The Use of Patients' Preferences in Family Practice

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The use of patients' preferences enables physician and patient to share responsibility for decision making. The use of preferences is especially appropriate when there is diagnostic uncertainty or when several alternative management strategies are available. When preferences are used, clinicians are likely to become sensitive to details of individual patients' lives that affect their illnesses and their responses to illnesses. Patient preferences may be influenced by how information is presented to them and by recent experiences in their own lives or in the lives of someone close to them. For effective decision making to occur, both physician and patient should be comfortable with the amount of decision-making responsibility given to each.

Medical encounters often involve the making of one or several decisions. Should a diagnostic test be ordered? What (if any) therapy should be instituted? The location of responsibility for making such decisions characterizes different types of physician-patient relationships. For example, one prominent biomedical ethicist describes an "engineering model" in which the physician is an applied scientist who presents facts to the lay person, but leaves all decision making to the latter. In the "priestly model," the physician, guided by the principle "benefit and do no harm," plays a paternalistic role with regard to the patient.[1]

Patients generally do not desire total control over medical decisions. They do, however, prefer partial input and responsibility for decisions made concerning them.[2] Other models of the physician-patient relationship, including the contractual,[1,3] the physician conscience,[4] and the collegial,[1] allow physician and patient to share responsibility when making decisions. Although theoretical advantages of patient participation in medical decision making have been stated,[5] the best way to accomplish such participation within the context of the physician-patient relationship is not clear.

One approach is to incorporate the preferences of patients and families into the decision-making process. A patient's preference may be defined as an action a patient would choose in a particular medical situation at a particular time, given a set of alternatives. In this paper primary care situations in which the use of preferences is particularly important are demonstrated, and the benefits derived from such an approach are specified. Some of the recognized biases known to affect preferences are discussed, and suggestions are made for dealing with them.

Situations in Which Patient Preferences Are Particularly Useful

In family practice, patient care management decisions may need to be made when no clear diagnosis is apparent. Different combinations of diagnostic and management strategies may be available for a situation, each of which offers particular advantages and disadvantages.

Case 1. A 24-year-old graduate student came to his family physician because of a sore throat and fever of two days' duration. He was noted to have

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an oral temperature of 101° F and an erythematous pharynx. No tonsillar exudate was noted. There was shotty, slightly tender, anterior cervical adenopathy bilaterally. Two alternatives were described to the patient. A throat culture could be obtained and treatment, based on its results, begun in one to two days. Alternatively, he could be treated with antibiotics now, taking the slight chance of an allergic reaction for the hope of earlier recovery. It turned out that the patient was about to take an oral examination at school, and that, to him, the small chance of a penicillin reaction was a risk worth taking if it might mean earlier recovery.

In this example, a decision needed to be made between two management alternatives that placed different weights on the need for accurate diagnosis and early therapy. It was important that the risks and benefits of potential time sick and the side effects of the two alternatives be compared for an optimal decision to be made. The patient's preference provided useful information for the clinician involved in making the decision.

Patient preferences have been shown to vary widely in this clinical situation.[6] It is difficult to predict an individual's preference without inquiring directly. It is important to ask, therefore, because the most appropriate management may depend on this information.

When a diagnosis is known, different therapeutic alternatives may still be available that, although leading to the same end, have different costs or side effects.

Case 2. Two women, both aged 22 years, were seen in the office on the same day, each with a one- to two-day history of pelvic pain. In both cases the history and physical findings were consistent with early pelvic inflammatory disease, and the decision was made to treat each with tetracycline. A choice was described to each between the use of generic tetracycline 500 mg four times a day for 10 days and doxycycline 100 mg twice a day for 10 days. The greater possibility of gastrointestinal side effects with generic tetracycline and the increased cost of doxycyline were described. The first patient, a secretary and single mother of three children, expressed a strong preference for the less costly alternative. The second patient, a college student, chose the more expensive drug. She stated that she could not risk the increased chance of becoming nauseated and missing time at school.

Advantages of Using Patient Preferences

The elicitation of patient preferences allows the patient to participate in medical decision making. Patient participation is consistent with the belief that patients should have some degree of control over their bodies and their health. The use of patients' preferences allows decision making to be less paternalistic and more responsive to the needs of individual patients. Small, easily overlooked details of individual's lives are often crucial in decisions that patients make when comparing preferences for alternatives presented to them. A greater sensitivity to these individual details is fostered by inquiring into an individual patient's preferences.

Case 3. A 35-year-old, gravida 3, para 2 woman was admitted to the hospital at term in labor. Her prenatal course had been uncomplicated. She had requested a postpartum bilateral tubal ligation. A healthy baby girl was delivered. The husband was present throughout. Manual removal of the placenta under light sedation was performed when the placenta had not spontaneously separated 30 minutes postpartum. On the first postpartum day she was found to be anemic, and a consultant gynecologist arranged for a preoperative blood transfusion. Her family physician discussed an alternative plan with her. She could return home, take iron tablets orally, and return at a later time for the tubal ligation procedure, which would avoid the blood transfusion and its attendant risks. She strongly preferred having the surgery done during the same hospitalization. Her preference changed at the last minute, however, after being informed of certain events occurring at home. Her husband, an alcoholic in remission, had begun to drink excessively. He had, without informing his wife or her physician, become quite anxious over the unexpected manual removal of the placenta. In fact, he felt quite certain that his wife was very ill and feared her death. With this additional information, the patient decided to go home and was discharged. The husband stopped drinking when his wife returned home. Tubal ligation was performed six months postpartum.

Physician decision making is influenced by many sociologic factors. The patient's social class, race, sex, income, and physical appearance have been shown to have an effect on physician decision making. Similarly, the personality, age, and sepciality of individual physicians may lead to differing decision-making styles and strategies.[7] Other external factors specific to individual deci-

sions, such as the time of day (or night) and location (physician's office, hospital, emergency ward) may also influence decision making. A clinician's view of a patient's situation is often a subjective one, based on information available through brief office encounters with that patient. The effects of available alternatives on his or her family, work, finances, and life style may cause the patient to view a situation quite differently from that of the physician. It is important, therefore, that physicians not make arbitrary decisions among diagnostic or therapeutic alternatives without some knowledge of patient preferences.

Finally, knowledge of patient preference increases the quality of physician-patient communication. In this way, an atmosphere of shared responsibility results in which the patient, who has the illness, and the physician, who has specialized knowledge regarding the illness and its therapy, work together. There is evidence that such communication promotes patient compliance and satisfaction with care.[5,8]

Problems Associated With the Use of Patient Preferences

It might seem from the above discussion that the use of patient preferences in medical decision making provides a sure path toward optimal medical care. However, the use of preferences is not without problems. Physicians dealing regularly with patients' preferences should be aware of some of the important determinants and biases that affect them.

Patients' preferences among options may depend upon the way information is presented. For instance, subjects in one study found surgery (with the risk of perioperative mortality) as a treatment for carcinoma of the lung more attractive when the risk of operative mortality was described in terms of the chances of living rather than the chances of dying.[9] Eraker and Sox[10] found patients' preferences regarding drug choices to depend on whether positive effects (such as the relief of pain) or negative effects (such as side effects) were emphasized. Although it is difficult to completely avoid such framing effects, one must be careful not to describe the benefits and hazards of alternatives in such a way as to significantly influence a patient's preference. A realistic appraisal of the benefits and risks of alternatives is crucial to the elicitation of meaningful preferences. A clinician may voice an opinion as to what he or she perceives the most appropriate alternative to be. Such advice, however, should be clearly labeled as such and should not preclude describing other alternatives to patients.

Recent experiences may influence patients' preferences.[11] Such experiences may have occurred in the patients' own lives, or in the life of someone close to them. In the previously described case 3, for example, it was subsequently revealed that the father of the patient's husband had died of hepatitis following a blood transfusion six months prior to the events described. At a later date, the husband admitted his marked concern over the possible need for his wife to have a transfusion when discussing his extreme anxiety over his wife's postpartum course.

The more vivid the memory of such an experience, the more it is likely to influence the patient's preferences. When strong preferences are voiced by patients, it is wise to inquire directly into any personal or family experiences that may be influencing them. A question such as "Have you or anyone you know ever had . . . ?" often elicits the necessary information. In this way, false conceptions about the probabilities of side effects, poor outcomes, or the nature of procedures can be corrected, and more reliable preferences may be determined.

The preferences of patients may cause problems if they conflict with moral principles of the physician. For example, a patient may ask a physician to either conceal the truth or to lie. Beauchamp and Childress[12] describe a case in which a child was in need of an organ transplant. The father, being the only available compatible donor, asked the physician to conceal this fact from the family. A physician may find such a request personally difficult to carry out. Although personal autonomy and the right to control over one's body is an important ethical principle, other moral principles (such as not lying or not doing harm to patients) may take precedence in such a situation. In family practice such a request may indeed be a clue to a problem in a family's functioning or communication patterns.

Issues of confidentiality become complex when there is more than one patient involved or when another person may be harmed by a deception. Family physicians may encounter such situations

while caring for an entire family. In individual cases the relative virtues of autonomy, confidentiality, and truth telling must be balanced. When a physician finds it impossible to comply with such a preference, he or she should explain these reasons to the patient. Alternatives can often be specified and offered to the patient or family.

Case 4. A 38-year-old man was treated for symptomatic gonorrhea. In the course of treatment, he asked the family physician to culture his wife as part of a regular examination and, if positive, to treat her without explaining the situation to her. The physician explained that such an act was not only unfair to the man's wife as a patient but also to the two of them as a couple. He further stated that although he was personally unable to carry out such a deception, he would be willing to be present when the patient explained the situation to his wife and would help with any attendant problems.

Discussion

Who should make medical decisions? Pellegrino and Thomasma[13] describe medicine (in part) as a "craftsmanship of healing," consisting of "an interpretive judgment relating science and experience to specific individuals." In this context, it is reasonable for clinician and patient to share decision-making responsibility. A clinician brings expertise and experience to an encounter with a patient. A patient lives with the results of any decision made, and, indeed, must be in agreement for most decisions to be carried out. How much responsibility should belong to each will depend on several factors.

The personalities of the patient and physician play a role in the making of decisions. Some patients and families resist taking an active role in medical decision making; others desire more responsibility. Physicians vary in the amount of responsibility they are willing to share with patients. The willingness to share responsibility may depend in part on the clinician's estimation of the patient's maturity and the appropriateness of the patient's preferences. It is important for a physician not to confuse a preference that seems truly harmful or representative of "bad medicine" with one that, although in disagreement with the clinician's own preference, would not be harmful or less beneficial to the patient.

For a decision to be effective, both patient and physician should be comfortable with the decision-making responsibility given to each. When a physician is dissatisfied in this regard, errors in diagnosis and treatment may occur.[14] Patient discomfort, on the other hand, may lead to noncompliance.

The ethical value of patient autonomy varies with the type, gravity, and urgency of the medical situation. In a life-threatening emergency, for example, the need for immediate care may not allow time for the full explanation of alternatives. In nonemergent situations, some patients, especially those lacking medical sophistication, may still begin with a limited ability to participate in medical decisions. Physicians are in a position, through using patient preferences, to involve patients in their own medical care. In this way, a patient may be encouraged to begin an educational process that could lead to greater autonomy at a later date.

The optimal use of patients' preferences clearly involves more than simply talking to patients, listing alternatives, and recording their likes and dislikes. An organized approach to the use of preferences is a medical skill requiring correct timing and the avoidance of bias. When correctly elicited, preferences help to structure a framework of effective medical decision making.

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