

Physician Recommendations and Patient Autonomy: Finding a Balance between Physician Power and Patient Choice

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Medical care in the United States has rapidly moved away from a paternalistic approach to patients and toward an emphasis on patient autonomy. At one extreme end of this spectrum is the "independent choice" model of decision making, in which physicians objectively present patients with options and odds but withhold their own experience and recommendations to avoid overly influencing patients. This model confuses the concepts of independence and autonomy and assumes that the physician's exercise of power and influence inevitably diminishes the patient's ability to choose freely. It sacrifices competence for control, and it discourages active persuasion when differences of opinion exist between physician and patient. This paper proposes an "enhanced autonomy" model, which encourages patients and physicians to actively exchange ideas, explicitly negotiate differences, and share power and influence to serve the patient's best interests. Recommendations are offered that promote an intense collaboration between patient and physician so that patients can autonomously make choices that are informed by both the medical facts and the physician's experience.

Ann Intern Med. 1996;125:763-769.

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Patients faced with serious medical decisions are subject to being over- or under-influenced by physicians. Imagine a patient who is admitted to an intensive care unit with a chronic, progressive illness and has a small but real chance of leaving the hospital alive if he submits to invasive treatment. The patient feels that he has suffered enough, and he requests supportive care only. By the luck of the draw, he has been assigned one of three hypothetical physicians. Dr. Able minimizes the patient's request for supportive care, heavily emphasizes the patient's small chance of recovery and her own strong belief that the patient should not "give up," and convinces the patient to continue receiving aggressive therapy. Dr. Baker makes sure that the patient understands his options and the statistics associated with them and then accedes to the patient's request for supportive care without sharing his own opinion, which is that the patient is making a serious mistake. Dr. Charlie enters into an extended dialogue with the patient, explores various alternatives, and recom-

mends that the patient try aggressive therapy. When the patient continues to request a palliative approach, Dr. Charlie struggles openly with the patient about her concern that he is making this transition prematurely. Through conversation, Dr. Charlie learns the rationale behind the patient's decision and assures herself that the patient is well informed. She then initiates a palliative care plan.

Data from SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment [1]) suggest that the dominant mode of decision making in acute care hospitals may still be the paternalism evidenced by Dr. Able. However, recognition of the value of patient autonomy has gained strength in the United States, and a new generation of physicians has been trained in a "patient-centered" approach (2). Some "patient-centered" physicians have gone beyond encouraging patients to participate in medical decisions, forcing them to make decisions almost independently. Dr. Baker allowed the patient in the above scenario to take full control of a critical decision, but he avoided the intense interaction that would have resulted if he had shared his own reservations. He tried to respect his patient's autonomy, but he did so at the cost of withholding his recommendations. On the other hand, Dr. Charlie allowed her patient to have a central role in the final decision but only after fully exploring the implications of that decision and sharing her belief that palliative care was not the patient's best choice. Such intense interactions between patient and physician may allow patients to exercise autonomy more powerfully by making choices that fully integrate the physician's experience with their own.

The Shift from Paternalism to Autonomy

Twenty-five years ago, most major medical decisions were left exclusively in the hands of physicians. They were usually made with beneficent intent but without open discussion, much less the full participation of the patient (3-6). This paternalistic approach had some benefits. Physicians struggled to make the best possible decisions on behalf of patients, and they spared patients and their families

Table. Characteristics of Two Medical Decision Making Models

Enhanced Autonomy Model	Independent Choice Model
Knowledge and expertise are shared between patients and physicians	Patient's experience and values dominate
Patient and physician collaborate	Patient has independence and control
Relationship-centered	Patient-centered
Physician serves as active guide	Physician serves as passive informer
Additive expertise (win/win)	Zero-sum interaction (win/lose)
Competence-based	Control-based
Dialogue-based	Discussion-based
Physician is personally invested in outcome	Physician is detached operative
Patient and physician have joint responsibility for patient outcome	Physician abdicates responsibility to patient

from agonizing about interventions that had little chance of working. Practitioners also had much more control over the way that medical technology, with its increasing potential to help as well as to harm, was used. In retrospect, physicians now see obvious problems with excessive paternalism: It can be difficult to determine what a patient's best interests are (7); inappropriate biases caused by sex, race, and socioeconomic status can affect decision making (8, 9); and patients can be deprived of the opportunity to make decisions that reflect the reality of their conditions. However, some of the truly beneficent potential of medical paternalism has been lost.

In the United States in the late 20th century, the pendulum has swung away from paternalism and toward patient autonomy (10, 11). Too often, "autonomous" patients and families are asked to make critical medical decisions on the basis of neutrally presented statistics, as free as possible from the contaminating influences of physicians. The causes of this trend are multifactorial. The consumer movement has taught patients to be more assertive, to question physicians' recommendations, and to demand interventions that might otherwise be withheld (12, 13). Many physicians feel that giving patients the full range of choices and withholding their own recommendations are safeguards against lawsuits (14, 15). The probabilistic nature of medical decision making in real life is in unnerving contrast to the grand successes and simplistic solutions suggested in the mass media (16, 17). The information explosion within the field of medicine has left physicians and their patients uncertain about whether the limitations they encounter are inherent in medicine or are a reflection of deficits in the physician's expertise (18, 19). Furthermore, when a bad outcome results from a good clinical decision, the chagrin that a physician feels is more emotionally painful—and the risk for being sued is higher—if that decision was recommended to the patient (16, 20). Many physicians have come to believe that the safest course is to withhold their recommendations and give patients the "choice" of any treatment they might "want."

We intend to show that physicians fail to use

their power appropriately when they withhold their guidance. This failure reflects a misunderstanding about the moral requirements of respecting patient autonomy. We compare an "independent choice" model of medical decision making with an "enhanced autonomy" approach (Table) and suggest ways to achieve a more effective, respectful balance between physician recommendations and patient choice.

Independent Choice

According to the independent choice model, the physician's primary role in medical decision making is to inform patients about their options and the odds of success. Patients should be free to make choices unencumbered by the contaminating influence of the physician's experience or other social forces (19). The independent choice model is literally "patient-centered" and requires that physicians withhold their recommendations because they might bias the patient (21). The physician should objectively answer questions but should avoid influencing the patient to take one path or another, even if the physician has strong opinions or if the patient asks for advice. After the patient makes the decision, the physician's duty is to implement the medical aspects of that decision. As evidence of the force and pervasiveness of the independent choice model, debates rage about whether patients have the right to choose futile treatment (22, 23) and continue it indefinitely (24).

A generation of physicians has now been trained under the independent choice model, and this has created new problems as serious as those posed by medical paternalism. The physician as a person, with values and experience, has become an impediment to rather than a resource for decision making. More objective treatment algorithms could better be presented by using interactive computer systems. Physicians may gradually regress from refusing to express their recommendations to not valuing them or to not even formulating them. Too often, the intense exchanges on medical rounds about what should be done have been replaced by a bland

recitation of statistics. The primary intellectual exercise is to cover all of the possibilities, the odds associated with them, and their implications for treatment. The central clinical tasks are to inform patients about their medical options and then to carry out patients' decisions. Patients in this situation often navigate treacherous medical terrain without adequate medical guidance.

Enhanced Autonomy

The independent choice model reflects a limited conceptualization of autonomy (25–27). Under this model, it is thought that an independent choice is best made with no external influence, even when one's competence to make the choice is limited. However, autonomous medical choices are usually enhanced rather than undermined by the input and support of a well-informed physician. Only after a dialogue in which physician and patient aim to influence each other might the patient fully appreciate the medical possibilities (28–31). Consider, by analogy, the decision to select medicine as a career. Few potential physicians made this decision by wandering alone in the desert to avoid being influenced by the biases of others. Most engaged both peers and senior mentors in extended conversations, confident that they could correct for any biases. The absence of valuable advice that would result if they did not engage experienced persons outweighed the danger that the final choice would be made as a result of inappropriate influence. It is patronizing to imagine that our patients cannot make decisions in a similar manner, especially when many are desperately asking for guidance.

Enhancing patient autonomy requires that the physician engage in open dialogue, inform patients about therapeutic possibilities and their odds for success, explore both the patient's values and their own, and then offer recommendations that consider both sets of values and experiences. This model is "relationship-centered" (both patient and physician, and sometimes family members and others, are included in the decision making process) rather than exclusively patient-centered (32). It denies neither the potential imbalance of power in the relationship nor the fact that some patients might be inappropriately manipulated or coerced by an overzealous physician. It assumes that an open dialogue, in which the physician frankly admits his or her biases, is ultimately a better protector of the patient's right to autonomous choice than artificial neutrality would be. Because the biases of a physician will probably subtly infiltrate the conversation even if he or she tries hard to remain neutral, it may be better to explicitly label these values than to leave them outside of the

conscious control of either participant. Empirical studies have shown that enhanced support of patient autonomy has been associated with better outcomes in substance abuse treatment, weight reduction, and adherence to treatment regimens (29–31).

The physician–patient dialogue that characterizes the enhanced autonomy model includes active listening, honest sharing of perspectives, suspension of judgment, and genuine concern about the patient's best interests (33). In contrast, discussions typical of the independent choice model are often restricted by concern over the potential for domination and control and therefore fail to fully explore positions and perspectives. In these discussions, physicians objectively share medical information but refrain from expressing their personal experiences and recommendations, ostensibly to enhance the patient's power to make an independent choice. Dialogues that enhance autonomy engender a different dynamic between physician and patient; their primary objective is to achieve as full an understanding of the meaning of the problem as possible. The assumptions, values, and perspectives of both participants are fully explored. Sometimes, this process of mutual exploration leads to the invention of new solutions; at other times, the meaning of an intervention changes for one or both participants.

The enhanced autonomy model allows the physician to support and guide the patient's decision making without surrendering the medical power on which the patient depends. The independent choice model assumes that if the patient is to gain power to make autonomous choices, the physician must correspondingly lose power. The enhanced autonomy model understands that power in the physician–patient relationship is not a zero-sum quantity (34). Accepting the physician's power to offer recommendations—while obligating the physician to fully understand the patient's reasoning when those recommendations are rejected—enhances rather than reduces the patient's power and competence.

Although the enhanced autonomy model discourages physicians from underusing their personal influence, the potential for the abuse of physician power should not be minimized. A trainee, by analogy, might unconsciously select medicine as a career to appease a dominating parent, only to find him- or herself conflicted and unhappy with the choice. Similarly, a dying patient made vulnerable by disease may agree to continue receiving aggressive life-sustaining treatment to appease a physician who cannot "give up." The obvious risks associated with the overuse of physician power and control mirror the risks associated with their underuse. A more nuanced balancing of risks and benefits is needed, in which neither the patient nor the physician acts in isolation from the other. Patients want physicians

who are not afraid to use their power, but they also want to trust them to use that power to assist them through a crisis and not to control or coerce them.

Implementing Enhanced Autonomy: Tailoring Power to the Person

An 84-year-old man presented to the emergency department with acute abdominal pain that was probably the result of a ruptured diverticulum. When he refused to have surgery, his primary care physician and his family were summoned to convince him to consent. They confirmed that the patient's refusal of treatment was consistent with his long-stated and deeply held beliefs. The patient had previously completed an advance directive, which stated that he wanted no medical intervention other than morphine for pain no matter what the problem or situation.

The physician had difficulty in accepting the patient's decision because the patient's condition was relatively easy to treat and the patient's quality of life seemed to be excellent. The physician tried to persuade the patient to accept treatment, promising that the treatment could be stopped if the suffering became too great. In addition to explaining the clinical reasoning behind her recommendation for surgery, the physician also explored the patient's reasons for refusal. The patient spoke movingly about watching his spouse and many friends die "in pieces" from the gradual deterioration of their bodies and minds. He feared ending up in a nursing home, dependent on strangers, or a burden to his children. He spoke about the loneliness of outliving his wife and most of his friends and about his limited quality of life even before this illness. He felt that he would be joining his wife in the next life, and he was emotionally and existentially prepared for death. After hearing his entire story, ensuring that he understood his alternatives, and discussing the situation with his family, the physician agreed to provide comfort measures only. The patient was put on a morphine drip and died quietly and comfortably within 24 hours.

To use medicine's power in a personalized way, physicians must become expert not only in the science of clinical medicine but also at learning about patients as unique human beings with life histories and values that must be used to guide treatment (35–38). Treating a ruptured diverticulum only with morphine makes no sense from a purely medical point of view. However, given this patient's values and views about quality of life, an appropriately expanded notion of the "medical viewpoint" might concur with the conservative treatment plan.

One might have resolved this clinical situation by resorting to simple ethical principles. For example,

our obligation to fight for life might have driven us to question this patient's competence to refuse treatment. If he had been delirious when he arrived at the hospital, he would probably have had surgery despite his advance directive and his physician's and family's knowledge of his wishes. Doubt could easily have been created about whether the advance directive covered this particular situation. On the other hand, one might appeal to the autonomy-based maxim that states that all competent patients have the right to refuse treatment. According to this principle, the morphine drip should have been started as soon as the patient's ability to make an informed decision could be confirmed. Instead of taking either of these approaches, the physician struggled through the issues with the patient, fully exploring his wishes until they were more comprehensible and making sure he fully appreciated what he was giving up. The physician actively tried to persuade the patient to consent to surgery. However, as the physician explored the patient's story of loneliness, his diminished quality of life, and his fears of the future, a more meaningful conceptualization of the problem began to emerge. This potentially divisive decision became part of a process during which patient, physician, and family all felt connected.

The central philosophical point of autonomy is respect for the patient as a person (39). It is not respectful to spare persons from advice or counsel just to maintain neutrality, nor is it respectful to treat persons according to rigid protocols, whether for "aggressive treatment" or "palliative care." Respecting a person means taking the time to listen to that person's unique story and ensuring that medical decisions are integrated into the current chapter of the patient's biography (35–39). If a patient's decision does not make sense in the context of his or her unique story, physicians must explore and come to understand discrepancies by asking detailed questions and openly sharing discomfort. Although the final decisions belong to patients, the decisions that result from the intense exchange of medical information, values, and experiences between physician and patient are generally more informed and autonomous than are those made simply on the basis of patient requests.

Patients and surrogate decision makers need their physicians' recommendations, as long as they have the freedom to accept or reject them. Because patients ultimately reap the benefits and burdens of medical decisions, we must end by respecting patient autonomy unless there is a very compelling reason not to do so. Yet to accept a patient's choice when it flies in the face of strong recommendations, without a full exploration and vigorous exchange of ideas and perspectives, can be tantamount to abandonment (40). This exchange between two persons who disagree but who both care deeply about what happens

to the patient often yields better decisions than those that would have been made by either the physician or the patient independently. Sometimes the decision itself does not change, but the meaning of the decision to both participants is more fully appreciated. At other times, exploration leads to a better decision, one that can embrace the best of both positions.

Recommendations for Enhancing Patient Autonomy

1. Share your medical expertise fully while listening carefully to the patient's perspective. Medical information should be transmitted in digestible pieces in language the patient can understand, and sufficient time should be allowed for questions. Physicians must also learn about the personal meaning that the decision being made has in the context of the patient's values and experience. Significant discrepancies between the patient's values and experiences and those of the physician require careful exploration to look for common ground. These exchanges take time.

2. Recommendations must consider both clinical facts and personal experience. Most patients want to hear their physician's perspective, but the patient's values and experience, as perceived by the physician, should be integrated into any recommendation. If the physician has strong personal views about the dilemma that the patient faces, he or she should openly acknowledge those views and give the patient some understanding about where they come from. Biases and relevant experiences should not be hidden but should be an integral, explicit part of the discussion.

3. Focus first on general goals, not technical options. Negotiating with the patient about the technical aspects of management without articulating the general goals of therapy often leads to the "choosing" of treatments that are not in the patient's best interests (41, 42). "Advance directive" questions, such as "Would you want to be put on a machine to clean your blood in case your kidneys stop working?" should be replaced by questions that focus on overarching goals ("If, in the future, you become severely ill and lose the ability to speak for yourself, would you want medical treatments used to prolong life or to keep you comfortable?") (43, 44). Of course, requests by patients for more details about the technicalities should be fully answered.

4. Disagreements should initiate a process of mutual exchange. When the physician's recommendations and the patient's wishes differ seriously, careful exploration should determine areas of agreement as well as differences (11, 41, 42). Agreement about the methods of treatment is unlikely when patient and physician disagree about the nature of the

problem, the prognosis, or the goals of treatment. Dissecting the problem into its component parts and exploring each aspect usually leads to a more meaningful conceptualization and the opportunity for creative problem solving.

5. Final choices belong to fully informed patients. It is hoped that during the process of informing one another, physician and patient will reach a common understanding of the clinical dilemma, the underlying values, and the best course. However, if serious disagreements persist, the final decision belongs to the patient. If the chosen course violates the physician's fundamental values, he should inform the patient of that fact and perhaps help the patient find another physician. It is hoped that such transfers will be rare.

6. Physicians must work to refine and express their own voices. We must do a better job of training medical students, residents, and practitioners to articulate their values and opinions in an open and modulated way. Recommendations are often the beginning rather than the end of an exchange that will ultimately determine the course the patient chooses. Deciding what and how to recommend, learning how to negotiate without dominating, and taking the risk of sharing responsibility for the bad outcomes that can result from good decisions requires practice and improves with experience. Being direct and honest with patients without over- or under-influencing them is a skill that should be developed during clinical training by integrating negotiation and power sharing skills with training in medical interviewing, clinical reasoning, and self-awareness.

Discussion

If these recommendations are to work, some of the sociocultural factors that make it risky for physicians to share recommendations also need to be addressed (12–20). Educational efforts directed exclusively toward physicians are likely to have limited effectiveness unless there is a simultaneous increase in public understanding of the consequences of two trends: 1) the increasing "medicalization" of our lives (12, 13) and 2) the overuse of medical technology in a futile attempt to eliminate uncertainty (45). Because these trends reflect complex sociologic phenomena, finding the middle ground between physician recommendations and patient choice is not simple.

Other moral considerations may override an individual patient's right to autonomous choice or even to participation in a decision. Justice may demand that one patient is not given what is individually optimal because another patient has a greater moral entitlement to a scarce resource. Thus, if the

hospital's intensive care unit is full and no patient is stable enough to be transferred from it, the relatively stable patient may be sent to a more distant intensive care unit. Professional integrity may also require that the physician refuse to provide requested treatments that have been established to be either futile or harmful (46). Furthermore, mental competence must be assured before patients can be allowed to make decisions that appear to be against their own best interests (for example, a suicidal patient who wants to be discharged probably should not be). These limitations can make the process of shared decision making more complex; however, they do not detract from the physician's primary duty, which is to support and enhance patients' abilities to make autonomous choices about health care.

By taking the risk of informing patients about their own feelings, values, and recommendations, physicians can deepen and enrich medical decisions so that they are both personal and professional. All medical decisions have value-laden consequences and thus should be made in the context of a multi-dimensional exchange of ideas, values, feelings, and experiences between physicians and patients. The physician is as much guide and fellow traveler as technician and medical expert. The spirited exchange that characterizes joint decision making by persons who care deeply about the patient's outcome, described in the enhanced autonomy model, is a far cry from both the coerciveness of paternalism and the remoteness of the independent choice model. Final choices belong to patients, but these choices gain meaning, richness, and accuracy if they are the result of a process of mutual influence and understanding between physician and patient.

Acknowledgments: The authors thank Geof Williams, Richard Ryan, and Ed Deci of the Rochester Motivation Group for helping conceptualize the distinction between autonomy and independence.

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