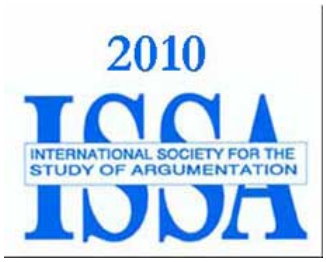
ISSA Proceedings 2010 – Shared Medical Decision-Making: Strategic Maneuvering By Doctors in The Presentation Of Their Treatment Preferences To Patients



1. *Shared decision making*

Shared decision making is a treatment decision making model that has over the last ten years increased in popularity as an alternative to models in which either the physician decides what is best for the patient and encourages the patient to consent to this decision, or in which the patient takes a decision after having been given the needed medical information and thus gives "informed consent" (Charles, Gafni & Whelan 1997).

Charles et al. (1997) argue that in neither of these models one can speak of shared decision making. In the first model, the patient is left outside the decision making process, in the second, the role of the physician is limited to that of transferring information instead of a real participation in the discussion (p. 683). According to Charles et al. "unless both patient and physician share treatment preferences, a shared treatment decision-making process did not occur". Légaré et al. (2008) provide the following definition of shared decision making:

a decision-making process jointly shared by patients and their health care provider […] It relies on the best evidence about risks and benefits associated with all available options (including doing nothing) and on the values and preferences of patients, without excluding those of health professionals (p. 1).

Frosch and Kaplan (1999) explain that shared decision making goes several steps further than informed consent:

Beyond presenting the patient with facts about a procedure, a shared decision making is a process by which doctor and patient consider available information about the medical problem in question, including treatment options and consequences, and then consider how these fit with the patient's preferences for health states and outcomes. After considering the options, a treatment decision is

made based on mutual agreement (p. 2).

2. *Comparison of the ideal of shared decision making with the concept of critical discussion*

As we have seen, the process of shared decision making is aimed at reaching a treatment decision on which both physician and patient agree, by discussing the pros and cons of possible treatment options in such a way that the views of both parties are taken into account. This type of discussion seems to be comparable with small group problem solving discussions, a type of discussion that Van Rees (1992, p. 285) considered to be "a plausible candidate for reconstruction as a critical discussion." Van Rees distinguishes various differences of opinion which can relate to all stages of the problem-solving process that have to be resolved by the participants in this type of discussion:

The participants may disagree on whether a problem exists at all, what it is (if it exists), what the potential solutions might be, by what criteria these solutions ought to be judged, and what the judgment ought to be (1995, p. 344).

Similarly, in the medical encounter participants may firstly disagree on the diagnosis: Is there really a medical problem? What is it exactly, and how serious is it? They may also disagree about the possible treatment options: Are these all the relevant options or should other options be considered? In the process of shared decision making, the criteria by which the solutions should be judged are largely predetermined by the instititutional context: Treatments should be the best possible treatment based on evidence and also fit with the goals, values and preferences of the patient. This does not mean, however that it will always be unproblematic to reach agreement about what the best treatment is, and thus arrive at the final stage in which a decision is made for a particular treatment (or for no treatment at all), since there are often many treatment options, none of which is clearly the best. There may thus be disagreement about which option is most in accordance with the evaluation criteria. Also, physician and patient may disagree on which criteria are the more important, the medical evidence or the patient's preferences.

The aim of the discussion between doctor and patient on what the best treatment would be is compatible with the aim of a critical discussion. But how do the principles of shared decision making relate to the rules for critical discussion? That the patient must be able to participate in the decision making, is also a dialectical requirement: Both parties should get the opportunity to put forward

their standpoints, arguments and criticisms. That the doctor should give an objective overview of the available treatment options and their pros and cons, however, is an institutional requirement intended to counterbalance the informational asymmetry between doctor and patient. Finally, that it is the patient who has to make the final decision from the available medically acceptable treatment options is, again, an institutional requirement: this is a legal right of the patient.

In this paper, I will focus on the discussion aimed at resolving the difference of opinion about the best treatment option for the patient. Making this decision is the main aim of the shared decision making process. As we have seen, in the process of shared decision making doctors are expected not just to give information to the patient, but also to state their own preferences. The question is however, how physicians may present their recommendations without unnecessarily restricting their patients' freedom of choice.

3. *Strategic maneuvering in the physician's presentation of treatments*

Although the model of shared decision making emphasizes the importance of both parties sharing their treatment preferences, many authors mention the risk that the doctor's preferences will have too much influence on the patient's decision. Frosch and Kaplan (1999) point out that even in a shared decision making context it cannot be taken for granted that physicians will be fully objective:

It is […] important to consider the possibility that physicians working within the framework of shared decision making may present the patient with biased information. Studies examining how physicians can present the patient with balanced reviews and how they can help clarify and apply patient preferences are sorely needed (p. 7-8).

According to Rubinelli and Schulz, argumentation can play an important role in advising patients about treatment options in such a way that the patient can participate in the decision making process:

Argumentation is an adequate instrument for the expression of doctor's standpoints. Argumentation can be used to balance an interaction where the doctor performs his/her expert role in front of a patient who seeks expertise in the first place, but who is the only responsible for the final decision to have a certain treatment. By constructing arguments doctors do not patronise the interaction (as they would if they imposed their biases without supporting them with reasons),

but rather they expose their standpoints to be evaluated and pondered by patients (2006, p. 360)

According to the extended pragma-dialectical theory developed by van Eemeren and Houtlosser (2002, p. 134-135), just like arguers in any other type of context, physicians engaged in a shared decision making process with their patient may be expected to attempt to combine the aim of arriving at a shared decision in a reasonable way with their aim of trying to get their own treatment preferences accepted. In other words: physicians may be expected to maneuver strategically in the discussion over which treatment should be chosen. According to van Eemeren and Houtlosser, "all the moves made in argumentative discourse can be regarded as designed both to uphold a reasonable discussion attitude and to further a party's case"(2002, 142). This does not mean that the two objectives are always in perfect balance. The strategic maneuvering may get 'derailed' and become fallacious if a party allows its commitment to a reasonable exchange of argumentative moves to be overruled by the aim of persuading the opponent (van Eemeren and Houtlosser 2002, 142).

One reason why it may be expected that physicians will attempt to get their own recommendations accepted at all cost is the socalled "micro-certainty, macro-uncertainty phenomenon" (Bauman, Deber & Thompson 1991): While physicians frequently disagree among themselves about the efficacy of a given treatment approach, they are typically quite confident that their individual treatment decisions are correct. This overconfidence may lessen the patient's role in decision making, all the more so since both clinicians and patients often equate confidence with competence. According to Faust and Ziskin (1988, p. 31-35) experts are expected to be able to state an opinion with reasonable medical certainty.

The physician's strategical maneuvering may be aimed at arriving at a decision that is, according to the physician, the best decision medically speaking. The pursuit of effectiveness in reasonableness is not necessarily aimed at achieving effectiveness for the individuals who carry out the strategic maneuvering, but may just as well be aimed at achieving effectiveness that is to the benefit of others they represent. As Jacobs (2002, p. 124) emphasizes, "at the level of institutional functioning", "arguments may fulfill public interests." However, if the physician is too much focused on getting his own choice of treatment accepted, there is a danger that this type of maneuvering may be contraproductive, since research has shown that physicians that allow their patients to have a greater say

in treatment decisions have more favorable patient outcomes:
In previous studies we and others […] have shown that when physicians are less conversationally controlling during office visits (asking fewer closed-ended questions, giving fewer directions, interrupting less frequently, and involving patients in treatment decisions), patients have better health outcomes. Data from this study suggest that giving patients choices about, control over, and responsibility for certain aspects of care have important implications for patient loyalty and satisfaction with care (Kaplan et al. 1996, p. 503).

When is there reason to believe that a physician's attempt to get his own choice of treatment accepted will endanger the shared decision making process? In practice, this may be hard to establish, since physicians are likely to attempt to present their own treatment preferences in such a way that they give the impression that they are adhering to the principles of shared decision making, that is, without openly violating any of the basic principles of this type of decision making. Sara Rubinelli and Peter Schulz (2006) have already given some examples of how the use of certain linguistic devices such as modal verbs in the presentation of the physician's standpoint can make it less clear that it is the patient who has to make the final decision. As a follow-up to this research, I shall briefly discuss some ways in which physicians may in practice attempt to give the impression that they are adhering to the three principles of shared decision making whilst discussing their preferred treatment option:
1. The patient participates in the decision making process about the best treatment
2. The doctor gives an objective overview of the available treatment options and their risks and probable benefits
3. The doctor leaves the final choice from the available treatment alternatives to the patient.

I shall relate each way of presenting the recommendations to one of these principles of shared decision making.

1. Presenting the recommendation in such a way that the patient seems to participate in the decision making process about the best treatment
A first way for physicians of presenting their recommendations is to do so in such a way that the impression is given that the patient participates in the decision making process, whereas in reality this is not the case.

One way of giving the patient the impression that he can participate in the decision making process while in fact it is only the doctor who is making the decisions about the best treatment is discussed by Karnieli-Miller and Eisikovits (2009). By not putting up for discussion the most important decision about which treatment to take, but instead, offering the patient choices on technicalities such as the timing of the treatment and ways to administer is, the physician makes it seem as if there is already agreement on the treatment. In other words, that a given treatment should be followed, is presented as if it were already a common starting-point. Karnieli-Miller and Eisikovits give the example of a case where the physician proposes a treatment of taking steroids without giving the patient the opportunity to react to this proposal. Immediately after having mentioned the treatment, the physician says:
(1) now about the medicine (steroids): I understand that you have problems swallowing pills… so we can start with an enema (another form of administering steroids) (Karnieli-Miller & Eisikovits 2009, p. 5).

According to Karnieli-Miller and Eisikovits, "this suggestion and partial solution creates an illusion of sharing an agreement about the critical decision: yes or no steroids" (2009, p. 5). In this way, the patient may get the impression that he participates in the decision making process, whereas in fact this participation is restricted to a discussion of secondary decisions, which presuppose an agreement on the most important treatment decision.

2. Presenting the available treatment options in such a way that the treatment preferred by the doctor seems the only reasonable option

A second way for physicians to present their recommendations is to do so in such a way that the impression is given that the treatment preferred by the doctor is in fact the only reasonable option. One way of achieving this effect is to present a certain treatment as the obvious choice, as the standard treatment. Pilnick (2004), for instance, has shown that in consultations between midwifes and expectant mothers who have to make a decision on whether they want to undergo antenatal screening, this form of screening was often presented as one of a number of routine tests:

there are a number of tests that must be introduced to expectant mothers in this first meeting, including blood tests for anaemia and hepatititis, and a test for HIV. These differ from antenatal screening tests for abnormality in that consent is

sought immediately (…) the presentation of antenatal screening alongside these other more straightforward and routinely carried out diagnostic tests may contribute to an interactional context in which screening itself is also perceived as routine (Pilnick 2004, p. 455-456)

This presentation may restrict the expectant mother's freedom of choice, since women do not necessarily equate a routine procedure with one that they have the right to accept or decline (Pilnick: 2000: 458).
Example 2 is given by Rubinelli and Schulz (2006, p. 370) as a way of leaving the patient choice since the doctors makes it clear "that what he advises is simply a proposal". According to me, this example might also be analysed as way of presenting a certain treatment as the best one, without giving any argumentation:
(2) D. This is then the main point. It has been confirmed during the surgery that it is a malignant tumour…
…
Thus, in these situations, we always propose a treatment based on chemotherapy

In this case, it is not just the fact that the treatment is presented as the standard treatment, but also the use of 'we' that may have the effect of making it difficult to object to the treatment proposed. As Karnieli-Miller and Eisikovits have pointed out, plurals are often used to "enhance credibility and lend authority to more threatening interventions" (2009, p. 5):
Once treatment decisions are made by a team of well-known, authorized professionals, an increase in trust and compliance can be expected […] The more threatening the suggestions concerning treatment are the more often the advice is given in the plural (2009, p. 5)

3. Presenting the recommendation in such a way, so that it looks as if the doctor is only giving the patient some information, not advice

A third strategy physicians may apply in presenting their recommendations is to do so in such a way that it looks as if they are only giving the patient some information, not advice, so that the impression is preserved that the decision is still up to the patient.
Physicians may for instance only mention undesirable consequences of a particular treatment, without explicitly advising against it or. Or they may just mention favorable consequences of a treatment without explicitly recommending it. In this way, the patient seems to have the freedom to draw his own

conclusions. Pilnick discusses how such supposedly informative communications may be perceived as recommendations:
Although many healthcare professionals are cautious about explicitly advising a particular course of action, the way in which information is interactionally presented can have advisory implications for clients. In particular, […] the use of 'contra-indicative' statements made by professionals, i.e. statements emphasizing the potential negative outcomes of a proposed course of action […] are likely to be heard as directive. […] Conversely, where the outcomes of a proposed course of action are presented positively […], a different point of view may be reinforced, albeit implicitly, in favour of the action. (2004, p. 459).

Example 3 may serve as an example:
(3) Speaking frankly, the addition of chemotherapy in this situation would increase the possibility of healing (Rubinelli and Schulz 2006, p. 366)

Another example is provided by Pilnick (2004). In the fragment, reference is made to two tests for Down's, one after 16 weeks and one after 12 weeks:
(4) the Town Hospital (0.2) the blood test (I/they) take, at sixteen weeks to do (0.2) tests for Spina Bifida and for Down's (0.2) CAN also screen for DOWN'S (0.4) and in the SAME WAY you get a risk facor of > 1 in 200 or les:s< (0.2) but of course >you're a little bit further on then, you're sixteen weeks or so (0.2) if you FIND OUT at TWELVE WEEKS > it gives us a lot more time (0.2) to sort anything out if you (0.2) if-if depending on which road YOU'D GO (p. 460).

Pilnick gives the following comment on this example:
'What is not said' here is any direct contrast of the two forms of screening. However, the fact that NT screening gives a lot more time to 'sort anything out' may be taken to imply its superiority, and hence desirability, contributing to an interactional context that does not necessarily give a sense of a considered decision to be made (2004, p. 460)

Thus, in the example, on the one hand it is suggested in an implicit way that having a screening after 12 weeks is preferable, but this is not said outright, nor are any reasons given, and the formulation ("depending on which road you'd go") still suggests that the choice is up to the expectant mother.

4. *Conclusion*
It can, in principle, be completely acceptable dialectically speaking for the doctor

to present the possible treatments in such a way that his own preference seems the most reasonable choice. When a doctor strongly recommends a specific treatment, this does not necessarily result in a violation of a pragma-dialectical discussion rule. Doing so can in principle also be in accordance with the ideal model of shared decision making. According to Charles, Gafni and Whelan (1999, p. 656), for instance, "the physician can legitimately give a treatment recommendation to patients and try to persuade them to accept the recommendation", provided he also attempts to take the patient's perspective into account. However, as we have seen in the examples just discussed, in some cases the physician's strategic maneuvering to get his own treatment preferences accepted may derail and become fallacious. This is for instance the case in example (1), where the physician presents the patient's agreement on the main treatment decision as a common starting point, thereby violating the starting point rule of a critical discussion. In other cases, such as for instance example (4), the maneuvering cannot be regarded as fallacious, since no rule for critical discussion seems to be violated. Nonetheless, the fact that no objective comparison of the different forms of screening and their benefits and risks is given, may be seen as inconsistent with the ideal of medical shared decision making, since it deprives the patient of the possibility to make a well-considered decision.

REFERENCES

Baumann, A.O, Deber, R. B., & Thompson, G.G. (1991). *Overconfidence among physicians and nurses: the 'micro-certainty, macro-uncertainty' phenomenon*. Social Science and Medicine 32 (2), 167-174.

Charles, C, Gafni, A. & Whelan, T. (1997). *Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango)*. Social Science and Medicine, 44 (5), 681-692.

Charles, C. A. Gafni & Whelan, T. (1999). *Decision-making in the physician-patient encounter: revisiting the shared treatment decision making model*. Social Science & Medicine 49 (5), 651-661.

Eemeren, F.H. van & Houtlosser, P. (2002). *Strategic maneuvering; Maintaining a delicate balance*. In: F.H. van Eemeren & P. Houtlosser (Eds.), Dialectic and Rhetoric. The Warp and Woof of Argumentation Analysis. Dordrecht, Boston, London: Kluwer Academic Publishers.

Faust, D., & Ziskin, J. (1988). *The expert witness in psychology and psychiatry*. Science 241, 31-35.

Frosch, D.L., & Kaplan, R.M. (1999). *Shared decision making in clinical medicine: past research and future directions*. American Journal of Preventive Medicine, 17 (4), 285-294.
Goodnight, T.G. (2006). *When reasons matter most: Pragma-dialectics and the problem of informed consent*. In P. Houtlosser & M.A. van Rees (Eds.), Considering Pragma-Dialectics. A Festschrift for Frans H. van Eemeren on the Occasion of his 60th Birthday (pp. 75-85), Mahwah, N.J.: Lawrence Erlbaum Associates.
Jacobs, S. (2002). *Messages, functional contexts, and categories of fallacy: Some dialectical and rhetorical considerations*. In F.H. van Eemeren & P. Houtlosser (Eds.), Dialectic and Rhetoric; The Warp and Woof of Argumentation Analysis (pp. 119-130), Dordrecht: Kluwer Academic.
Kaplan, S.H., Greenfield, S., Gandek, B., Rogers, W.H. & Ware, J.E. (1996). *Characteristics of physicians with participatory decision-making styles*. Annals of Internal Medicine 124 (5), 497-504.
Karnieli-Miller, O. & Eisikovits, Z. (2009). *Physician as partner or salesman? Shared decision-making in real-time encounters*. Social Science & Medicine 69, 1-8.
Legaré, F., Elwyn, G., Fishbein, M., Frémont, P., Frosch, D., Gagnon, M-P. … & van der Weijden, T. (2008). *Translating shared decision-making into health care clinical practices: Proof of concepts*. Implementation Science 3 (2), 1-6.
Pilnick, A. (2004). *'It's just one of the best tests that we've got at the moment': the presentation of nuchal translucency screening for fetal abnormality in pregnancy*. Discourse and Society 15, 451-465.
Rees, M.A. van (1992). *Problem solving and critical discussion*. In F.H. van Eemeren, R. Grootendorst, J. A. Blair & Ch.A. Willard (Eds.), Argumentation Illuminated (pp. 281-291), Amsterdam: Sic Sat.
Rees, M.A. van (1995). *Analysing and evaluating problem-solving discussions*. Argumentation 9 (2), 343-362.
Rubinelli, S., & Schulz, P. (2006). *'Let me tell you why!'.When argumentation in doctor-patient interaction makes a difference*. Argumentation 20, 353-375.
Schulz, P.J., & Rubinelli, S. (2008). *Arguing 'for' the patient: informed consent and strategic maneuvering in doctor-patient interaction*. Argumentation 22, 423-432.