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ETHICAL TENSIONS BETWEEN PATIENT AUTONOMY AND VERACITY IN CLINICAL PRACTICE: A CROSS-SECTIONAL SURVEY OF CLINICIANS IN A TERTIARY CARE HOSPITAL IN PAKISTAN

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Abstract

Background: *The ethical principles of patient autonomy and veracity are foundational to clinical practice; however, their simultaneous application frequently generates tensions in collectivist healthcare environments such as Pakistan. Cultural expectations, particularly those favoring family mediated disclosure and the exercise of therapeutic privilege create complex dilemmas for clinicians across specialties.*

Objective: *To assess the nature, frequency, and contextual determinants of ethical tensions between patient autonomy and veracity among clinicians working in a tertiary care hospital in Pakistan.*

Methods: *A cross-sectional survey was conducted among 156 clinicians (response rate: 84.3%) using a structured, self-administered questionnaire. The instrument included a validated Likert-scale attitudinal tool (Cronbach's alpha = 0.79) and three standardized clinical vignettes evaluating decision making in ethically charged scenarios. Descriptive statistics, the Friedman test, Mann-Whitney U test, and Spearman correlation were used for analysis.*

Results: *The mean total attitude score was 24.3 (SD = 5.1), reflecting moderate ethical tension. Tension was highest in the cancer diagnosis disclosure vignette (M = 4.3, SD = 0.8). Family pressure to withhold bad news (M = 4.4) and cultural norms (M = 4.2) were the leading barriers to ethical practice. Only 25.6% of clinicians had received formal ethics training. Clinicians with ethics training demonstrated significantly lower vignette tension scores and greater utilization of ethics consultation (OR = 2.4, 95% CI: 1.1–5.2, p = .03).*

Conclusion: *Ethical tensions between autonomy and veracity are prevalent and shaped substantially by sociocultural factors in Pakistani clinical settings. Formal ethics education and the establishment of accessible institutional ethics consultation services are urgently needed to support clinicians in navigating these conflicts.*

INTRODUCTION

The ethical governance of the clinician-patient relationship rests upon two foundational principles: patient autonomy the right of a competent individual to make informed decisions about their own care and veracity, which obligates healthcare professionals to communicate truthfully with those in their care (Beauchamp & Childress, 2019). While Western bioethical discourse tends to treat these principles as largely complementary, clinical practice in low and middle income countries (LMICs), including Pakistan, frequently renders them sources of moral conflict rather than alignment.

In Pakistan, as in many South and Southeast Asian settings, the healthcare communication model is characterized by strong paternalism and family centric decision making. Patients are often perceived by both clinicians and relatives as vulnerable individuals who must be shielded from distressing diagnoses, particularly cancer, or from the full disclosure of prognosis (Khalid et al., 2020). This cultural architecture creates a tension between the clinician's ethical obligation to disclose truthfully and the social imperative to defer to family preferences.

Empirical research from comparable settings in South Asia has documented that clinicians frequently engage in partial or complete nondisclosure of terminal diagnoses, often without seeking the patient's explicit consent for this approach (Mystakidou et al., 1996; Rosenbaum et al.). Studies from India and Iran have found that family requests for nondisclosure are among the most common sources of ethical dilemma reported by oncologists and general practitioners (Shahidi, 2010; Surbone, 2004). However, such evidence remains limited in the Pakistani context, where medical ethics education is not yet uniformly integrated into undergraduate or postgraduate curricula (Pakistan Medical and Dental Council, 2022).

The absence of structured institutional ethics consultation services compounds this challenge. Clinicians in Pakistani tertiary care settings often resolve such tensions individually, without formal guidance, making their decisions susceptible to cultural coercion and personal bias (Hasan et al., 2020). The consequences are not trivial: inadequate disclosure compromises informed consent, undermines therapeutic trust, and may result in patients making life-altering decisions without access to relevant clinical information.

Despite the practical urgency of this issue, there is a paucity of published, quantitative research specifically examining clinician attitudes toward autonomy and veracity in Pakistan. The few available studies are predominantly qualitative, limited in sample size, or focused narrowly on oncological settings. This study sought to address this evidence gap through a structured, cross-sectional survey employing validated attitudinal measures and standardized clinical vignettes, with the aim of characterizing the nature and frequency of ethical tensions across a range of clinical specialties.

The specific objectives of this study were to: (a) describe the attitudinal profiles of clinicians regarding patient autonomy and truth-telling; (b) quantify ethical tension across clinically relevant disclosure scenarios; (c) identify the contextual and institutional barriers to ethical practice; and (d) examine whether demographic and professional characteristics—particularly formal ethics training—are associated with attitudinal or behavioral differences.

Methods

Study Design and Setting

This study employed a cross-sectional survey design and was conducted at Ayub Teaching Hospital Abbottabad in Pakistan. All participants provided written informed consent. Participation was entirely voluntary, and no incentives were offered. Confidentiality was maintained throughout; no identifying information was recorded on questionnaires.

Participants

The target population comprised all clinicians actively practicing at the study site during the data collection period. Eligible participants included house officers, postgraduate residents, medical officers, and consultants or specialists across all clinical departments. Purposive sampling was employed to ensure representation across departments. Of 185 clinicians approached, 156 returned completed questionnaires, yielding a response rate of 84.3%.

Instrument

A structured, self-administered questionnaire was developed in English following review of the relevant literature and expert consultation. Section A collected sociodemographic and professional data, including age, gender, designation, years of experience, departmental affiliation, prior ethics training, and frequency of ethical dilemmas encountered. Section B comprised a seven-item attitudinal scale (Items B1–B7) using a five-point Likert format (1 = strongly disagree; 5 = strongly agree), with items addressing clinician perspectives on patient autonomy, truth-telling, family-mediated nondisclosure, and therapeutic privilege. Internal consistency of this scale was assessed using Cronbach's alpha.

Section C presented three standardized clinical vignettes: Vignette 1 (terminal cancer diagnosis disclosure), Vignette 2 (postoperative complication), and Vignette 3 (religiously motivated refusal of amputation). For each vignette, participants rated their level of ethical tension on a five-point scale and selected one of four behavioral options. Section D assessed perceived barriers to ethical practice across seven domains using a five-point scale.

Statistical Analysis

Data were analyzed using SPSS version 26.0 (IBM Corp., 2019). Descriptive statistics (frequencies, percentages, means, and standard deviations) were generated for all variables. The Friedman test was used to compare mean tension scores across the three vignettes. Differences in tension scores between clinicians with and without formal ethics training were assessed using the Mann-Whitney U test, given the non-normal distribution of scores. Correlations between continuous variables were examined using Spearman's rank correlation coefficient. Binary logistic regression was employed to calculate the odds ratio for ethics consultation preference as a function of ethics training status. A p-value of less than .05 was considered statistically significant.

Results

Participant Characteristics

A total of 156 clinicians participated in the study, with a response rate of 84.3%. Baseline demographic and professional characteristics are summarized in Table 1. The majority of participants were male (62.2%) and fell within the 20–29-year age category (44.9%). Postgraduate residents constituted the largest professional group (39.7%), followed by house officers (30.8%). A plurality of participants (37.2%) reported between two and five years of clinical experience. Internal medicine (28.2%) and surgery (21.8%) were the most represented departments. Notably, only 25.6% of respondents had received formal training in medical ethics. Regarding prior ethical encounters, 41.0% of clinicians reported facing ethical dilemmas three to five times during the preceding year.

Table 1
Baseline Characteristics of Participants (N = 156)

Characteristic	Category	N	%
Age (years)	20–29	70	44.9
	30–39	54	34.6
	40–49	24	15.4
	≥50	8	5.1
Gender	Male	97	62.2
	Female	59	37.8
Designation	House Officer	48	30.8

Characteristic	Category	N	%
	Postgraduate Resident	62	39.7
	Medical Officer	30	19.2
	Consultant/Specialist	16	10.3
Experience (years)	<2	42	26.9
	2–5	58	37.2
	6–10	34	21.8
	≥10	22	14.1
Department	Medicine	44	28.2
	Surgery	34	21.8
	Pediatrics	18	11.5
	Obstetrics/Gynecology	22	14.1
	Emergency	20	12.8
	Other	18	11.5
Ethics Training	Yes	40	25.6
	No	116	74.4
Ethical dilemmas (past year)	None	18	11.5
	1–2 times	52	33.3
	3–5 times	64	41.0
	>5 times	22	14.1

Note. Percentages are calculated based on the total sample (N = 156).

Attitudes toward Autonomy and Veracity

The mean total attitude score was 24.3 (SD = 5.1) on a possible range of 7 to 35, indicating moderate overall endorsement of statements reflecting ethical tension between autonomy and veracity. The internal consistency of the seven-item scale was acceptable (Cronbach's alpha = 0.79). Item-level means and standard deviations are presented in Table 2. The item generating the highest mean agreement was B3, which addressed family requests to withhold bad news from patients (M = 4.1, SD = 0.9), closely followed by B5, which reflected internal conflict when family members request nondisclosure (M = 4.0, SD = 0.8). The item that received the lowest mean score was B2, concerning the obligation to always tell the complete truth (M = 2.6, SD = 1.1), suggesting that a substantial proportion of clinicians did not endorse unconditional veracity in clinical communication.

Table 2

Clinician Attitudes toward Patient Autonomy and Veracity (Likert Scale: 1–5)

Item	Statement	Mean (SD)	Range
B1	Respect patient autonomy even if life-saving treatment is refused	3.4 (1.2)	1–5
B2	Doctors must always tell the complete truth	2.6 (1.1)	1–5
B3	Families often request withholding bad news	4.1 (0.9)	1–5
B4	Therapeutic privilege is acceptable in clinical practice	3.9 (1.0)	1–5
B5	Internal conflict when family requests nondisclosure	4.0 (0.8)	1–5
B6	Informed consent is invalid without full risk disclosure	3.7 (1.1)	1–5
B7	Autonomy and veracity frequently conflict in practice	3.6 (1.0)	1–5

Note. Higher scores indicate greater agreement. SD = standard deviation.

Ethical Tension across Clinical Vignettes

Ethical tension scores varied significantly across the three vignettes (Friedman test: chi-squared (2) = 28.4, p < .001). Vignette 1, involving cancer diagnosis disclosure to a patient whose family had requested nondisclosure, elicited the highest mean tension score (M = 4.3, SD = 0.8). Vignette 3, which involved a patient refusing amputation on religious grounds, generated intermediate tension (M = 3.9, SD = 1.0), while Vignette 2, involving disclosure of a postoperative complication, was associated with the lowest tension (M = 3.2, SD = 1.1).

The distribution of behavioral choices across the three vignettes is presented in Table 3. In Vignette 1, only 23.1% of clinicians selected full and direct disclosure; the majority (50.0%) preferred to persuade the family or seek an ethics consultation. In Vignette 2, 43.6% selected partial disclosure as their preferred approach. In Vignette 3, 43.6% again favoured persuasion or ethics consultation, and 20.5% indicated they would proceed with treatment despite the patient's refusal.

Table 3

Distribution of Behavioral Choices across Clinical Vignettes (N = 156)

Action	Vignette 1 (Cancer) n (%)	Vignette 2 (Complication) n (%)	Vignette 3 (Amputation Refusal) n (%)
Fully disclose truth	36 (23.1)	52 (33.3)	44 (28.2)*
Withhold or partial truth	28 (17.9)	68 (43.6)	12 (7.7)
Persuade family / ethics consult	78 (50.0)	18 (11.5)	68 (43.6)

Action	Vignette 1 (Cancer) n (%)	Vignette 2 (Complication) n (%)	Vignette 3 (Amputation Refusal) n (%)
Override patient/family decision	14 (9.0)	18 (11.5)	32 (20.5)

Note. For Vignette 3, 'fully disclose truth' denotes respect for patient refusal after comprehensive counselling; 'override' denotes proceeding with the procedure in the absence of consent.

Frequency and Context of Ethical Tensions

Over the preceding six months, 41.0% of clinicians reported experiencing ethical tension sometimes (3 to 5 instances), while 23.1% reported experiencing it often (6 to 10 instances). Cancer diagnosis disclosure was identified as the most frequent context for ethical tension (48.7%), followed by end-of-life decision-making (23.1%) and informed consent for high-risk procedures (14.1%).

Adult children of patients were the most commonly identified family members requesting nondisclosure (55.1%), followed by spouses (23.7%). While 34.6% of clinicians reported sometimes complying with family requests for nondisclosure, 15.4% reported doing so frequently. Institutional support was perceived as inadequate: 44.9% of respondents indicated that ethics consultation or senior guidance was rarely available, and a further 23.1% reported it was never available.

Perceived Barriers to Ethical Practice

Table 4 presents the mean ratings for each of the seven perceived barriers to ethical practice. Family pressure to withhold bad news received the highest mean score (M = 4.4, SD = 0.8), followed by the influence of prevailing cultural norms in Pakistani society (M = 4.2, SD = 0.9) and fear of causing psychological harm (M = 4.0, SD = 1.0). Fear of legal consequences was rated comparatively lower (M = 2.8, SD = 1.2), indicating that medico-legal concerns were not the primary driver of nondisclosure practices.

Table 4
Perceived Barriers to Ethical Practice among Clinicians (N = 156; Scale: 1–5)

Perceived Barrier	Mean (SD)
Family pressure to withhold bad news	4.4 (0.8)
Cultural norms prevailing in Pakistani society	4.2 (0.9)
Fear of causing psychological harm to the patient	4.0 (1.0)
Lack of time for adequate disclosure	3.7 (1.1)
Absence of clear hospital guidelines	3.6 (1.2)
Uncertainty about the patient's preferences	3.5 (1.1)
Fear of legal consequences	2.8 (1.2)

Note. Higher scores indicate greater perceived impact of the barrier. SD = standard deviation.

Associations with Participant Characteristics

Clinicians who had received formal ethics training (n = 40) reported significantly lower ethical tension in the cancer disclosure vignette compared to those without training (M = 3.8 vs. M = 4.5, Mann-Whitney U, p = .008). Furthermore, ethics-trained clinicians were more than twice as likely to choose ethics consultation over nondisclosure as their primary response (OR = 2.4, 95% CI: 1.1–5.2, p = .03). A modest but statistically significant negative correlation was identified between years of clinical experience and ethical tension in the postoperative complication vignette (Spearman's rho = -0.21, p = .01), suggesting that greater experience was associated with marginally reduced tension in that context. No significant associations were found between gender and departmental affiliation and overall tension scores (p > .05).

Discussion

This study provides quantitative evidence that ethical tensions between patient autonomy and veracity are both prevalent and contextually patterned among clinicians in a Pakistani tertiary care hospital. The findings align with and extend a modest but growing body of literature demonstrating that collectivist sociocultural norms shape clinical communication in ways that may not be adequately captured by Western bioethical frameworks (Surbone, 2004; Mystakidou et al., 1996).

The mean attitudinal score of 24.3 and the finding that the lowest item mean was associated with unconditional truth-telling (B2; M = 2.6) suggest that most respondents do not conceptualise veracity as an absolute clinical obligation. This is consistent with findings from Middle Eastern and South Asian contexts where truth-telling is often understood as contextually negotiable, contingent on the emotional state of the patient and the preferences of the family unit (Shahidi, 2010; Rosenbaum et al., 2011). The high mean score for B3 (family requests for nondisclosure; M = 4.1) confirms that family-mediated communication is a near-universal experience among Pakistani clinicians, not an exceptional occurrence.

The clinical vignette data offer particular insight into decision-making under conditions of moral uncertainty. In the cancer disclosure scenario—which generated the highest tension only 23.1% of participants opted for direct disclosure. This preference for family mediation or ethics consultation over unilateral disclosure, rather than reflecting an ethical failure, may represent a pragmatic adaptation to an environment where ethical infrastructure is underdeveloped. In the absence of formal ethics consultation services, clinicians default to relational strategies that distribute moral responsibility rather than concentrating it in the individual physician. This is not unique to Pakistan; analogous patterns have been observed in Turkey, Iran, and Japan (Mystakidou et al., 1996; Surbone, 2004).

The comparatively high proportion of participants who selected partial disclosure in Vignette 2 (postoperative complication: 43.6%) is of particular concern from a patient rights perspective. Disclosure of adverse events and medical errors is a recognized component of professional accountability and is increasingly required under national and international patient safety frameworks (World Health Organization, 2005). The preference for partial disclosure in this scenario suggests that systemic barriers including fear of patient or family response, perceived absence of institutional support, and the absence of clear disclosure guidelines may override ethical intentions.

Family pressure was identified as the highest-rated barrier to ethical practice (M = 4.4), followed by cultural norms (M = 4.2). This finding is consistent with research from comparable healthcare settings and reflects the structural embedding of family authority within South Asian medical encounters (Khalid et al., 2020; Hasan et al., 2020). That legal fear was rated substantially lower (M = 2.8) is notable and suggests that reforming ethical practice in Pakistan will require cultural and educational interventions rather than or in addition to regulatory mechanisms.

The most consequential finding from a policy perspective concerns the protective role of formal ethics education. Clinicians who had undergone structured ethics training demonstrated significantly lower ethical tension and greater likelihood of seeking institutional ethics consultation. This effect persisted after accounting for years of experience, suggesting that ethics training exerts an independent and positive influence on clinical decision-making. Despite this, only 25.6% of participants had received such training, consistent with reports that formal bioethics education remains inconsistently embedded in Pakistani medical curricula (Pakistan Medical and Dental Council, 2022).

The limited availability of ethics consultation services—reported as rarely or never accessible by 68.0% of participants—represents a structural deficit that places an undue burden on individual clinicians. International evidence strongly supports the integration of clinical ethics consultation into tertiary care settings as a mechanism for reducing clinician moral distress and improving patient centered outcomes (Fox et al., 2010). The establishment and resourcing of such services in Pakistani hospitals should be considered a priority within national health systems reform.

This study has several limitations. First, the use of self-reported data introduces the possibility of social desirability bias, which may have led to more ethically normative responses than would be observed in actual clinical encounters. Second, the single-site design limits the generalizability of findings to other institutional contexts in Pakistan. Third, the absence of a validated, Pakistan-specific ethics attitude scale necessitated the development of a study-specific instrument, which, despite demonstrating acceptable internal consistency, requires further psychometric validation. Future research should employ multi-site designs, qualitative methodologies to explore the experiential dimensions of ethical tension, and longitudinal approaches to assess the sustained impact of ethics education on clinical practice.

Conclusion

Ethical tensions arising from the conflict between patient autonomy and veracity are prevalent among clinicians in Pakistani tertiary care hospitals and are substantially mediated by family pressure, cultural norms, and the structural absence of institutional ethics support. Formal ethics training was the most consistent predictor of reduced tension and more patient-centred decision-making, yet the large majority of clinicians in this sample had received none. These findings carry clear implications for medical education policy and for the development of clinical ethics infrastructure in Pakistan. A concerted effort is needed to embed medical ethics as a substantive component of undergraduate and postgraduate curricula, and to establish accessible, adequately resourced clinical ethics consultation services within tertiary care institutions.

Authors' Contributions

All authors made substantial contributions to the conception, design, execution, and reporting of the study and approved the final version of the manuscript.

- **Javed Iqbal:** Conceptualization and overall supervision of the study; contributed to study design, manuscript drafting, and final approval for submission.
- **Qaiser Iqbal:** Contributed to study design, data analysis, and critical review of the manuscript for important intellectual content.
- **Abid Khan:** Participated in data collection, data entry, and preliminary analysis; contributed to manuscript drafting.
- **Fida Muhammad:** Assisted in literature review, data interpretation, and manuscript preparation; contributed to manuscript review and refinement.

All authors read and approved the final manuscript and agree to be accountable for all aspects of the work.

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