

place to support partnership, including information materials. Perhaps more urgently, research is needed to show the effect of involving children in decisions and to indicate how partnership can be managed in practice.

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What do we mean by partnership in making decisions about treatment?

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For many decades, the dominant approach to making decisions about treatment in the medical encounter has been one of paternalism.¹⁻⁷ In recent years this model has been challenged by doctors, patients, medical ethicists, and researchers who advocate more of a partnership relation between doctors and patients.²⁻⁸⁻¹³ The reasons for this challenge have been described in detail elsewhere and include the rise of consumerism and the notion of consumer sovereignty in healthcare decision making; the women's movement with its emphasis on challenging medical authority; the passage of legislation focusing on patients' rights in health care; and small area variations in doctors' practice patterns that seem unrelated to differences in health status.⁷ Though the first three factors are seen as either contributors to or facilitators of patients' participation in making decisions about health care, the fourth highlights the imprecision or the "art" of medical care¹⁴; patients with similar clinical problems may receive different treatments from different doctors, due in part to systematic variations in practice patterns across geographical areas.^{14 15}

The call for doctor-patient partnerships opens up options beyond paternalism for approaching the task of making decisions about treatment. But it also raises new complexities. Because a partnership between patient and doctor can take different forms, it is not intuitively apparent what this model would look like. The *Oxford English Dictionary* (1995) defines a partner as "a person who shares or takes part with another or others." This definition leaves several important questions unanswered. For example, does the concept of a partnership imply that both doctor and patient need to share all parts of the decision making process? What is it that both parties are sharing, and to what degree? Who is responsible for determining if a partnership is possible and for initiating the first steps?

Summary points

Doctor-patient partnerships in making decisions about treatment can take different forms

Three theoretical treatment decision making models are the paternalistic, the shared, and the informed

Most clinical consultations use elements of these theoretical models, and these may change as the interaction unfolds

Doctors need to be aware of and be able to identify and explain the treatment options available

If doctor-patient partnerships are to be promoted in clinical practice, current disincentives such as time and funding constraints will need to be restructured

Is there room for variation in patients' and doctors' roles while still retaining the concept of a partnership? What are the clinical contexts within which a doctor-patient partnership is most needed? Drawing on our earlier conceptual papers,^{6,7} this article identifies and describes different types of partnerships that can be developed between a doctor and patient in the context of making decisions about treatment.

Theoretical models

In the figure, treatment decision making is broken down into different analytical steps or stages (though in

reality these may occur together in an iterative process): information exchange, deliberation or discussion of treatment preferences, and deciding on the treatment to implement. Information exchange can be further subclassified according to the flow, direction, type, and amount of information exchanged.

Paternalistic model

The characteristics of the paternalistic model are well known. In the purest form of this model, the patient passively acquiesces to professional authority by agreeing to the doctor's choice of treatment. An assumption underlying this model is that the doctor will make the best treatment decision for the patient and can do so without eliciting personal information from the patient or involving him or her in the decision making process. There is no sharing of any of the decision making steps in this model so, by definition, a doctor-patient partnership does not exist.

In cases where both the patient and the doctor prefer this approach, it can be argued that they have entered a form of partnership based on agreement about how the process should be undertaken. But this would require an explicit discussion of alternative decision making models and an explicit agreement by the doctor to adopt the patient's preferred model. Neither of these are likely to occur if the doctor adopts a paternalistic model at the outset of the decision making process.

Informed model

The informed model involves a partnership between doctor and patient that is based on a division of labour. In the information exchange stage, for example, the doctor leads and the communication is one way, from doctor to patient. The doctor communicates to the patient information on all relevant treatment options and their benefits and risks. The amount and type of information communicated includes, at a minimum, sufficient information to enable the patient to make an informed treatment decision.

Information transfer is seen as the key responsibility and only legitimate contribution of the doctor to the decision making process. This model assumes that the deliberation and decision making steps are the sole prerogative of the patient. The doctor is accorded no legitimate claim for involvement in these phases or legitimate investment in the treatment decision that the patient makes. Eddy, a doctor who advocates this approach, states the case clearly: "The people whose preferences count are the patients, because they are the ones who will have to live (or die) with the outcomes. . . Ideally, you and I are not even in the picture. What matters is what Mrs Smith thinks. . . It is also quite possible that Mrs Smith's preferences will differ from Mrs Brown's preferences. If so, both are correct, because "correct" is defined separately for each woman. Assuming that both women are accurately informed regarding the outcomes, neither should be persuaded to change her mind."⁸

Shared model

In contrast to the informed model, the essential characteristic of the shared model is its interactional nature in that the doctor and patient share all stages of the decision making process simultaneously.^{6, 7} In its

Analytical stages		Paternalistic model	Intermediate approaches	Shared model	Intermediate approaches	Informed model
Information exchange	Flow	One way (largely)		Two way		One way (largely)
	Direction	Doctor ↓ patient		Doctor ↓ ↑ patient		Doctor ↓ patient
	Type	Medical		Medical and personal		Medical
	Minimum amount	Legal requirement		Anything relevant for decision making		Anything relevant for decision making
Deliberation		Doctor alone or with other doctors		Doctor and patient (plus potential others)		Patient (plus potential others)
Who decides what treatment to implement?		Doctors		Doctor and patient		Patient

Models of decision making about treatment

purest form, there is a two way exchange of information, both doctor and patient reveal treatment preferences, and both agree on the decision to implement. This approach assumes that both the patient and the doctor have a legitimate investment in the treatment decision; hence, both declare treatment preferences and their rationale while trying to build a consensus on the appropriate treatment to implement. The challenge for doctors using this model is to create an environment in which the patient feels comfortable expressing his or her treatment preferences (including doing nothing or watchful waiting).

Intermediate approaches

The figure also indicates that there are intermediate approaches. Doctors in a clinical encounter may not use a pure model, but rather a hybrid of elements of more than one model.

The reality of clinical decision making

In the real world of everyday practice, many clinical decision making interactions are likely to reflect some form of hybrid model. Human behaviour rarely conforms to ideal types. Given the often dynamic, complex, and personal nature of the doctor-patient relationship, the decision making model adopted at the outset of a clinical encounter may not unfold according to the pattern of the ideal type but instead be modified to reflect the needs of individual patients.

A doctor, for example, who favours a shared decision making model (by our definition) may find, as the interaction proceeds, that the patient has gained enough confidence and gathered enough information to make the decision on his or her own. At this point, the process might shift from a shared to more of an informed model as a result of the learning that has occurred in the interaction itself. Given this possibility, assessing patients' preferences for participation in making decisions about treatment is perhaps more appropriately conceptualised as an ongoing task for the doctor, rather than an assessment made, either implicitly or explicitly, at the outset of the encounter.

Clinical contexts for partnership relationships

The importance of developing some form of partnership in making decisions about treatment depends on the specific clinical context as well as patients' and doctors' preferences. When patients bring minor everyday problems (such as a rash) to the doctor and there is a routine and simple treatment of benefit, there is no compelling clinical need to initiate a process of eliciting patients' preferences about how the decision making process should proceed, especially when the time available for each interaction is limited.

The need for some form of doctor-patient partnership is most compelling when the patient presents with a serious or life threatening illness; different treatment options exist, with different benefits and risks; and outcomes are uncertain. In this situation, the stakes are high and there is no one "right" treatment. Since the patient will bear the consequences of whatever treatment is implemented, it is important that his or her values and preferences are known and respected. Patients in this situation are likely to feel vulnerable and may not initiate such a discussion; it is the doctor's responsibility to ensure that this occurs.

In current healthcare systems, both time and funding constraints can act as disincentives for doctors to explore and respond to patients' preferences regarding the type of partnership they would prefer in the process of making decisions about treatment. Both of these potential barriers are amenable to policy change if the political will to do so exists. Whether current disincentives are restructured into incentives depends on the priority given to the goal of facilitating doctor-patient partnerships in making decisions about treatment relative to other competing clinical and health system goals.

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A memorable patient

On the power of communication

Let us call her Frederica for the sake of anonymity. I had been the family doctor for many years, and had attended to her late parents as well as her siblings. She was a 40 year old unmarried woman with a great zest for living, a unique sense of humour, and a modest awareness of her physical beauty. She spent her annual summer holiday basking in the hot sun of the Côte d'Azur, whence she sent me a breezy picture postcard with her own inimitable funny remarks.

Though our relationship was strictly professional, I think that we both had a secret admiration for each other, and so it was with poignant sympathy that I had to tell her that the lump in her breast about which she had come to consult me was indeed malignant. Her predictably calm and fatalistic response came as no surprise to me. However, she made me promise, almost with hand on the Bible, that when the time came when she developed secondaries I would be honest with her and not put her off with childish deceptions. I gave her my word.

Time went by and she continued to have her annual holidays in the south of France, wearing her immaculate prosthesis-assisted bikinis, and she continued to send me her amusing picture postcards. And then the inevitable happened and she presented with agonising and unrelenting backache.

We neither of us spoke of the fear in our minds, but the x ray examinations were arranged and the analgesics prescribed, and

the talk centred on the trivial and banal. The pain had been severe enough to keep her bed bound.

When I came to her home to give her the results of the tests, I said, "Do you remember that you once asked me to make a promise to you?"

She looked me in the eye with a quizzical expression on her face. "Yes," she said, "I remember."

"Well," I continued, "do you still want me to keep that promise?"

"No," she replied, as she buried her head in her pillow, and in that incandescent instant a monosyllabic utterance bore witness to us both that I had kept my word.

Hyman Davies, *general practitioner, Manchester*

We welcome articles up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.