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SCIENTIFIC CONTRIBUTION

Patient education as empowerment and self-rebiasing

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Abstract The fiduciary nature of the patient-physician relationship requires clinicians to act in the best interest of their patients. Patients are vulnerable due to their health status and lack of medical knowledge, which makes them dependent on the clinicians' expertise. Competent patients, however, may reject the recommendations of their physician, either refusing beneficial medical interventions or procedures based on their personal views that do not match the perceived medical indication. In some instances, the patients' refusal may jeopardize their health or life but also compromise the clinician's moral responsibility to promote the patient's best interests. In other words, health professionals have to deal with patients whose behavior and healthcare decisions seem counterproductive for their health, or even deteriorate it, because of lack of knowledge, bad habits or bias without being the patients' free voluntary choice. The moral dilemma centers on issues surrounding the limits of the patient's autonomy (rights) and the clinician's role to promote the well-being of the patient (duties). In this paper we argue that (1) the use of manipulative strategies, albeit considered beneficent, defeats the purpose of patient education and therefore should be rejected; and (2) the appropriate strategy is to empower patients through patient education which enhances their autonomy and encourages them to become full healthcare partners as opposed to objects of clinical intervention or entities whose values or attitudes need to be shaped and changed through education. First, we provide a working definition of the concept of patient education and a brief historical overview of its origin. Second, we examine the nature of the patient-physician relationship in order to delineate its boundaries, essential for understanding the role of education in the clinical context. Third, we argue that patient education should promote self-rebiasing, enhance autonomy, and empower patients to determine their therapeutic goals. Finally, we develop a moral framework for patient education.

Keywords Patient education · Patient–physician relationship · Self-rebiasing · Persuasion

Introduction

The fiduciary nature of the patient-physician relationship requires clinicians to act in the best interest of their patients. Patients are vulnerable due to their health status and lack of medical knowledge, which makes them dependent on the clinicians' expertise. Competent patients, however, may reject the recommendations of their physician, either refusing beneficial medical interventions (e.g., interventions deemed too burdensome such as chemotherapy) or procedures based on their personal views that do not match the perceived medical indication (Lo 2000). In some instances, the patients' refusal may jeopardize their health or life but also compromise the clinician's moral responsibility to promote the patient's best interests. In other words, health professionals have to deal with patients whose behavior and healthcare decisions seem

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counterproductive for their health, or even deteriorate it, because of lack of knowledge, bad habits or bias (Shaw and Elger 2013) without being the patients' free voluntary choice. The moral dilemma centers on issues surrounding the limits of the patient's autonomy (rights) and the clinician's role to promote the well-being of the patient (duties).

In these circumstances patient education (as opposed to "simply" informing patients) becomes an important tool for clinicians to rely on that aims at empowering patients to become more autonomous concerning their health and management of it. The understanding would be that education is used to help patients make better choices in line with their values and not to manipulate them, i.e. to use education in an ethical and professional way. However, due to their training and professional identity, clinicians have a priori a sound understanding of medical conditions and sometime could use, wrongly, "beneficent manipulative strategies" (i.e. the use of controlling schemes to achieve particular decisions about clinical procedures and outcomes that are deemed to enhance the well-being of patients without their explicit consent) instead of patient education.

In this paper we argue that (1) the use of manipulative strategies, albeit considered beneficent, defeats the purpose of patient education and therefore should be rejected; and (2) the appropriate strategy is to empower patients through patient education which enhances their autonomy and encourages them to become full healthcare partners as opposed to objects of clinical intervention or entities whose values or attitudes need to be shaped and changed through education. First, we provide a working definition of the concept of patient education and a brief historical overview of its origin. Second, we examine the nature of the patient-physician relationship in order to delineate its boundaries, essential for understanding the role of education in the clinical context. Third, we argue that patient education should promote self-rebiasing, enhance autonomy, and empower patients to determine their therapeutic goals. Finally, we develop a moral framework for patient education.

Patient education

Defining patient education

Before we turn to the main focus of this article, we need to provide a working definition of the concept of patient education and a brief historical overview of its origin. According the World Health Organization,

> therapeutic patient education is designed to train patients in the skills of self-managing or adapting treatment to their particular chronic disease, and in coping processes and skills…Therapeutic patient education is education managed by health care providers trained in the education of patients, and designed to enable a patient (or a group of patients and families) to manage the treatment of their condition and prevent avoidable complications, while maintaining or improving quality of life. Its principal purpose is to produce a therapeutic effect additional to that of all other interventions (pharmacological, physical therapy, etc.) (Rabbone et al. 2005).

The World Health Organization definition points to two key elements. First, the process of training patients must be patient-centered and adapted to the development of the disease and the life style of the patient with the goal to manage the disease long-term through various pedagogic means (World Health Organization 1998; Rabbone et al. 2005). Second, patient education should be integrated in the fabric of the healthcare system in order to provide learning and psychosocial support with regard to the nature of the disease, the treatment recommended, the behavior related to health and illness, and the organization providing care (Rabbone et al. 2005).

While it can be said that the overall goal of the education is partly the same as for information (i.e. assist patients make informed and wise healthcare decisions), education goes further in that it provides a framework to patients for understanding treatment options but also the management of the disease and its behavioral implications for a potential successful outcome. To sum up education aims at the following additional goals: (1) determine specific therapeutic goals in order to improve disease management, (2) increase treatment adherence, (3) promote healthy behavior and contain cost, and (4) empower patients and increase their participation concerning healthcare decisions (Deccache and van Ballekom 2010). Some studies have demonstrated the benefits of patient education in terms of health status and disease management. A study on asthma revealed that patient education could diminish attacks by 75 %, decrease the number of visits at the emergency room and the number of hospitalizations by 80 %, school absenteeism by 90 %, and the costs of treatment by 50 % (Sandrin-Berthon 2000; Couturaud et al. 2002).

Education has been gradually integrated in the clinical setting in the last 30 years and has proven to be efficient but there is still some reluctance to embrace it fully. Eric Drahi, a primary care physician, outlines some of the reasons: (1) physicians lack the necessary training to have the role of an educator and a physician in the clinical context; (2) the opportunities to get training to become a more effective physician–educator are lacking; (3) the translation of patient education into every day medical practice poses challenges; and (4) most hospitals have adopted a group approach to patient education which does not provide “one on one” opportunities to interact with patients (Drahi 2009). Other limits include the lack of time and no health insurance coverage for education activities, in variable proportions according to the countries (Deccache and Aujoulat 2001).

Origin of the concept

The 1960s and 1970s witnessed various changes in the practice of medicine. One major transformation occurred in the patient-physician relationship. Medical paternalism was questioned, rejected, and ultimately replaced by a patient-centered healthcare approach (Jonsen 1998). The re-conceptualization of the patient-physician relationship positioned both persons on an equal moral ground and empowered patients to have the final say in their healthcare decisions (Engelhardt 1996). This approach has strived to “provid[e] care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (Institute of Medicine 2001).

This shift of power in the clinical encounter resulted in the need for patients to be better informed about their health conditions, prognosis, and treatment options (Lenz et al. 2012). As the “authority” of clinicians over their patients diminished, patients gradually accepted their new role as decision makers. However, with more autonomy the burden of responsibility to make the appropriate healthcare decision became heavier on the patients’ shoulders. To deal with this redistribution of power, patient education has provided the means to provide information through a longer process and make sure that patients understand it and acquire necessary practical skills such as using insulin injection devices or empowerment to act according to their long-term and not short-term values.

Nurses first functioned as “educators” in the clinical context in the early part of the twentieth century (Roter et al. 2001; Lagger et al. 2008). They served as liaison between the patient and the family, explained various medical procedures, provided advice on hygiene, on nutrition, and on health promotion (Bastable 2005). In the 1960s and 1970s, a gradual emphasis on patient education took place in Europe, with the Netherlands leading the way on the continent, and in the United States (Hoving et al. 2010). In 1972, Leona Miller, a physician from California, demonstrated the effect of education on diabetic patients (Miller and Goldstein 1972). She implemented an educational strategy that empowered diabetic patients to take charge of their healthcare allowing them to control their diabetes without increasing the consumption of medications (Lagger et al. 2008). In the 1980s patient education continued to develop in conjunction with the emergence of patients’ rights and patient advocacy organizations (Hoving et al. 2010). The 1970s and 1980s paved the way for patients to become active participants in their healthcare. To this end, educational programs were developed in the 1990s to allow patients to self-regulate and manage their medical conditions. Ultimately patient education helped to bring an end to the paternalistic model and led to a shared decision-making approach making patients healthcare partners (Hoving et al. 2010). Patient education has been included as more or less standardized good practice approach in the follow up of numerous chronic diseases such as diabetes, asthma, cardio vascular diseases, HIV infection, and hepatitis C infection (Sandrin-Berthon 2000; Couturaud et al. 2002; Lenz et al. 2012; Miller and Goldstein 1972; Ernst et al. 1996; Kolor 2005; Sengupta and Roe 1996).

Based on this brief historical overview, it is necessary to address some potential confusion about the precise scope and nature of health education as opposed to health information. For the sake of clarity we provide the following working definitions. Health information or providing health information to a patient is the act by which a provider communicates all relevant clinical facts to a patient about his or her health condition. This information includes data about the nature of the condition, symptoms, diagnosis, treatments options, etc. On the other hand, health education is a more complex process since it requires the provider to create a learning environment that promotes learning, communication with learners (patients), establishing the right context for learning, and addressing potential challenges to the learning process. In other words, health education demands knowledge in how to treat a medical condition but also a robust understanding of the principles of teaching and learning geared toward the specific needs of patients and their decisional needs. One example of such approach is the Patient Decisional Needs Trajectory (PDNT) that identifies eight categories of patient needs (informational, physical, behavioral, emotional, practical, spiritual, social, and cognitive). The PDNT can serve as “a guide to foster continuity of care, and to provide individualized patient decision support” and “encourages providers to incorporate patients’ clinical, personal and decisional needs while providing decision support” (Politi et al. 2011).

The focus on health education is that of influencing individual health choices, aiming less at persuasion and more on support. The goal is not one on manipulation and compliance but rather empowerment and facilitation of choice, fostering permanent change in an individual’s capability or disposition. Effective health education may produce change in knowledge and understanding or ways of thinking; it may also bring about some shift in belief or attitudes facilitating the acquisition of skills.

Conceptualizing the clinical encounter

Before we can delve more thoroughly into the role of patient education in the clinical context, we need to examine the nature of the patient-physician relationship. Ideally this special relationship ought to be based on the values of the patient and the clinician, and allow room for a constant development in order to enhance trust and mutual respect. As Pellegrino rightly notes, "the physician-patient relationship is a moral equation with rights and obligations on both sides…that…must be balanced so that physicians and patients act beneficently toward each other while respecting each other's autonomy" (Pellegrino 2008). The clinician provides facts about diagnosis, treatment options, and prognosis with the aim to allow the patient to make informed health decisions and ultimately motivate him or her to make the appropriate behavioral changes to improve his or her health status. Although the patient does not have absolute power in the management of his or her health, he or she is responsible to preserve, enhance, and promote his or her own health status. Consequently the relationship between the patient and the clinician is a form of agreement established within the constraint of specific roles: the patient is the initiator due to a particular need and the clinician, as the expert, provides his or her expertise to address specific health problems.

In the light of these considerations, we can state that the clinical encounter can be described as a relationship based on the two essential pillars of trust and integrity for the following reasons. Current clinical ethics is mostly geared toward principles, duties, and rules as epitomized by principlism and the principles of beneficence, non-maleficence, justice, and autonomy. However, the abstract nature of these principles does not capture the complex nature of moral life, within and outside the clinical context. As James Drane, in relation to American medical ethics, rightly points out current ethical theories stressing principles on behalf of agency reflects a narrow perspective on moral life:

> Modern Americans identify with science and technology, to the point of looking at their own lives through these narrow perspectives. What science identifies as real is what is physical and measurable. Acts, therefore, are real, but not a person's character or inner self…The fact that the self is forgotten in ethics is not too difficult to understand. In some sense, both modern ethics and modern American medical ethics reflect contemporary life (Drane 1988).

We cannot provide a full analysis in what follows, but in the context of our analysis we argue that moral philosophy, and its implications for clinical ethics, ought to go beyond an ethic grounded on abstract principles, duties, and rules in conjunction with technical knowledge but rather focus on an agency oriented ethic. The technical and empirical aspects of medicine are not to be dismissed but integrated within the context of the healing relationship. This relationship deals with human beings, one of them (the patient) with specific physiological, psychological, and existential needs, and consequently morality constitutes an essential dimension in the delivery of health care (Jotterand 2002). In other words, the outcome of the clinical encounter depends on the clinician's ability to apply scientific knowledge grounded on moral values inherent to the moral agency of the person delivering care. To quote Drane again,

> to insist on a place for character in medical ethics is to say that the original meaning of ethos (the inner self) is relevant to what goes on in medicine…By individual acts of selfless caring for the sick, a doctor becomes a caring self. By repeated just acts, he makes himself just…Doctors, like everyone else, or perhaps more so than others, develop certain attitudes, dispositions and character traits. Medical ethics, it seems, should be concerned with this fact (Drane 1988).

For this reason, we adopt a framework of patient education whereby behavioral change is understood as a dynamic process of causal relations between the clinical and the patient. First, we need to consider the patient who offers him or herself to the clinician as an "object for observation and manipulation" as part of the clinical encounter. The "objectification" of the patient does not mean a lack of autonomy and a passive submission to the will of the clinician since the clinician always acts based on the patient's permission. Within the boundaries of clinical practice the clinician maintains a fair amount of autonomy due to his or her expertise and strives to achieve an ideal state of health *for the patient* defined by standards of care and accepted medical procedures in general. The autonomy of the clinician, however, is never absolute, either with respect to the patient (who requested help) or to others. The autonomy of the clinician is always understood within the confines of medical professionalism whose aim is the attainment of health or the prevention of disease. Of course, the concept of health in the clinical encounter presumes a subjective dimension because the focus is on the health of that particular patient who makes decisions based on his or her values and goals in life.

As the above framework demonstrates without trust and integrity on both parts, the clinical encounter cannot be established appropriately to achieve the health, or prevention of disease, of the patient. That being said, the outcome of each educational intervention on the part of the clinician remains the responsibility of the patient. The clinician is in a subsidiary role while providing guidance and expertise.

A layer of complexity is added when considering the role of divergent values (including multicultural values) in the clinical encounter. To further elaborate on this point, a progredient approach to preventive and therapeutic interventions must be adopted. The most basic level refers how disease affects particular organs and bodily functions. For instance, lung cancer is a type of cancer that begins in the lungs and therefore affects the patient's breathing. The second level concerns the somatic integrity of the individual. It is a holistic view that considers the body as an organic synthesis. While lung cancer might start in the lung, it is likely that it will threaten the integrity of the body, first of all through the lack of oxygen if the lungs malfunction and second because it will spread to other parts of the body. The next level of analysis, the diachronic phase, describes how the particular facts of the disease and of the whole organism have a history. The act of diagnosing required the collection of information about a narrative related to the patient's lifestyle and history, which provide clues as to the etiology of the disease. Relevant information, such as whether the patient is a smoker, and for how long, helps the clinician make clinical judgments to establish the best course of action for the improvement of health. In this latter phase, the attention centers on the psychological dimensions of illness such as the reasons for smoking, i.e. stress reliever, social activity, etc., in which a set of values define the exchange of information but also the clinician's ability to provide an accurate diagnosis and suitable treatment options.

The dialogue between the clinician and the patient becomes even more intricate when disagreement occurs due to an ethical issue arising in the exchange of information. In these cases, the default position is to refer to the principle for respect for persons that assumes the rights of the patient to decide about his or her health and the duties of the clinician to provide an accurate diagnosis and treatment options. However, this model is insufficient to capture the nature of the clinical encounter. It emphasizes too much the autonomy of the patient, obliging him or her to start a decision-making process partly in isolation because the assumption is that the clinician's role must remain subsidiary. This approach significantly restricts trust and ultimately may result in an impersonal and dehumanizing relationship, removing the clinician's opportunity to educate the patient. In addition, this approach raises a fundamental ethical issue in health care practice due to the stark conflict arising from the intersubjectivist approach of principlism in which the principles of autonomy, beneficence/non maleficence and justice might come sometime in conflict. Those principles, while having a great importance individually, bewilder the agent in answering the question: What do I do in front of a patient who persists in making unhealthy choices? One is not able to answer the question because such principles are not hierarchized and are placed on the same level (i.e. the autonomy of the patient is equal to that of the physician).

The point here is not to support a blind medical paternalism, which is inadequate and anachronistic, but to highlight the lack of acknowledgment of the limits of freedom (the individual's freedom may conflict with the interests of society at large, see in this regard the ethical issues arising from the HIV infection). Rather we underline the need for a reflection about the nature of the "good" at stake in prevention and the patient-physician relationship.

The crucial point in the preventive, diagnostic, therapeutic and rehabilitative decision making is the interpretation to be given to the term good. What good? What is the nature of the good? To fill the gap left by principlism, Pellegrino sought to clarify what should be understood by the good of the patient. He argues that the "optimal end of healing is the good of the whole person" (physical, emotional, and spiritual good) and consequently each aspect of the good of the patient must be brought into proper relationship (Pellegrino 2001). First, we must consider the medical good associated with the knowledge of health professionals, which are morally committed to enhance the good of the patient. That said the good of the patient cannot be reduced only to the medical good for two reasons. Such approach would subjugate the patient to an ethical imperative (i.e. the medical good) that would ignore the values of the patient reducing ethics to a preventive intervention (and/or therapeutic treatment), technical in nature. Furthermore, to ground the indication of preventative intervention on the medical good implies that clinical judgment are based on the very idea of quality of life without taking into account the values and perspectives of the patient. Ultimately, however, these various aspects of the good of the patient requires an acknowledgement of a form of "supreme good" which is the standard the patient and the clinician will refer to in their choices. Such good is ontological in nature and stands outside the realm of the clinical context. It is on the idea of "supreme good" that patients and clinicians are likely to mitigate conflicts.

Education versus benevolent persuasion

In everyday clinical practice, medical decisions reflect a compromise between what the patient and the physician and medical staff decide together. However, there are instances where patients behave or make decisions that could potentially pose a danger to self or others. Or, patients may cognitively know what to do, but lack will-power or practical skills to put their decisions into practice. In these circumstances, clinicians feel obligated to embody the role of an educator as part of the fiduciary nature of their professional role. While these two roles (clinician and educator) overlap, they have specific functions in the clinical encounter. These functions will depend on what input patients need. When a patient does not follow the clinician's instructions based on agreed upon therapeutic goals due to forgetfulness, reluctance, weakness of will or lack of knowledge, education is a paramount way to promote change in behavior and increase adherence in line with long term patient goals and values.

Education, however, can be used for various purposes, either to empower patients to make judicious decisions or to exercise some pressure on them to comply. Various psychological techniques are available to clinicians to channel their patients' decisions. For instance, Swindell, McGuire and Halpern argue that "beneficent persuasion" offers venues for clinicians to optimize health decision-making—position we will challenge in what follows. They assert that traditional models of medical decision making put too much emphasis on rationality, that is, choices tend to maximize utility and do not change regardless of how information is presented. Swindel et al. point out that this approach has been challenged by behavioral economists who have demonstrated that people do not make decisions based on rational choices but rather on biases and heuristics that influence decision-making (Swindell et al. 2010). To offset the influence of biases and heuristics Swindell et al. propose the use of persuasion derived from decision-making psychology to optimize medical decisions. In their view, this method is ethically justified as long as clinicians limit their role in ascertaining the patient's best interests and goals, and rebias the patient toward them (Swindell et al. 2010).

The toolbox of persuasive techniques include: (1) vivid depictions of a particular condition (e.g., showing pictures of a patient with advance lung cancer), (2) defaults (e.g., make certain procedures mandatory, e.g., screening); (3) regret (e.g., urging patients to think about the potential consequences of not complying with the clinicians recommendations); and (4) refocusing (e.g., emphasize on the patient's abilities to overcome challenges based on past experiences) (Volandes et al. 2009; Halpern et al. 2007; Richard et al. 1996; Gallois et al. 2012; http://oxforddictionaries.com/?region=us). Swindell et al. argue that these techniques are appropriate in the clinical setting because they help patients to achieve benefit in line with their long-term wishes:

> Using knowledge of decision-making psychology to rebias patients to persuade them to engage in healthy behaviors or make good treatment decisions is ethically justified when the patients' biases or heuristics are distorting their decisions in harmful and potentially correctable way…clinicians may frame health decisions to patient to make better choices, i.e. less biased and more consistent with their long-term goals (Swindell et al. 2010).

Contrary to the view advanced by Swindell et al., we argue that what they call "beneficent" persuasion as a set of techniques to rebias patients toward their best interests and goals is too restrictive, has unjustified manipulative aspects, and therefore undermines the purpose of patient education. A bias is an "inclination or prejudice for or against one person or group, especially in a way considered to be unfair" (http://oxforddictionaries.com/?region=us). So biases are factors affecting one's cognition based on personal, social, political, religious or ideological premises or, relevant to the medical context, resulting from inaction (omission), short terms desires, or wrong information (Shaw and Elger 2013).

The use of persuasion to rebias patients, albeit toward their interests and long-term goals, is problematic because it does not take seriously enough how the process could potentially result in the imposition of the clinician's values and the patient has no control to make sure that it is correctly based on what he/she defined him/herself—here we exclude situations when a patient does not have decision making capacity and in this such circumstance it is legitimate to "impose" a particular course of action if the clinical act is in the best interest of the incapacitated patient. Being a dynamic process that aims at the empowerment of the patient, patient education implies an active involvement on the part of the educator in shaping and guiding the patient to achieve specific therapeutic goals. The difference between ethically adequate education and "beneficent persuasion" as proposed by Swindell et al. is that there is an ongoing process controlled by the patient to determine and adapt the patient's priorities which avoids the potential creation of new biases—considered morally unacceptable (Shaw and Elger 2013). Although education conveys, to a certain extent, the values of the educator and therefore the potential for manipulation is real, ethically appropriate forms of education are characterized by the way in which they engage in a constant dialogue with the patient to reaffirm and clarify his/her goals. An example is motivational counseling of drug addicts. The educational process does repeatedly establish with the patient what his/her goals are and this strategy is the main reason for its success.

Some might object that patient education is simply another, more elaborate and sophisticated, technique on the part of the clinicians to impose their values on patients. While we recognize that there is always the danger of such imposition, because of the nature of human relationships, patient education as defined earlier seeks to provide individualized patient decision support within a framework that addresses the patient's needs. Contrary to beneficent persuasion (that may be indeed beneficent), patient education always "should aim to change the way that patients think, feel and behave toward [their condition] and should actively help facilitate them in their rehabilitation" (Borwell 2009). Consequently, the goal of patient education is not simply therapeutic but also psychological, cognitive and behavioral so that patients feel empowered to take charge of their recovery.

Clinicians might want to use psychological strategies with the intention to protect the patient from him to herself, avoid harm to others or produce a behavioral change. However, techniques that do not empower patients defeat the purpose of patient education in the long run not only from an ethical point of view, but also based on empirical data. Studies show that behavior modification requires patients to share the underlying values in order to maintain the healthy behavior in the long run.

Patient education as self-rebiasing

Given that the boundaries between ethically adequate education and manipulative persuasion can be fuzzy, it is important to examine in more detail how and when techniques to change a patient's decisions or behavior become coercive tools, or create further biases that undermine the autonomy of patients rather than an instrument that empowers them to determine their own therapeutic goals. Hence the issues we need to address is 1) whether techniques such as beneficent persuasion to rebias patients' decisions are manipulative, even when they promote their interests and well-being, and 2) determine the ethical boundaries in patient education.

Before we can delve into these questions we need to define few terms. Previously we distinguished the two concepts of health information and health education, stating that the latter was a complex process by which patients enhance their ability to make health related decisions through learning and behavioral changes. Further distinctions are needed between the terms educate, manipulate, and persuade. To *educate* in the clinical context is to "make the patient more autonomous concerning his/her disease, more actor than observer, more engaged in the decisions that concern him/her" (Gallois et al. 2012). To *manipulate* means to "control or influence (a person or situation) cleverly, unfairly, or unscrupulously" (Ackerman 1982) or "to control or play upon by artful, unfair, or insidious means especially to one's own advantage" (http://www.merriam-webster.com). The last term that needs to be defined is *persuasion*. Shaw and Elger argue that there are at least three different types: (1) the removal of biases, (2) the recommendation of a particular course of action based on justified reasons, and (3) the potential creation of further biases (Shaw and Elger 2013). The first two types are morally acceptable, although unacceptable in some circumstances while the third type is "normally impermissible but sometimes acceptable in rare cases" (Shaw and Elger 2013).

Based on these definitions beneficent persuasion is not per se manipulative or does not create necessarily new biases. However, as stated previously, Swindell et al.'s type of "beneficent persuasion" does not aim to enhance the autonomy of the patient, but simply re-channels the reasons for behavioral change or the decision-making process toward particular therapeutic goals defined according the professionals, not the patients. "Beneficent persuasion" as proposed by Swindell et al. does not empower patients to make their own informed decisions at later stages when the external agent performing the re-biasing is not present anymore. The goal of patient education is precisely to avoid this dependence and to enhance autonomy, understanding, and personal responsibility to enable patients to make health decisions on their own. For this reason, we contend that "beneficent persuasion" should be abandoned on behalf of a stronger commitment to patient self-determination through education and partnership, which results in long-term empowerment.

This is not to say that the clinical staff remains somewhat distant or uninvolved in the process of educating patients about their medical conditions and treatment options. On the contrary, the main difference between beneficent persuasion and empowerment is that in the latter case the source of motivation lies within the patient and not in the agency of the clinician or the medical staff. If therapeutic goals have been established ahead of time these can change. The clinician might not be aware of this alteration and could impose particular views, norms or values based on previous therapeutic goals. The rebiasing in the "beneficent persuasion" model takes place after a limited exchange of information about the patients' long-term goals. The clinician might later interpret behavioral change as non-compliance or as a search for excuses on the part of the patient to reject particular medical recommendations. Conversely, the empowerment model is based on a partnership grounded on the idea that the source of the rebiasing comes from within the decision maker. The potential for manipulation or imposition of values is thus diminished since the patient remains the agent initiating and generating behavioral change. In short, patient education strives as much as possible toward empowering patients for self-rebiasing.

An ethical framework for patient education

After having, in the preceding sections, established the function (empowerment) and goal (self-rebiasing) of patient education we need now to turn to its ethical framework. Four main premises provide the background for our analysis. First, education is not completely neutral because the agency of the educator always shape and influence the values and norms conveyed through human interaction. Second, we need to acknowledge the pluralistic context in which health care delivery occurs. Competing moral frameworks and various assumptions influence the patient–physician relationship and can create disagreements. Third, clinicians are not just conveyors of information but also educators. If various factors have recast the power differential between the patient and the physician, a certain degree of inequity still subsists due to the potential impact of illness on cognitive, psychological and social capabilities (Ackerman 1982). Fourth, as pointed out, some degree of influence occurs on the part of the physician over the patient and therefore it is crucial to make the distinction between influence and manipulation.

Each of these four premises requires trust to regulate the relationship between people who are potentially in disagreement within the clinical context. Effective patient education will require not only the use of adequate tools and forums to increase health literacy (defined time frame, audiovisual aids, individual counseling, written materials, patient forums, internet, etc.) to communicate relevant information but also strategies to build trust. Education always conveys norms and values and therefore it demands on the part of the patient to count on the physician's integrity to make suggestions that will benefit him/her. In addition, in our pluralistic context we cannot assume that the patient and the physician will share common moral values. The patient must be confident that the physician will respect his or her values. Finally, it is impossible to remove the physician's influence on the patient due to the nature of the relationship. Trust will delineate the boundaries of the clinical encounter to avoid deception.

Any practice in the clinical context that does not enhance trust between the medical establishment and patients and does not ground its justification on short- (compliance, treatment) and long-term (management, healthy behavior) therapeutic goals remains not only inefficient but ethically questionable. Only when patients feel in charge of their care and empowered to make decisions can the clinical staff position itself to provide suitable information for the patients in order to create the conditions for change without the constraint of an outside pressure. Patients understand the reasons for change in order to optimize treatment and integrate them in their lives by creating the necessary setting for a sustained healthy living. In short, patient education is a type of self-rebiasing where patients are agents of change rather than objects to change.

In our opinion any psychological technique or educational strategy to increase adherence or change of behavior can be used if (1) it empowers patients to become healthcare partners and to make their own healthcare decisions; (2) it aligns with patients' therapeutic goals; (3) it does not cause harm (psychological or physical) to oneself or others—in some circumstance undermining the autonomy of a patient might be required to avoid a public health threat; and (4) it respects the deontological framework of medical practice based on the nature and goals of the patient–physician relationship (fiduciary relationship).

Conclusion

In the clinical context the role of education is to (1) help patients learn about their condition, treatment options, risks and benefits of treatment options, etc.; (2) clarify areas of concerns either expressed by patients or perceived by the clinical team; and (3) empower patients to achieve determined therapeutic goals. The power differential in the clinical encounter and the potential impact of illness on patients demands high moral standards to enhance patient autonomy and empowerment. These standards must protect patients against manipulation and deception. Even if they seem to promote their interests and improve their well-being within a short timeframe, these strategies are in general not able to promote sustainable change of patient behavior. In this paper, we argued that when confronted to damaging health behaviors, the role of clinicians is to create the conditions for patients to become healthcare partners to achieve self-rebiasing as way to optimize health outcomes.

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