

COMMENTARY

Dr Google v Dr Real: Is it unethical to dismiss patients who self-diagnose?

VANGIPURAM HARSHIL SAI, CHIRAMANA HARITHA, VANGIPURAM SHANKAR

Abstract

With online information at their fingertips, patients increasingly present with self-diagnoses — a trend that both empowers and complicates care. Many clinicians react with dismissal, seeing such behaviour as a challenge to their expertise. But is it ethical to disregard patients who Google their symptoms? Through a case vignette and analysis grounded in autonomy, epistemic justice, and beneficence, we argue that dismissal reflects a deeper failure of ethical engagement. Medical education must evolve to equip future doctors with humility and communication skills to guide, not guard, patients in an information-saturated world.

Keywords: patient autonomy, cyberchondria, epistemic justice, doctor-patient relationship

Introduction

In contemporary clinical practice, patients frequently arrive at consultations having searched their symptoms online, a phenomenon termed the “Google-informed patient.” Surveys indicate that 70% of internet users seek health information, reflecting a shift toward self-directed health literacy [1]. This trend challenges traditional medical authority but offers opportunities for deeper engagement if clinicians respond constructively.

The risks of online misinformation — diagnostic errors, health anxiety, and unsafe self-treatment — are well-documented [2]. However, this reflection focuses on clinicians’ responses to patient-initiated research rather than its accuracy. Dismissal of such efforts can erode trust, delay care, and overlook valid concerns [3]. Societal factors, including limited healthcare access, long wait times, and distrust in medical systems, drive patients online. For instance, rural patients or those facing financial barriers may rely on the internet as a first resource, while others, burnt by past medical dismissals, seek agency through self-diagnosis [4].

Historical context

Historical precedents of self-diagnosis — whether grounded in cultural beliefs, community narratives, or personal heuristics — reveal that the human impulse to interpret illness is both ancient and adaptive. Long before the advent of digital tools, individuals sought meaning in symptoms through familial wisdom, folk remedies, or shared stories within their communities. This interpretive instinct is neither new nor inherently misguided. What distinguishes the contemporary moment is the internet’s ability to dramatically accelerate, amplify, and externalise this process — transforming what was once a private act of meaning-making into a public,

searchable, and often socially reinforced behaviour that now intersects directly with clinical practice [5].

Clinical vignette: a missed diagnostic opportunity

Meena, a 31-year-old teacher, presented to a gynaecology clinic with chronic pelvic pain and painful periods. After researching online, she suggested, “I think it could be endometriosis — my symptoms match.” The resident, overwhelmed by a busy schedule, responded, “The internet isn’t reliable. It’s probably stress.” No tests were ordered. Meena felt invalidated. Over the next year, she consulted multiple clinicians, each dismissing her as anxious or hormonal. Her pain intensified, disrupting her work and personal life. A laparoscopy eventually confirmed stage III endometriosis, complicating her fertility. Meena reflected, “I knew something was wrong, but I had to fight to be heard.”

Meena’s case mirrors broader patterns. Patients with depression or stroke symptoms have faced similar dismissals after citing online research, resulting in delayed care and harm. These examples highlight the clinical and ethical costs of dismissing patient concerns.

Self-diagnosis vs cyberchondria: clinical differentiation

Symptom-related internet searches have become a normal part of patient behaviour, often reflecting curiosity, health ownership, and a willingness to participate in decision-making. When guided appropriately, such inquiry can enrich clinical dialogue and foster trust. However, “cyberchondria” — defined as excessive, anxiety-amplifying online health research — represents a distinct behavioural pattern with clinical implications. Patients affected may progress rapidly from mild symptoms to catastrophic interpretations, sometimes resorting to unnecessary investigations or unproven therapies [6].

While this phenomenon has been widely documented internationally, Indian data underscore its relevance in local contexts. A 2019 cross-sectional study among IT professionals in Chennai reported that 55.6% exhibited features consistent with cyberchondria, including repeated symptom checking, reassurance-seeking, and heightened emotional distress. This high prevalence suggests that cyberchondria is not an exception, but a significant concern in digitally literate populations [7].

Crucially, not all online engagement reflects pathology. Distinguishing between curiosity-driven exploration and compulsive, anxiety-driven behaviour is essential. The former

invites clarification and education; the latter may signal underlying psychological distress and warrant a different clinical approach. Reflexively equating all internet-informed patients with cyberchondriacs risks eroding the therapeutic relationship and missing valid concerns [6].

Self-diagnosis vs cyberchondria: healthcare implications

Cyberchondria may place an additional burden on healthcare systems by contributing to frequent consultations, diagnostic overuse, and fragmented care. Yet, the solution is not discouraging patient engagement, but rather contextual interpretation of their digital behaviour. Clinicians must learn to identify behavioural red flags — such as escalating anxiety, inability to accept reassurance, or fixation on rare diseases — through brief screening or clinical intuition.

Responding effectively requires balancing empathy with appropriate guidance. Strategies may include offering credible information sources, validating concerns without endorsing misinformation, and referring for mental health support when needed. Avoiding premature labelling helps preserve patient trust, promotes shared understanding, and ensures that digitally engaged patients remain active partners in their care [7].

Ethical considerations: autonomy and epistemic justice

Modern clinical ethics requires balancing medical expertise with respect for patient autonomy, which includes the right to access and interpret health information. While misinterpretation is recognised risk in this process, it calls for clinical engagement that corrects misinformation without dismissing patient's intent.

Additionally, such dismissal may constitute epistemic injustice [8]. Testimonial injustice arises when patient input is undervalued due to implicit bias — for example, attributing a woman's concern about endometriosis to anxiety. Hermeneutical injustice occurs when patients, especially from marginalised backgrounds, struggle to articulate their symptoms and receive little interpretive support from clinicians. A psychiatric patient reporting somatic symptoms, for instance, may be prematurely labelled and under-evaluated.

Ethical responsiveness entails more than correcting misinformation — it involves actively listening, recognising the patient's effort to participate, and supporting informed dialogue. This approach promotes shared decision-making and reinforces a care environment grounded in respect, not hierarchy.

Systemic barriers and clinical realities

Clinicians addressing patient self-diagnoses face genuine systemic pressures: limited consultation time, high patient volumes, and increasing documentation demands. These

constraints are further compounded when patients present with fixed beliefs based on online research, often requiring clinicians to spend additional time explaining why certain symptoms do not align with feared conditions. For instance, a patient convinced they have a rare illness may resist alternate explanations, insist on unnecessary investigations, or dismiss reassurance — prolonging consultations and complicating care.

More than just a time burden, such encounters demand cognitive effort. Clinicians may need to clarify misunderstood concepts in anatomy, physiology, or pharmacology, particularly when patients reference complex medical terminology without context. This interpretive labour — disentangling partial truths from misinformation — is rarely acknowledged in clinical workflows.

Still, these challenges reinforce the evolving role of the clinician as an interpreter of information. Brief validation (eg, "That's a reasonable concern — let's go through it together") can diffuse tension and re-establish trust. Structured strategies such as gently correcting misconceptions, setting conversational boundaries, and directing patients to reliable resources can improve engagement while minimising repeat visits. These practices align with the tenets of patient-centred care advocated by bodies such as the General Medical Council, American Medical Association, and India's National Medical Commission [9].

Rather than seeing self-diagnosis as a threat, clinicians must reframe it as a prompt for guided dialogue. With calibrated communication, even challenging consultations can become opportunities to build trust, correct course, and uphold clinical integrity in the digital age.

Reframing clinical encounters

Reframing clinical interactions with self-diagnosing patients calls for intentional yet efficient communication strategies that acknowledge autonomy while maintaining clinical direction.

- Initiating the conversation with, "What did you read online?" invites openness and signals respect for the patient's effort.
- Misconceptions can be addressed through gentle clarification — eg, "That's an interesting interpretation, though evidence points elsewhere" — which corrects without confrontation.
- Rather than dismissing all digital research, clinicians can recommend credible resources such as the Ministry of Health and Family Welfare (MoHFW), AIIMS public health education platforms, or MedlinePlus India.
- Validating the patient's engagement — "You're clearly invested in understanding your health" —

fosters collaboration and encourages shared decision-making.

These interactions not only mitigate the risks of misinformation and cyberchondria but also reinforce the clinician's role as a trusted interpreter in a complex digital ecosystem. Thoughtful guidance transforms potential conflict into an opportunity for partnership, anchoring the clinical encounter in empathy, education, and mutual respect.

Medical education: addressing the hidden curriculum

Medical training often overlooks self-diagnosing patients, while a hidden curriculum of condescension — evident in terms like “Google scholar” — encourages dismissal. This fosters fragility, ill-preparing clinicians for patient disagreements.

Curricula should promote epistemic humility through: a) OSCE scenarios with self-diagnosing patients, testing communication skills; b) Workshops on explaining complex concepts in lay terms; c) Reflective assignments on handling patient challenges. These reforms equip students for digital-age consultations, fostering resilience and collaboration.

Socio-structural drivers of self-diagnosis

Self-diagnosis is not merely a digital habit but often a consequence of deeper structural inequities. Individuals from marginalised communities — whether defined by gender, caste, geography, or chronic illness status — may experience repeated diagnostic delays, dismissal, or communication breakdowns within the healthcare system [10]. In such contexts, online search becomes an act of necessity, not defiance. For example, women with persistent pain conditions are frequently labelled as “stress-related” or “hormonal,” prompting them to seek clarity, often delaying treatment.

Structural remedies — such as longer consult times, inclusive training, and community-based outreach — are urgently needed. In the interim, clinicians must recognise online research as a signal of unmet need and respond with curiosity, not condescension, to rebuild therapeutic credibility.

Conclusion

Self-diagnosis reflects a shift toward patient empowerment, driven by digital access and systemic gaps. Dismissing Google-informed patients risks harm, erodes trust, and perpetuates injustice. Clinicians must respond with empathy, education, and collaboration, even amidst time constraints. Medical education should equip future doctors with the skills to engage with self-diagnosing patients, fostering humility and resilience. The future of medicine lies in partnerships

where clinicians guide patients through digital noise, building care grounded in evidence and mutual respect.

Authors: Vangipuram Harshil Sai (vangipuramharshilsai@gmail.com, <https://orcid.org/0009-0007-5456-2921>), All India Institute of Medical Sciences, Ansari Nagar, New Delhi, 110029, INDIA; Chiramana Haritha (corresponding author — drharitha2014@gmail.com), Senior Consultant, Medical Oncology, CR Reddy Super speciality Hospital, Leela Mahal Road, Nellore, Andhra Pradesh, 524001, INDIA; Vangipuram Shankar (drshankarvangipurapu@gmail.com, <https://orcid.org/0000-0002-9707-6786>), Senior Consultant, Radiation Oncology, Apollo Proton Cancer Center, Tharamani, Chennai, Tamil Nadu, 600041, INDIA.

Conflict of Interest: None declared

Funding: None

Author Note: This reflection draws on clinical experiences during undergraduate oncology training. All patient details are anonymised to ensure confidentiality.

To cite: Sai VH, Haritha C, Shankar V. Dr Google v Dr Real: Is it unethical to dismiss patients who self-diagnose? *Indian J Med Ethics*. Published online first on October 23, 2025. DOI: 10.20529/IJME.2025.079

Submission received: May 22, 2025

Submission accepted: September 15, 2025

Manuscript Editor: Olinda Timms

Copyright and license

©Indian Journal of Medical Ethics 2025: Open Access and Distributed under the Creative Commons license (CC BY-NC-ND 4.0), which permits only non-commercial and non-modified sharing in any medium, provided the original author(s) and source are credited.

References

- Chen YY, Li CM, Liang JC, Tsai CC; Health Information Obtained From the Internet and Changes in Medical Decision Making: Questionnaire Development and Cross-Sectional Survey. *J Med Internet Res* 2018;20(2):e47. <https://doi.org/10.2196/jmir.9370>
- Tan SS, Goonawardene N. Internet Health Information Seeking and the Patient-Physician Relationship: A Systematic Review. *J Med Internet Res*. 2017;19(1):e9. Published 2017 Jan 19. <https://doi.org/10.2196/jmir.5729>
- Gopichandran V. Trust in healthcare: an evolving concept. *Indian J Med Ethics*. 2013;10(2):79-82. <https://doi.org/10.20529/IJME.2013.027>
- Balarajan Y, Selvaraj S, Subramanian SV. Health care and equity in India. *Lancet*. 2011;377(9764):505-515. [https://doi.org/10.1016/S0140-6736\(10\)61894-6](https://doi.org/10.1016/S0140-6736(10)61894-6)
- Nettleton S, Burrows R, O'Malley L. The mundane realities of the everyday lay use of the internet for health, and their consequences for media convergence. *Sociol Health Illn*. 2005;27(7):972-992. <https://doi.org/10.1111/j.1467-9566.2005.00466.x>
- Makarla S, Gopichandran V, Tondare D. Prevalence and correlates of cyberchondria among professionals working in the information technology sector in Chennai, India: A cross-sectional study. *J Postgrad Med*. 2019;65(2):87-92. https://doi.org/10.4103/jpgm.JPGM_293_18
- Agrawal V, Khulbe Y, Singh A, Kar SK. The digital health dilemma: Exploring cyberchondria, well-being, and smartphone addiction in medical and non-medical undergraduates. *Indian J Psychiatry*. 2024;66(3):256-262. https://doi.org/10.4103/indianjpsychiatry.indianjpsychiatry_570_23
- Fricker M. *Epistemic Injustice: Power and the Ethics of Knowing*. Oxford University Press; 2007. <https://doi.org/10.1093/acprof:oso/9780198237907.001.0001>
- Barry MJ, Edgman-Levitan S. Shared decision making—pinnacle of patient-centered care. *N Engl J Med*. 2012;366(9):780-781. <https://doi.org/10.1056/NEJMp1109283>
- Werner A, Malterud K. It is hard work behaving as a credible patient: encounters between women with chronic pain and their doctors. *Soc Sci Med*. 2003;57(8):1409-1419. [https://doi.org/10.1016/S0277-9536\(02\)00520-8](https://doi.org/10.1016/S0277-9536(02)00520-8)