept of libertarian paternalism in the medical field, discussing its main points from hard cases. To this end, we employed national and international jurisprudence, as well as the analysis of bioethical doctrine and the applicable national legislation.

Medical paternalism *versus* patient autonomy

The right of patient autonomy is one of the main contributing factors to breaking the barrier of what has become known as "medical paternalism." Kraut [7] clarifies that the term "paternalism" does not have, *a priori*, a negative connotation. "Paternalism" corresponds to caring behavior in the relationship between father and child, insofar as the father seeks the best for his child.

But when patients are legally capable, in full use of their cognitive capacity and responsible for their own acts, there is no basis to sustain that their relationship with doctors must adapt to classic paternalism, which excludes the patient from the decision-making process. In many cases, this unhealthy dynamic ends up undermining fundamental rights [8].

In this regard, we must emphasize that the very concept of health as the object of medical practice has transformed throughout history, overcoming its strict definition as the mere absence of disease. As Sarlet and Molinaro [9] point out, the concept of health is currently approached from a systematic perspective, identifying itself with the idea of physical, mental and social well-being, as recommended by the preamble of the 1946 World Health Organization Constitution [10]. In other words, physicians should not only be concerned with the patient's physical well-being, but also with the psychological and even social consequences of a certain medical intervention.

On the other hand, one cannot ignore that the medical professional is the most capable of making an effective decision regarding

a particular treatment. In this sense, it is imperative to investigate how autonomous personal decisions in fact are. Would it be fallacious to state that people always determine themselves autonomously? According to Thaler and Sunstein [1], the answer is affirmative, since the belief that most people's choices and decisions are the ones that best serve their interests is based on a false assumption.

This leads us to believe that the paternalistic nature of medical activity cannot be entirely discarded. We cannot exclude the professional's participation when it comes to deciding which procedure is most suitable for the patient. One must recognize that the physician is the most qualified person for identifying the best treatment and prevention options, even though this greater aptitude cannot serve as a subterfuge for removing the patient's autonomy.

Respect for the patient's decision-making abilities: the need for dialogue

Informed consent and its principles, such as advance directives, are among the most emblematic instruments in breaking with the medical paternalism paradigm, serving as mechanisms to ensure patient autonomy and stimulate dialogue. Doctor-patient relationships based solely on the scientific knowledge held by the former and the submission of the latter are widely regarded as outdated. Piovesan and Dias point out that *the relationship between doctor and patient has undergone drastic changes. The vertical link between them, founded on paternalism, has begun to give way to a horizontal link, based on patient autonomy* [11].

Although medical science is technically apt to choose the most effective treatment for a given patient, the procedure can only be performed after the patient's full informed consent. One must distinguish, then, between the best treatment according to medical science and the best treatment according to the patient's own conscience. Greater treatment efficacy does not oblige the patient to consent, since the best technique and procedure are not always compatible with the patient's interests and subjective values.

As Beauchamp and Childress [12] explain, respect for consent – and consequently for patient autonomy – means considering their will, instead of assuming it according to the premises and subjectivity of a third party. *Consent should refer to an individual's actual choices or known preferences, not to presumptions about the choices the individual would or should make* [13].

In this sense, breaking with strictly paternalistic doctor-patient relationships entails respect for the patient's capacity to carry out free, autonomous, and rational decisions. Such observance of consent does not extend, however, to those who are unable – due to a disease, and especially a terminal disease – to individually make the best decisions (for example, when the patient has a depressive disorder). In this case, Putz and Steldinger [14] point out the desire to refuse treatment or the desire to die should not receive medical support, since the illness is characterized precisely by patients' lack of rationality, which removes their autonomy to choose.

Thus, urgent treatment should not be avoided because the sick person is unable to reason during the decision, but the same is not true for patients under good cognitive conditions. Their will must first be confronted with an assessment of their cognitive faculties at the moment of choice; if the choice proves to be rational and autonomous, it must be respected.

Putz and Steldinger [14] argue that physicians are permanently bound to the patient's will, whether they agree with it or not. For jurists, any disrespect to *Patientenverfügung* (advance healthcare directives) directly violates patient dignity, even if the intention was to save him. American philosopher and bioethicist Dan Brock, in turn, clarifies that each side of the doctor-patient relationship *brings something to the decision-making process that the other lacks, and* (...) *communication is necessary to decisions that best serve the patient's well-being* [15].

The claim that imputing the decision exclusively to patients forces them to obtain absolute knowledge on all treatment-related information, as only then they could decide in a conscious and thoughtful manner, leads to the conclusion that renouncing one's right to choose and one's autonomy would be the most appropriate answer.

This is because most people lack any scientific and technical knowledge regarding medical treatments and, even when they do, it is quite scarce. The most logical thing then would be to leave the choice to a professional who is specifically qualified and prepared to do so.

Even if some of the premises of this statement are true, they are insufficient to justify removing the patient's power of choice. The exercise of autonomy itself contemplates these possibilities. The ability to opt for or refuse a specific treatment entails the decision of accessing all the information needed for such choice, which must be provided by the physician if the patient so requires. The latter may even delegate decision-making entirely to the doctor, entrusting him with power of decision for each and every action. As Beauchamp and Childress [12] point out, it is the exercise of autonomy that legitimizes the patient's delegation of power to a trusted doctor.

Excluding patients from decision-making harms their dignity, since this ignores their personal interests. Under this logic, the patient, endowed with reason and the capacity for self-determination, is now treated – to paraphrase Kant's [16] categorical imperative – only as a means, a mere instrument for someone else's actions.

All in all, the autonomy of patients in their relations with medical professionals has progressed significantly. In fact, such recognition of patient autonomy has been the subject of regulations and resolutions by the CFM, which, before the legislative vacuum, has started to regulate the rights of the sick.

Informed consent in light of the Federal Council of Medicine's regulations

Following the overall development of medical legislations – such as the German legislation that recognizes treatment refusal as a legitimate possibility since 2005 [17] –, on November 9, 2006, CFM instituted Resolution 1,805 [4] regarding orthothanasia. In September 2009, it also established a code of medical ethics [18] broadly defined by the corroboration and defense of patient autonomy, a characteristic preserved in the new Code of Medical Ethics (CEM) [3], instituted in 2018 and later modified by CFM Resolutions 2,222/2018 [19] and 2,226/2019 [20]. CFM Resolution 1,995/2012 [5], which addresses patients' advance directives, is also worthy of mention.

Already in Chapter I, the 2018 CEM [3] insists upon the centrality of patient autonomy, giving patients, in an inversion of paternalistic logic, the possibility of choosing procedures and treatments, subjecting the doctor to their will, as long as all decisions are adequate to the case and have a scientific basis. Imbued with the logic of this autonomy and freedom, physicians must remain attentive to the patient's will, knowing that consent is their main link. This is a direct consequence of the information and counseling duties provided for in the 2018 CEM [3], which already featured in the 2009 CEM [18].

As Dadalto and Savoi emphasized, *contemporaneity has been witnessing the emergence of informational and interpretative relationship models. In the first model, doctors act as expert technicians in the topic in question; their responsibility is to present patients with data regarding their illness; after the facts are explained and the numbers are provided, the decision is left to the patient* [21]. In other words, it is up to the professional to provide the sick with all the necessary and pertinent information (as long as such conduct does not cause the latter any harm) regarding diagnosis and the available treatments or procedures.

Moreover, the doctor must advise the patient, indicating which treatment – according to the literature and to medical science in general – is the most effective, without resorting to any type of coercion. Thus, a healthy relationship is based on bioethical principles, whose adequate understanding, as Azevedo and Ligiera [22] state, sheds light on the ethical legitimacy of refusing certain treatments and therapies.

Considering the *caput* of article 41 (CEM) [3], it seems that respect for autonomy is not absolute: the physician is prohibited, for instance, from practicing active euthanasia, even if this corresponds to an autonomous decision by a patient or his legal representative. But the sole paragraph of this same article leaves room for orthothanasia, as long as it results from an incurable and terminal disease and that the

wishes of the patient or his legal representative are clearly manifested as to dismissing obstinate therapeutic action and limiting treatment to palliative care [3].

To provide a more in-depth interpretation of this article, we should point out its conformity with CFM Resolutions 1,995/2012 [5] and 2,232/2019 [6], which aim to regulate the patient's advance directives as well as treatment refusal rights. These enable terminally ill patients to refuse certain treatments, limiting themselves to receiving palliative care. Their underlying logic is also defended by Fernandes and Goldim, who point out that *the Brazilian system is already well underway in terms of building a normative model for the self-determination of patients in end-of-life and terminal situations, as long as accompanied by the proper advisement and medical care* [23].

However, we must distinguish orthothanasia (palliative treatments) from passive euthanasia. The refusal of treatments in cases of imminent death without terminal or incurable disease still lacks any normative support. As previously explained, the possibility of refusing treatment is limited to cases of terminal illness, meant to avoid unreasonable obstinacy.

By analyzing Brazilian regulations, so far it seems safe to say that patient autonomy must be respected, especially in terminal cases; but some limits to this autonomy can be identified, even if they remain somewhat unclear. Moreover, we should point out that CFM regulations do not always correspond to the current legislation, with a legal gap remaining as to orthothanasia and respect for the patient's autonomy.

In any case, respect for autonomy means valuing freedom and, consequently, patients' responsibility regarding individual decision-making processes. As Brock [24] points out, autonomy must coexist with a co-related sense of power, so that individuals cannot evade the consequences of their autonomous decisions.

The physician cannot be responsible for a free and informed decision made by the patient, even if the consequence of such decision is death. The doctor would be responsible only for the information provided, for the way it was directed to the sick person and for the technique used in the selected procedure.

Choice architect: conformation of autonomy to medical paternalism

The analysis of the regulations concerning the doctor-patient relationship and the theoretical construction regarding respect for patient autonomy suggests that medical activity is facing an impasse. Marked since its beginning by an eminently paternalistic character, how can the medical professional fulfill this demand? This article proposes what Thaler and Sunstein [1] called "libertarian paternalism."

In *Nudge* [1], the authors develop the idea of "choice architects," people whose greater technical and scientific knowledge makes them responsible for helping others to understand their respective specialties. The choice architect must not only provide all the necessary information to those who does not belong to the field of knowledge in question, but also advise and instigate them to make the best decision according to technical and scientific parameters.

However, this advice and incentive should never embarrass the person who seeks the expert's support. Thaler and Sunstein [1] argue that choice architects must not impose their ideas, but only present all the available possibilities to their interlocutors. They are certainly allowed to express their opinions, indicating a certain behavior as preferential, but never in a coercive manner [1]. In this model, paternalism leads to a certain conduct, but individual freedom of choice remains, hence the term "libertarian paternalism."

In the medical-hospital context, libertarian paternalism comes from the physician – after all, as the holder of technical and scientific knowledge, the professional would assume the role of "choice architect." It is up to the doctor to inform patients about all aspects of their conditions, for an adequate understanding of the diagnosis, treatments and procedures, and consequences of non-intervention. The doctor must indicate – by presenting the risks, chances of success and effectiveness of each treatment – the most effective option according to technical and scientific parameters, entrusting the final decision to the patient.

A careful reading shows that even the CEM is somewhat in tune with the notion of libertarian

paternalism. In fact, Chapter II provides that *it is the physician's right* (...) *to indicate the procedure that is appropriate for the patient, observing scientifically recognized practices and respecting the current legislation* [25]. Likewise, article 24 of Chapter IV states that physicians *must guarantee patients the exercise of their right to freely make decisions regarding their own personhood or well-being, and must not employ their authority to impose limits on such an exercise* [26].

This item should be read along with article 34, which obliges the physician *to inform the patient of the diagnosis, prognosis, risks and objectives of treatment, except when direct communication may cause harm* [27], and with article 13, which prevents the physician from *failing to clarify the patient about the social, environmental or professional determinants of the patient's disease* [28]. In the same direction, article 22 requires doctors to obtain *patient or legal-representative consent* [29], providing for the instrument of informed consent, an essential tool for respecting patient autonomy, as already explained.

Non-maleficence and beneficence: parameters of libertarian paternalism

Before analyzing specific cases, it is important to draw some considerations on the principles of medical beneficence and non-maleficence. Besides establishing limits to the autonomy of both patients and doctors, these principles help guiding the implementation of libertarian paternalism. Despite their close proximity, the practical application of these two principles can prove to be nearly antagonistic. While beneficence has to do with providing patients with the best treatment possible, respecting their autonomy and search for more appropriate alternatives, the principle of non-maleficence can be an obstacle to unreasonable doctor attitudes, even when these attitudes are intended to do what is best for the patient.

It is not always easy to distinguish beneficial procedures from unsuccessful ones. According to Dadalto and Savoi, death *has become a postponable event, where the limit for medical intervention is often elastic and imponderable* [30]. The unconditional attempt to restore health or artificially maintain the patient's life may assume several forms, from useless and merely palliative treatments to the maintenance of irreversible coma, known as "dysthanasia" or "unreasonable obstinacy."

According to Gawande [31], a medical *ethos* centered on opposing death, combined with the desire for immortality, created a problem in the patient-doctor relationship: doctors, patients and family members immerse themselves in an often-irrational fight for an irrecoverable life. The issue with unreasonable obstinacy, therefore, is not circumscribed to medical conduct alone, but also to the patient's very autonomy, wherein treatments that are provenly useless cannot be justified. In this sense, the principle of non-maleficence, together with the prohibition of unreasonable obstinacy, limits both medical conduct and patient autonomy, seeking a solution to respect for dignity and avoiding unnecessary forms of suffering.

In a context where both physician attitudes and patient autonomy may lead to unsuccessful procedures, it is necessary to promote dialogue between the involved parties, establishing clear limits. While technical barriers are imposed to the doctor, the patient may establish limitations according to religious or philosophical convictions, which can be recorded in a living will.

Dialogue is important because the concept of dysthanasia is flexible, since a treatment one patient regards as unacceptable another may see as absolutely plausible. If patients make it clear that they are against certain procedures, opting to receive only palliative care, there seems to be no possibility of dysthanasia. But what if the patient's living will reveals the wish to be submitted to unreasonable therapeutic obstinacy? Should the doctor respect the patient's will in this case?

As Dadalto and Savoi argue, dysthanasia limits the patient's autonomy by harming *the fundamental premise of the medical art:* primum non nocere *(first, do no harm)* [32]. The authors also point out that the *contradiction between the living will and the medical profession's ethical-disciplinary rules is a limitation of the former, not the latter, and therefore the living will provision must be interpreted as unwritten* [32].

According to article 41, sole paragraph, of the CEM, *in cases of incurable and terminal disease,*

the physician must provide all available forms of palliative care without undertaking useless or obstinate diagnostic/therapeutic actions. The doctor must also consider the explicit will of the patient, or, in case the latter is not feasible, the will of the patient's legal representative [33]. For able patients, the problem seems simple to solve: a dialogue between the parties, with the doctor clarifying the possibilities of treatment and respective consequences, pointing out which measures are useless. Having said that, we now analyze hard cases based on the idea of libertarian paternalism.

Jehovah's Witnesses

One of the most debated cases regarding bioethics and patient autonomy is that of Jehovah's Witnesses. Due to their beliefs and dogmas, these religious patients refuse any type of treatment involving blood transfusion. Considering this impasse, the question arises: would treatment refusal be legitimate even in cases where it would invariably lead to death? A related issue also emerges: what defines the scope of "imminent risk of death"?

Although CEM [3] allows physicians to ignore treatment refusal in cases of imminent risk of death (article 31), the Law has already recognized the legitimacy of this refusal. When judging the interlocutory appeal 70032799041, the Court of Justice of the State of Rio Grande do Sul (TJRS) understood that freedom of belief should prevail, with a treatment option that preserves the patient's dignity:

Interlocutory Appeal. Unspecified private right. Jehovah's Witness. Blood transfusion. Fundamental rights. Freedom of belief and dignity of the human person. Prevalence. Option for medical treatment that preserves the applicant's dignity. The contested decision granted the appeal regarding blood transfusions against the applicant's express will, in order to preserve her life. The applicant is an able, lucid person. From the first moment she sought medical attention, she expressed her disagreement with treatments that would violate her religious convictions, especially blood transfusions. The applicant cannot be subjected to a medical treatment with which she does not agree and which, in order to be executed, would require the use of police force. Although it intends to preserve life, said medical treatment takes from her the dignity derived from religious belief, possibly rendering her remaining existence meaningless. Free will. There is no state prerogative to "save people from themselves" when the person's choice does not imply a violation of social or third-party rights. Protection of the right to choose, a right based on the preservation of dignity, so that the applicant is only subjected to medical treatment compatible with their religious beliefs. Appeal granted [34].

This topic continues to be the subject of CFM opinions, resolutions and discussions, still far from consensus. We have, for example, CFM Opinion 12/2014 [35], in which the Council responds to questions from the Jehovah's Witnesses Association regarding treatment refusal involving blood transfusion, considering the precepts of CFM Resolution 1,021/1980 [36]. The council clarified, at the time, that no adult person who is able of deciding for himself can be forced to receive treatment contrary to his will, and that there is no clear definition regarding the term "imminent risk of death." Thus, it is *urgent to publish a new Resolution and for CFM Resolution No. 1,021/80 to be revoked, after the elaboration of precise, clear and objective technical guidelines, within a maximum period of six months, determining the limits and parameters of blood transfusion as a treatment indication* [37].

In 2018, one year before CFM Resolution 1.021/1980 [36] was revoked, the Regional Council of Medicine of Minas Gerais, after being asked to issue an opinion (103/2018) on the scope of the term "imminent risk-of-death situations," reiterated the following understanding: *as established in the resolution currently in force* [CFM Resolution 1.021/1980], *in situations of imminent risk of death, preservation of life remains a valid precept. However, this decision has not been fully established. Current legislation, in particular CR88* [Brazil's 1988 Constitution], *privileges the right to life; jurisprudence, on the other hand, sometimes considers dignity as or even more important than life. There is no consensus on the topic, but from an ethical*

point of view, the current resolution allows for transfusion to take place in this case [38].

In 2019, five years after CFM Opinion 12/2014 [35], CFM Resolution 1,021/1980 [36] was finally revoked by CFM Resolution 2,232/2019 [6], but article 3 of the new resolution maintained the exact previous understanding of doctors' conduct in cases of imminent risk of death. In other words, in extreme situations, doctors may perform blood transfusion even against the patient's will [6].

In the same year, due to difficulties in establishing criteria as to the primacy of either the right to life or self-determination (the latter linked to the dignity of the human person), the Federal Prosecution Service (MPF) presented the Statement of Non-Compliance with Fundamental Precept 618 [39]. Among other points, this document questions the scope of Resolution CFM 1,021/1980, requesting the withdrawal of item 2 of CFM Processual Opinion 21/1980, adopted as an annex to the resolution that prescribes: *in case of imminent danger to life, the doctor shall perform blood transfusion regardless of the patient's or patient guardians' consent* [36]. MPF's rationale clearly refers to the autonomy of the patient's will, understanding that, even in extreme cases, preserving the patient's decision-making power entails respect for their dignity, which may prevail even when in conflict with the right to life.

Under libertarian paternalism, treatment refusal would also be legitimate insofar as the treatment violates dignity, and the patient would be responsible for such decision. Doctors, in turn, could advise against such conduct by pointing out the physical and technical consequences, but would not have the right to impose a non-consensual treatment or procedure.

Such conclusion, however, does not prevent doctors from refusing to assist the patient, referring them to another professional. Considering the fundamental rights that also protect doctors and all hospital staff, Putz and Steldinger [14] point out that professionals' freedom of conscience must also be respected, as long as the case in question does not entail imminent death and patients are able to find another professional for treating them. In the same vein, item VII of Chapter I of the CEM states: *doctors will exercise their profession with autonomy, not being obliged to provide services that contradict the dictates of their conscience or to provide services for those who they do not wish to, except in the absence of another doctor, in cases of urgency or emergency, or when doctor refusal to treat may harm the patient's health* [40].

This scenario was even reviewed by the TJRS in Civil Appeal 70071994727 [41], which discussed the conflict between doctors' professional freedom and patients' religious freedom – the professional's right to refusal was assured. In the case, a Jehovah's Witness, who had been indicated a surgical procedure for transurethral resection of the prostate, refused an eventual blood transfusion treatment due to religious beliefs. The anesthesiologist, for reasons of conscience and based on the CEM [3], refused to participate in the surgery.

Modifying the condemnatory sentence, the TJRS [41] upheld the interlocutory appeal, deciding that the patient's indemnity claim was unfounded. The court found that – given the absence of an imminent risk of death and the possibility of referral to another morally and ideologically unimpeded professional – the doctor's conduct was licit, following the example of the Supreme Federal Court when judging the Internal Interlocutory Appeal in Extraordinary Appeal 988796 [42].

Final considerations

In a scenario of rapid scientific evolution, constant promotion of autonomy and growing demand for technical knowledge on the part of the doctor, libertarian paternalism presents itself as a viable option for maintaining a certain degree of paternalism in the doctor-patient relationship without rejecting the patient's self-governance and right to choose. Despite the patient's limitations in decision-making, especially regarding the lack of technical and scientific knowledge, patient autonomy cannot be suppressed, as this would give rise to situations of violation of patient dignity.

It is up to doctors, therefore, to exert their roles as choice architects, imbuing the duty to inform with new meanings. On this basis, professionals may begin to adopt a different attitude when providing information to the patient, whether

in the diagnosis or in the different phases of treatment. As previously discussed, the physician must not only give the patient all the necessary and pertinent information, but also advise on and even indicate the most appropriate treatment according to technical and scientific parameters, designing, according to best practices, the way in which this information is given.

As such, the patient will be induced or instigated ("nudged") towards a certain behavior, but without this encouragement becoming a form of coercion or imposition. Patients will thus be able to make the best decision, considering not only technical aspects, but also subjective and personal ones. Their autonomy – and, ultimately, their dignity – will remain intact.

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