Commentary

From paternalism to benevolent coaching

New model of care

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In the modern North American context, the patient-centred approach has become the foremost ideology of medicine.[1] The patient's centrality and participation in decision making have emerged as strong themes,[2] with the result that antipaternalism has become the predominant philosophical position regarding the physician-patient relationship.[3]

Given this development, our commentary poses the following questions: What if, in the intimacy of the consulting room, some patients request an authoritarian form of guidance—which we refer to here as *benevolent coaching*—from their physicians? Can an approach to care that allows for the potential exercise of authority fit with the core values of dedication that underpin the patient-centred care model?

Complex picture of paternalism

Two recent sources of information impel us to raise these questions. First, in a study we conducted, paternalism emerged as a recurrent theme in the analysis of 25 in-depth interviews with GPs providing care to patients with multimorbidity in the most deprived areas of Montreal, Que. In these interviews, many GPs confided that they had not abandoned what they defined as paternalism, arguing for its nuanced adoption. Of note, all 25 GPs selected for our study had been identified by their colleagues as having developed strategies for creating positive therapeutic alliances with patients living in poverty.[4] These GPs' admissions drew our attention to the selective use, in this context, of what they considered to be a paternalistic approach to care.

In addition to this empirical material, the second impetus for our commentary is the work of researchers such as Sandman and Munthe[1] and Sutrop,[5] who recently proposed different ways of seeing paternalism, suggesting a more complex picture than previously envisioned. Interestingly, Sandman and Munthe[1] proposed that the 2 most common models of decision making—paternalism and patient choice—are not necessarily incompatible with a shared decision-making model. Similarly, Sutrop[5] argued that there should be no conflict between autonomy and the version of paternalism that she refers to as *beneficence,* because the two could coexist.

These reflections and our empirical data have prompted us to contribute to the current debate in family medicine by proposing a new model of care to be embedded in the patient-centred approach. We argue that the adoption of a benevolent form of coaching by physicians would provide some patients with the tools they need to deal with chronic illnesses and difficult social situations—indeed, that benevolent coaching could, under certain circumstances, help to empower some patients.

Some GPs we interviewed used the term *paternalism* to refer to the compassionate and humane approach they adopted when they believed their patients requested and needed it. However, the approach described by the GPs contrasts in many respects with the harsher version of the term[6] that has historically been associated with pejorative themes such as dominance and subordination. We have therefore adopted the expression *benevolent coaching* to emphasize physicians' compassionate intentions in providing care and in guiding patients toward what they consider to be the most appropriate options. This expression more suitably reflects the comments of our interviewees as well as our own observations. It further avoids contributing to a dichotomous model in which paternalism and patients' autonomy are opposed.

Therefore, we define *benevolent coaching* as a combination of accompaniment, guidance, and committed support and availability. It arises out of a flexible approach and an in-depth understanding of the patient's multiple chronic conditions and social context.

To satisfy the definition of *benevolent coaching,* the physician's approach must meet 3 criteria. First, it must be based on the patient's individual needs and conditions. Second, to be ethically sensitive, benevolent coaching must be adopted in response to the patient's request or needs—implicit or explicit—or with the patient's approval, even if only retroactively available, as in cases of temporary incapacity. Also, a patient might request guidance at one point and prefer autonomy at another when facing new circumstances or health conditions.[7] Third, benevolent coaching implies a need and willingness to adapt one's practice.[8] Benevolent coaching calls upon physicians' flexibility

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and judgment—acquired through experience—rather than on a list of rules.

Indeed, with reference to vulnerable populations, interviewees emphasized the potential benefits of adopting benevolent coaching in 3 specific circumstances. These cases illustrate how physicians' experience can shape their practices.

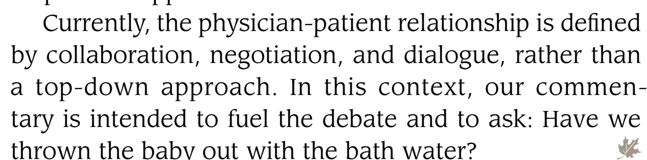
Benefits of benevolent coaching

First, some older patients feel more secure having family physicians determine their path of action because they see physicians as authority figures. Second, encouraging patient autonomy among immigrants and refugees unfamiliar with Western health care might impede the creation of a positive therapeutic alliance. Third, physicians explained that, with drug-addicted patients, an authoritative approach with strict limits is key to achieving sustained and effective care relationships. Physicians' experiences with these patient groups led them to assume a more directive role.

From these first-hand data we can see that, when certain criteria are met, benevolent coaching might properly suit the needs and demands of specific patients and thereby represent a new model of patient-centred care. We question the appropriateness of uncritical adoption of either a shared decision-making model or a patient-centred approach—which assumes an active and informed patient—if it leads to patients' needs not being seriously considered and addressed. Why not provide benevolent coaching if the patient requests it or if the physician believes the patient needs it?

In the context of urban poverty, we consider that adapting practice to meet patients' expectations is a matter of *social competence,* which we define as the process of acquiring tools through experience to build positive alliances with patients despite social distance.[4] The 3 circumstances mentioned above strongly suggest that what the GPs called *paternalism*—but which we identify as *benevolent coaching*—offers a concrete point of analysis to further explore the notion of social competence as a context-relative, individual-specific, and socially responsive approach.

Currently, the physician-patient relationship is defined by collaboration, negotiation, and dialogue, rather than a top-down approach. In this context, our commentary is intended to fuel the debate and to ask: Have we thrown the baby out with the bath water?



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Competing interests
None declared

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