

Physician-Patient Relations: No More Models

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Abstract

Currently, the common theoretical models of "preferred" decision-making relationships do not correspond well with clinical experience. This interview study of congestive heart failure (CHF) patients documents the variety of patient preferences for decision-making, and the necessity for attention to family involvement. In addition, these findings illustrate the confusion as to the designation of surrogate decision-makers and physicians in charge. We conclude that no single model of physician-patient decision-making should be preferred, and that physicians should first ask patients how they want medical information and decision-making to be handled.

Introduction

In recent clinical experience, we have found ourselves dissatisfied with the current models of "preferred" physician-patient relationships for patient involvement in decisions regarding their treatment. While we remain committed to patient autonomy, it has seemed that many patients want to defer decisions to their physician, that they are more comfortable discussing their conditions and the treatment options with family members present and, at a basic level of underlying concern, that they are often confused about the process. The research reported here was undertaken in an effort to address these concerns.

Background: Physician-Patient Relationship Models

Empirical research directed toward the complex issue of patient-physician interaction in medical decision-making is rather limited. Models of physician-patient interaction with respect to decision-making have been developed, but they remain largely theoretical. Degner and Sloan (1992), for example, distinguished three role models (patient active, collaborative, and passive) encompassing five levels ranging from "patient prefers to make the final decision" to "leave all decisions to the doctor." Charles, Gafni, and Whelan (1999) distinguish paternalistic, shared, and informed models. This conceptualization envisages the relationship along a continuum with the "shared" model being the preferred mid-point between physician paternalism and patient autonomy. In the most widely discussed analysis of physician-patient relationships, Emanuel and Emanuel (1992) elaborated four models:

- a. *Paternalistic*: physician makes decisions for the patient's benefit independent of the patient's values or desires
- b. *Informative*: physician provides information, patient applies values and decides.
- c. *Interpretive*: patient is uncertain about values, physician, as counselor, assists the patient in elucidating his or her values.
- d. *Deliberative*: Patient is open to development, physician teaches desirable values

Emanuel and Emanuel argue in favor of the deliberative model, viewing the others as exceptions to the norm that require justification.

Turning attention to the dynamics of decisions, the Ontario team mentioned above accepted the Paternalistic-Shared-Informed continuum of relationships and elaborated a theory of the steps of the decision-making process (Mansell et al. 2000). Researchers in California, furthermore, separated "decisions about technical aspects of treatment from preferences for outcomes" (Frosch and Kaplan 1999); and, other studies have detected differences in patient preferences for involvement related to the nature of the illness and the severity of the decision (Mansell et al. 2000).

The assumptions and models used in these studies have generally had serious shortcomings, however. We identified the following issues:

1. Models of medical decision-making have treated the patient *alone* outside of his or her social context as the subject in the physician-patient relationship. Our experience indicates that many patients do not want to decide alone, however; they prefer family or friends to be involved and they want advice from a spouse, son or daughter before they make the final decision. At times, patients even request to delegate decisions to someone they think has better judgment or a better grasp of the facts. As long as the physician-patient model is that of an individual autonomous patient and a single physician in a decision-making context, the preferences of these patients will be ignored. While some studies have included family influence as a variable (Bradley et al. 1996), these have been limited to situations in which the patient is incapacitated and thus have not figured significantly in the elaboration of patient-physician interaction models.
2. While previous studies have generally involved attempts to discover or elaborate the *best* decision-making model or the *best* decision process,

in our experience patients differ greatly in their preferences: some patients want their physician to act paternalistically while others want full information and yet others seem to distrust any treatment recommendation until they are fully convinced. In short, there appears to be considerable variety in patients' preferences for decision models, so the search for a single best model is based on a misguided assumption that one protocol fits all.

3. Another observation about these studies is that the question of medical decision-making has often been limited to end-of-life issues and focused on the question of refusing life-sustaining treatment. We believe it ought rather to be conceived within a larger context of medical care and in light of the full range of patient-physician interaction.

Research and Results

For this study we interviewed 51 patients admitted to a large teaching hospital with a diagnosis of congestive heart failure. We chose congestive heart failure patients because these people were likely to have had extensive hospital experience and thus more familiarity with physician-patient relationships. The subjects were evenly divided male and female, 68% had a high school education or less. All were clearly capable of participating in physician-patient interaction.

Even before getting to the details of physician-patient communication we found some disturbing facts. Only 62% of the patients could correctly identify their attending physician-in-charge according to the medical record (37.2% of the sample had had two or more physicians-in-charge since admission). While 38.8% of the patients believed they had a Living Will, only 26% had Living Wills noted in their charts. When asked "Have you appointed anyone to make your medical decisions for you if you are not able to make them for yourself?" 70.6% of these patients indicated that they had appointed someone, but only 13% had a surrogate decision-maker listed in their medical record (nurses, questioned separately, believed that 41.2% of these patients had an appointed surrogate). We suspect that this data is not unique to our institution, but further research should be directed toward this issue. Clearly, it is difficult to study physician-patient relationships if patients do not know which physician is in charge of their care.

As to communication preferences, while 74.5% of our subjects said they wanted "as much information as possible" about their condition, only 43% of these patients felt they had "complete understanding" of what the physician told them, and 59.8% said they felt the physician understood them completely.

The aspect of communication that concerned us most, however, was the social context. Our results confirmed our suspicions. 76.5% of our sample said that they nor-

mally talk with family or friends about decisions; 75.7% of these said they usually take the advice offered, and another 18.9% said that they "sometimes" take such advice. 78.4% said they would want a family member or friend present when a physician comes to discuss an operation, and 68.6% would want someone else present when a physician came to discuss discharge. Family and friends are important for support as well as for advice on medical decisions: 72.5% of these patients would want someone with them if they were "very, very ill" and the physician came to speak to them about their condition. But we found considerable variety here as well: 23.5% would want the physician to tell them the bad news alone; and, at the other end of the spectrum, two patients said they would want the physician to discuss this with a family member or friend even before telling them.

In the area of patient input into treatment decisions, we found considerable variation. Using a scale with "Physician Decides" at one end and "Patient Decides" at the other, we interpreted anything less than "Physician Decides" to mean that the patient wanted *some* input into the treatment plan. We also separated the types of decisions to be made and found, as we expected, that patients wanted more input into some decisions than into others. We found that these patients wanted the most input into the questions of whether they needed home health services, whether they would be put on a ventilator, what sort of diet they would have, and the prescription of expensive medications. The results are shown in Figure 1.

Decision	% of Patients wanting some involvement	% of Patients wanting the doctor to decide
Diuretic prescription	10.4	89.6
Which blood pressure medication	17.6	82.4
Expensive medication	38.0	62.0
Diet	47.1	52.9
Anticoagulant	20.0	80.0
Oxygen clip/mask	27.5	72.5
Ventilator	51.0	49.0
Home Health Services	65.3	34.7
Discharge	19.6	80.4
Frequency of blood tests	25.5	74.5
Echocardiogram	14.0	86.0

Figure 1. Patient desires for involvement in treatment decisions

Further analysis revealed a pattern of inconsistency in patient attitudes and behavior. There was no significant correlation between patients wanting input into the decision to be put on a ventilator and their having legally appointed surrogates. In fact, patients without legally appointed surrogates were evenly divided as to their preferences for input into medical decisions. Nor was there a statistically significant correlation between patients being able to identify their physician in charge and their desire to have input into health care decisions. Even among those patients who indicated that they had not appointed someone to make their decisions, a significant majority indicated that they did want input into the question of whether they would have home health services. We believe these inconsistencies reflect a state of affairs with regard to medical decision-making that is quite confusing to patients.

Conclusions

The variety of patient preferences found in this study indicates that individuals do differ significantly from one another in what they expect from their physicians, with regard to communication. Part of the problem is systemic or organizational. With the modern practice of team and consultant care (at least in tertiary care hospitals), patients are confused as to which physician is really in charge. Many believe that they have indicated who should make decisions for them if they are incapacitated, but this is not reflected in the records. They rate the understanding between physicians and patients at 60% or less even though three quarters of them want all the information they can get.

The social dimension of communication came through especially strong in this study. Patients talk with family members and friends about decisions and want them present both for support and advice when discussing treatment. The strong preferences we found for involving family and friends in physician-patient communication should lead to a reconsideration of the concept of patient autonomy.

While the study showed considerable desire on the part of patients for input into treatment decisions, we note that many patients want to leave most of the decision-making to their physicians. Desired input into treatment decisions also varied according to the decision to be made. Over half wanted to be consulted about whether they would have a ventilator and two-thirds wanted some say in whether home health services were needed. On the other hand, few patients wanted much input into what they apparently saw as strictly medical decisions. Reflecting on our own clinical practice we must admit that we think of patients involvement much more often when considering recommendations for surgery, chemotherapy or life-sustaining interventions like the use of a ventilator than when considering home health or the cost of prescriptions.

No More Models: Just Ask the Patient

Given the variety of patient desires concerning communication, it seems unreasonable to believe that any one model of decision-making will fit all patients. Even "shared decision-making" or a "deliberative model" (both of which can surely mean different things to different people) cannot be prized as ideals in a world in which many people want to defer to their physicians or to involve their relatives and friends in difficult decisions.

If we give up the "one model fits all" ideal, however, we need an alternative. Our suggestion is to ask the patient. We don't mean asking the patient what treatment he or she wants, we mean asking the patient how he or she wants the communication and the decision-making to be handled. The approach we propose—which is not a model or protocol for physician-patient communication—is simply that the physician should clarify the communication situation with the patient prior to discussing treatment decisions.

The first step in the communication process is to clear-

ly identify the participants within the health care team and their respective roles. Current hospital practice features teams of physicians, shared physician practices, multiple consultants and countless support staff involved in patient care: and patients are understandably confused. The patient and his or her family should know that there is indeed a physician-in-charge and that this physician has responsibility to explain the patient's condition, the treatments proposed, and the risks and benefits anticipated. This means that consultants and other members of the team should clearly defer to the physician-in-charge and not give the impression that they are making the ultimate recommendations. It also means that the physician-in-charge should clearly indicate his or her role and ask what sort of decision-making the patient wants. This does not exclude second opinions or explanations that can be given by consultants; it only means that the physician-in-charge ought to be clearly in charge in the eyes of the patient and that this physician should come to an understanding of the patient's preferences for communication.

As to the decision-making interaction, the initial focus should be the social context: who does the patient want to be present for support and advice when treatment decisions are discussed with the physician? The patient may want no one present — that is what about a quarter of our patients indicated. Or the patient may want family members or friends, as the great majority told us. The only way to find out is to ask the patient.

The next question should be how much information the patient wants. Most want the whole story, but about 25% of our sample wanted some limitations so they could consider just the important information. Again the physician won't know how to manage the information unless he or she asks the patient.

Finally, different care decisions should be treated differently. While we expected that patients might not be too interested in which diuretic would be prescribed, we were surprised to discover just how concerned they were with home health assistance and the cost of prescriptions. And again, the only way to find out in which decisions the patient wishes to be involved is to ask the patient.

Our conclusion, therefore, is that physicians do not need an elaborate communication protocol, a preferred model of interaction, or a decision flow chart to manage patient communication effectively. To aim for conformity to a "best" or preferred model of physician-patient decision-making may actually undermine patient autonomy. We believe that physicians will be guided in the right direction, and will actively take into account the differences between individual patients, if they simply ask the patient how he or she wants the interaction conducted.

Disclosures

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