

**F**amily practice became a medical specialty around the same time that medical consumerism began to transform the nature of the physician-patient relationship. The majority of current family physicians were trained during an era when patient (and family) autonomy largely replaced beneficence as the paramount ethical principle for guiding medical decision making. In keeping with their counterculture tendencies, family physicians probably subscribed to this nontraditionalist view much more so than other medical specialists. Despite their espoused belief in patient autonomy, family physicians often behave in paternalistic ways with patients.

The article by Peters provides a compelling argument for justified paternalism with selected patients. At first glance, it appears to suggest that physicians use paternalism only with patients with low ability and desire to participate actively in medical decision making. Two other styles, deferential and directed, also contain strong features of paternalism—making decisions for patients, filtering information and options, and convincing patients to make good decisions (good as defined by the physician). Only the participatory style is free of paternalistic features. The proposed scheme seems reasonable, but family physicians who follow it need to be aware that they will be constraining patient autonomy to a significant degree most of the time. Such constraint may be more necessary and conscionable in the new era of cost-effective managed care.

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