COMMENTARY

"What Should I Do, Doc?"

Some Psychologic Benefits of Physician Recommendations

RECENTLY, I was speaking with an elderly patient about a small prostate cancer discovered by his urologist. The urologist recommended a course of treatment and the patient wondered what I thought about it. I explained that the "correct choice" depended on his views of the tradeoff between watchful waiting and early therapy. After I explained the clinical risks and benefits of these 2 strategies, he asked me, "What would you do if you had this cancer?"

"This is your decision to make," I explained. He looked confused. "Let me try an example," I replied. "What are you going to watch on TV tonight?" "The football game," he responded. "Bad decision," I said, "You should watch the figure skating competition on channel 19 instead." He looked at me incredulously. "But I don't like figure skating." "Exactly!" I exclaimed, "I can't tell you what to watch on TV tonight because the 'right choice' depends on your preferences. The same thing goes for deciding about your prostate cancer." He seemed to understand my point. He looked me in the eyes and said, "Okay, doc. What would you do if you were me?" I recommended watchful waiting and he breathed a sigh of relief.

Getting patients involved in their medical decisions can often be challenging. Patients often want physicians to make treatment recommendations. Yet such recommendations are almost never value neutral, and providing patients with recommendations will feel, to many, like a throwback to the "good old days" of physician paternalism.

In this article, I discuss several circumstances in which physician recommendations can improve patient decision making, thereby helping patients make decisions that better reflect their own preferences.

THE CONTROVERSIAL ROLE OF PHYSICIAN RECOMMENDATIONS IN MEDICAL DECISION MAKING

The past 2 decades have witnessed a revolution in theory and teaching about the importance of patient preferences in medical decision making. In the old days, paternalistic physicians prescribed tests and treatments for their patients without serious inquiry into what their patients wanted. Sometimes physicians did not even inform patients of their diagnoses, for fear that the news would be too much for patients to handle.[1] Now, however, experts in law,[2,3] ethics,[4,5] medical decision making,[6,7] and communications[8] have convincingly argued that medical decisions are not purely medical, but also involve value judgments.[9,10] A woman at high risk for breast cancer because of a genetic mutation may be able to maximize her long-term survival by having a prophylactic mastectomy. But, whether she ought to have a prophylactic mastectomy depends largely on her preferences.[11] These experts have urged physicians to involve their patients in important medical decisions. And these urgings have had some effect. Although doctor-patient communication is far from perfect,[8] physicians are more likely than ever to involve patients in their decisions.[1]

Somewhat overlooked in debates about autonomy and paternalism has been theoretical exploration of the proper role of physician recommendations in medical decision making. Some experts have proposed what Carl Schneider[12] refers to as a "mandatory autonomy model" of clinical decision making,[13] whereby patients are required to make their own decisions and clinicians are obligated to urge patients to engage in the decision-making process. By this model, there is no theoretical justification for physician recommendations. Instead, physicians (and other clinicians) should limit their role in the decision-making process to that of information providers. Other experts offer a less-strict view of patient autonomy; Schneider refers to this as the "optional autonomy model."[12] According to this model, patients have the right to ignore information and to cede decision-making authority.[14] Empirical research shows that most patients hold views consistent with the optional autonomy model, preferring to receive relatively complete medical information from their clinicians while sharing decision-making authority with them.[15-18] In line with this optional autonomy model, physicians' recommendations would be theoretically justified because they would promote patients' autonomous rights to cede some of their decision-making authority.

Most physicians do not support the idea of mandatory autonomy and, thus, recognize the moral justification for providing at least some patients with treatment recommendations. Indeed, research

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has shown that physician recommendations have a huge influence on patients' treatment decisions.[19] However, physicians may feel uncomfortable making these recommendations, recognizing that other clinicians, given the same patients, would make different recommendations. Moreover, physicians' discomfort will not be relieved by the knowledge that many of their patients want them to make treatment recommendations. After all, many patients are so used to paternalistic physicians that they are uncomfortable with any other treatment style.

Is there a proper role for physician recommendations in medical decision making? Research has demonstrated that patients' decisions are often influenced by subtle cognitive biases and by their unwillingness to bear the brunt of responsibility for high-stakes decisions. In the right circumstances, physician recommendations can improve medical decisions by reducing the influence of cognitive biases and by shifting part of the responsibility for decision making away from patients and their families.

DOES AVERSION TO HARMS OF COMMISSION EVER CAUSE PATIENTS TO MAKE BAD DECISIONS?

At the height of a polio epidemic in the early 1970s, news reports and lawsuits proliferated because experts had learned that the most popular polio vaccine occasionally caused polio. At the same time, experts had also learned that the likelihood of causing polio was 10-fold or so less than the likelihood that the vaccine would prevent polio. Nevertheless, thousands of parents decided not to vaccinate their children. Many parents believed that if their child contracted polio through a vaccine it would be their fault, whereas if the child contracted polio through "natural causes," it would be Mother Nature's fault.

These parents' good intentions should not be questioned. It is a well-known psychological phenomenon that people are more averse to harms of commission than to harms of omission.[20,21] But their decisions deserve scrutiny; because of their aversion to polio vaccines, many of their children contracted polio.

Psychology studies suggest that many life decisions are influenced by attitudes toward omissions and commissions. For example, when people are asked to look back over their lives and state what they most regret, the majority cite omissions rather than commissions.[22,23] A man says he regrets his decision not to take a semester abroad during college, or his decision to chicken out on a risky business venture. He is less likely to mention regret about choosing to take the semester abroad and coming down with dysentery, or about attempting a risky business venture that failed. By contrast, when making decisions (and thus, when looking forward rather than backward), most people anticipate that they will regret commissions more than omissions. A man decides not to ask out an attractive acquaintance because he fears the pain of rejection. He overlooks the possibility that, as time marches on, he will suffer painful memories thinking about what might have been.

People may overreact to harms of commission out of a sense that they do not want to feel personally responsible for bad things that might happen as a result of decisions they make.[24] In medical contexts, this fear frequently arises in discussions about advance directives and do-not-resuscitate (DNR) orders. Even after physicians provide graphic descriptions of resuscitation, elaborate hanging of crepe, and exhaustive lists of statistics about dismal patient outcomes after resuscitation, families may be reluctant to request a DNR status for their loved ones out of a sense that they would somehow be contributing to their deaths. And who could blame them? People do not want to feel like their loved ones would be alive if they had made different decisions.

Attitudes toward omissions and commissions may also be influenced by the different ways people perceive gains and losses. In general, losses loom larger to people than similarly sized gains.[25,26] For example, when given a 50/50 chance of either winning $100 (if a fair coin comes up heads) or losing $100 (if it comes up tails), most people prefer not to flip the coin. As nice as it would be to win $100, the prospect of losing $100 is a bigger deal. Thus, when making medical decisions, people may overreact to harms of commission because they perceive those harms as losses, whereas they perceive harms from omission as foregone gains.

There is no gold standard for determining whether health care decisions are "good or bad," or "right or wrong." But there is reason to believe that people's fear of harms of commission unduly influences their decisions. For example, people's perceptions of what constitutes gains and losses are quite unstable.[27] People's decisions can often be arbitrarily influenced by whether a situation is framed in ways that makes them perceive options as gains or losses.[28] Few people would want a cancer treatment that carries a 10% mortality rate, whereas many would opt for a treatment with a 90% survival rate. When described in terms of mortality rate, the treatment conjures up people's aversions to losses.

SOME CIRCUMSTANCES IN WHICH PHYSICIAN RECOMMENDATIONS CAN IMPROVE PATIENTS' DECISIONS

In the right circumstances, physician recommendations can improve patients' medical decisions by shifting their perception of what constitutes an omission and a commission, by shifting the locus of responsibility to the physician, and by changing their perception of what constitutes gains and losses.

Imagine a woman who is reluctant to ask a physician to vaccinate her elderly father for influenza out of fear that she will blame herself for any harm that comes to him from being vaccinated. Her physician explains the risks and benefits of the vaccine and says, "I routinely recommend vaccination for all patients your father's age. Is it okay if I vaccinate him?" The physician's recommendation has shifted her perception of what constitutes an omission and a commission. If she is passive, her father will get vaccinated. If she wants her father to go without the vaccine, she must actively override the physician's recommendation.

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This shift in what constitutes an omission and a commission also leads to a shift in the perceived locus of responsibility. Because of this recommendation, the physician will share the blame and responsibility for any ill effects of the vaccine. At the same time, if the woman overrides the physician's recommendation and decides not to vaccinate her father, she will feel responsible for any harms that come to him from failing to get the vaccine. Finally, the recommendation will shift her reference point about what constitutes a gain and a loss. Since the default option now is for her father to get vaccinated, any harm from the vaccine will be viewed as a foregone gain. In contrast, if she declines to get him vaccinated, any harm from going without the vaccine will loom larger because it will be perceived as a loss. In short, the physician recommendation has shifted the psychology of this situation in ways that should increase the chance that she will let the her father be vaccinated.

Discussions of DNR could be similarly improved by physician recommendations. Imagine a physician who, after discussing treatment goals with a family, recommends that their loved one not be resuscitated and asks the family if they concur. Once again, the definition of what constitutes an omission and a commission has shifted. So, too, has the locus of responsibility. The physician made the DNR decision, not the family. If their loved one dies, it is the physician who decided not to resuscitate him, not the family. In fact, if anything, the families will now feel responsible for any harm that comes to their loved one from being resuscitated. In my experience, families are often relieved when DNR discussions are framed as recommendations rather than open-ended questions.

ARE PHYSICIAN RECOMMENDATIONS SIMPLY PATERNALISM IN SHEEP'S CLOTHING?

Some physicians might feel that any new justification for physician recommendations is simply a step backward into the "bad old days" of physician paternalism. They have a legitimate concern. After all, physicians can take their understanding of the psychology of decision making and use it to cajole patients into one treatment or another. They can frame their recommendations in ways that influence patients into making what the physicians decide are "good" decisions.

This is an important objection. However, physicians need to recognize that even decisions to withhold a recommendation are not value neutral. If a patient asks her physician for a recommendation and the physician declines, that physician has influenced the patient's decision. The physician has essentially told the patient that the onus is on the patient to make the decision. Yet, in many cases, patients request recommendations from physicians because they are overwhelmed by the decisions they are facing, and want someone else to take responsibility.

Another important way I respond to this criticism is to point out that the proper role and timing of physician recommendations depend on clinical context. One extreme context is typified by smoking cessation advice. Physicians typically feel justified in telling patients that they should quit smoking, and in offering them help to do so. Of course, these discussions are best performed in a nonjudgmental manner. But, physicians do not simply make sure that patients understand the risks and benefits of tobacco—they encourage them to quit smoking.

The other extreme is typified by cancer decision making. For example, when a man develops prostate cancer, he must decide whether to pursue surgery, radiation, or watchful waiting. These different approaches have different outcomes, including different chances of impotence and incontinence. These are very personal decisions that men have to make. In such cases, it makes less sense for physicians to launch right into a treatment recommendation without getting a sense of what patients' values are.

THE CHALLENGE OF MAKING PHYSICIAN RECOMMENDATIONS APPROPRIATELY

As clinical situations approach this latter extreme of cancer decision making, physician recommendations should be delayed but not necessarily withheld. Physicians should first try to explain alternatives to patients and probe patients' values. Often explaining treatment alternatives in itself will lead patients to tell physicians about their preferences. After explaining treatment alternatives and probing patients' values, physicians should try to determine whether patients have any treatment preferences, or even get some idea of whether the patients even want a clinical recommendation. Ultimately, however, even in these clinical circumstances, when patients desire physician recommendations, physicians should feel justified in providing the recommendations. Of course, the recommendations are accompanied by appropriate caveats, but at some point, refusals to give patients treatment recommendations are not necessarily benefiting anyone.

Although physician recommendations can sometimes improve medical decisions, it would be a mistake to return to good old-fashioned paternalism. Physicians need to remain aware of the very powerful role their recommendations can play in people's treatment choices, and of the undue ways their recommendations can influence patients.

The challenge for physicians is to use their influence for the best purposes. Physicians should not make treatment recommendations that promote their own interests against those of patients. This is easier said than done. A urologist recommending aggressive treatment for early prostate cancer may or may not be unduly influenced by his own interests. When physicians worry that their own interests or specialty biases are influencing their recommendations, they should encourage patients to get second opinions and also try to make their biases explicit to patients. Of course, second opinions may lead to contradictory recommendations. As difficult as conflicting recommendations can be for patients, these recommendations still leave patients with the option of accepting one recommendation or another, rather than feeling like they made the entire decision by themselves. When patients face difficult decisions, they are often going to learn that there is

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no simple right or wrong medical answer. In these situations, it is plausible to think that a series of even contradictory physician recommendations is more comforting than a series of nonrecommendations.

When physicians make recommendations to their patients, they should make it easy for patients to overturn their recommendations. A simple way for physicians to do this is to remind patients that many of their other patients have made choices that go against their recommendations and that they are still happy to have them as patients.

It is also important to get patients to talk out loud about their values before making treatment recommendations. Often, this type of conversation will make it easier for physicians to determine what recommendation is most appropriate for a patient and whether the patient is comfortable deciding what to do without receiving a recommendation.

As concerned as physicians should be about the influence their treatment recommendations have on patients' decisions, they should be just as nervous about the influence that nonrecommendations could have. Many times, people are afraid to make difficult decisions. By refusing to make recommendations, physicians are still influencing people's choices. If people do not want to get vaccinated because they fear vaccine side effects, it would be irresponsible for physicians not to recommend the vaccine.

Ultimately, the distinction between letting patients make decisions and giving patients a treatment recommendation is often very subtle. But it still matters to patients that we relieve them of some of the stress of decision making. I recall admitting a patient with emphysema to the hospital to treat an acute pulmonary infection. The question came up about whether, if he got any worse, he would want to be transferred to the intensive care unit and intubated until we had time to see whether the antibiotics worked. He asked me what I thought. I said it depended on what chance he was willing to take of being unable to get off the ventilator. I said, if he was the type of person who would go on a ventilator even if he had only a 1% chance of getting off, then he should be put on the ventilator. If he was the type of person who needed more assurance than that, then the ventilator might not be the best way to go. Then, rather than ask him what he wanted to do, I simply asked him what kind of patient he was. He said, "I'm the kind of person who's willing to take a chance, even if it's only 1%." I replied, "Then I recommend, for now, we keep open the option of ventilation." I don't know who made that decision, but I think it was the right one at the time.

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