Guest Editorial

Ought patients to follow professional advice?

Discrepancies between the aims and actions of patients and health professionals produce heated, often confused, and sometimes illuminating debate. The rhetorical question posed above cannot be answered without considering further questions about what it is that patients and professionals want and value, which areas of life and care they are expert in, and how advice is elicited, offered and interpreted. These questions in turn invoke ethical dilemmas about beneficence and autonomy. To make matters worse, we cannot even agree on which words to use: 'Compliance' implies compulsion and control; 'adherence' is more neutral, implying that one 'sticks' to something, whether one's own intentions or a medical regime; 'concordance' sounds pleasant, suggesting harmony between patients and their professionals. All three words, however, include 'agreement' as part of their definitions.[1] It seems as though 'concordance' between patients and their professionals during a consultation would be a good thing, as would subsequent 'adherence' to their shared decisions, but that 'compliance' would be too coercive.

The traditional medical view was that professionals know best, and so patients should do as they are told. Although apt in some circumstances, such as surgical emergencies, this approach is increasingly rejected as ineffective, unethical and irrational. It can be counter-productive because those patients who are intimidated by an insensitive authoritarian approach are less likely to adhere or to return for long-term care. It can be unethical if it infringes on patients' autonomy, assuming on their behalf what they want from health care and coercing them to act accordingly. Hence the increasing emphases on patient-centred care, negotiated care plans, informed choice and so on.[2] Reliance on professional authority can be irrational because health professionals, like other people, are not always rational, that is, logical and reasonable. Professionals' illogical processing of information, that may itself be biased, is well recognised.[3] Being reasonable, in this context, includes accommodating patients' views and preferences. However patients too may be illogical and unreasonable, for example having distorted interpretations of risks and benefits, or behaving inconsistently with their knowledge, wants and intentions.

Given these problems, is it possible to reach the right decision and to do the right thing? Is it possible even to think coherently about conflicts between patients' and professionals' knowledge, power, values, intentions, communication styles and behaviour? It is tempting to conclude that everything is, and should be, relative: that there is no objective rationality, what is right depends on one's point of view, conflicting values cannot be reconciled, and patients should just be helped to do what they want to do. Should we embrace irrationality and relativism?

A useful framework is provided by philosopher Jurgen Habermas, who has staunchly defended rationality from the trend of relativism, and whose social theory has been fruitfully applied to health care.[5,6] Habermas is especially concerned about the way technical rationality penetrates and distorts private life, especially through the influence of unaccountable experts working in

bureaucracies of the welfare state.[7] Relevant health care examples that come to mind include clinicians persuading patients to adopt healthier lifestyles and take drugs to control silent risk factors, scientists developing evidence-based clinical practice guidelines, and public health physicians optimising populations' health by manipulating patient and professional behaviour. These processes are beneficent and rational in some ways, but they could be invasive and damaging in others.

Habermas' starting point is that communication is the basis of all social activity.[7,8] People participate in communication voluntarily, with the aim of attaining shared understanding or agreement. Communication will only be successful, valid and rational if: facts about the external world can be understood and accepted by participants; their norms and values can be respected and accommodated; and their intentions and expressions are sincere. Communication will fail if participants cannot agree about the facts, do not respect each others' values, or mistrust or try covertly to manipulate each other. Any outcome of communication is right if the process was right.

This general framework is readily applicable to patients' and professionals' relationships and behaviour. It suggests that patients and professionals can come to the right decisions if they can understand and agree on pertinent evidence (e.g. about risks and effectiveness), if they accept each other's values (e.g. about coping in the present or reducing future risks), if they are frank and trusting, and if they are not coerced. It is also a suitable framework for researching distorted communication during clinical decision-making, using objective and interpretative research methods, and for designing better ways of managing chronic illness. It does not guarantee that patients will stick to their plans. Lapses of memory, changed attitudes or new circumstances may intervene. But a process of communication aimed at agreement, as defined above, would provide a firm foundation for intentions which are more likely to be followed because the participants believe in them. This does not imply that patients always know best, or that their views cannot be questioned, but does propose that their participation in decision-making is essential. As Habermas argues:

> '… nothing better prevents others from perspectivally distorting one's own interests than actual participation. It is in this pragmatic sense that the individual is the last court of appeal for judging what is in his best interests. On the other hand, the descriptive terms in which each individual perceives interests must be open to criticism by others. Needs and wants are interpreted in the light of cultural values. Since cultural values are always components of intersubjectively shared traditions, the revision of the values used to interpret needs and wants cannot be a matter for individuals to handle monologically.'[9]

Perfect communication sounds utopian – how can it be optimal during a 7 minute consultation? But scarcity does not rule out either ethics or rationality, and distorted communication is likely to be inefficient. For chronic conditions in particular, there is a need for thorough discussion at the outset; after that there are ample opportunities for dialogue.

Ought patients to follow professional advice? It is more pointed to ask: should they follow decisions that they have freely chosen and agreed to, after weighing up their own priorities, in the light of expert knowledge? As they are the ones who have to live with their decisions, the answer must be that it is up to them. But health professionals can help a lot by trying to reach such a situation. Once we have clarified what we mean, and worked out how seemingly incompatible ideas can be reconciled, we are better placed to answer more concrete questions about when and how to discuss what with whom.

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