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Institutional constraints on strategic maneuvering in shared medical decision-making

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In this paper it is first investigated to what extent the institutional goal and basic principles of shared decision making are compatible with the aim and rules for critical discussion. Next, some techniques that doctors may use to present their own treatment preferences strategically in a shared decision making process are discussed and evaluated both from the perspective of the ideal of shared decision making and from that of critical discussion.

Keywords: shared decision making, critical discussion, strategic maneuvering, doctor-patient consultation, treatment preference.

1. Shared decision making

Shared decision making is a treatment decision making model that has over the last ten years come to be regarded by many as the ideal format for doctor-patient consultations.¹ The model can be seen 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 et al. 1997). Charles et al. (1997) argue that in neither of these two 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”.

In this paper, we aim to give an analysis of the way in which the institutional constraints of the medical consultation influence physicians’ strategic maneuvering

aimed at convincing their patient to choose a particular treatment option. To this end, we will first compare the aims and principles of the process of shared medical decision making with those of the pragma-dialectical ideal model for critical discussion. Next, we will discuss a number of techniques that doctors may use to present their treatment preferences strategically within the constraints of a shared decision making process, and will evaluate to what extent these strategic maneuvers should be seen as fallacious or not.

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 institutional context: treatments should be the best possible treatment (within the institutional possibilities) 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. In this paper, we 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.

The institutional requirement that a doctor discusses the treatment options with the patient imposes on the doctor what we can refer to as an 'institutional' burden of proof. According to this requirement, the doctor is under an institutional obligation to discuss the treatment options available to the patient, even in those cases where the patient does not actually disagree with the doctor about these options.² The doctor should not just inform the patient about the benefits and risks of the different possible treatments, but should also indicate what his own preference is and why this is so. If he leaves it completely up to the patient to weigh up the pros and cons, he is not fully participating in the decision making process. In view of this burden of proof, the doctor is required to anticipate a difference of opinion between himself and the patient and to justify his point of view.³ As Rubinelli and Schulz argue, 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 patronize 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)

Since the discussion about the best treatment option requires the doctor to discuss the various treatment options, the discussion about the best treatment option available to the patient is a discussion of a multiple⁴ difference of opinion. In this discussion, disagreement between the doctor and the patient can be anticipated in relation to the inter-related points of view discussed above. As they discuss their multiple difference of opinion, physicians and patients are expected to conduct their discussion within the boundaries of reasonableness. Furthermore, they should of course also pursue the institutional goal of establishing what the best possible treatment option is, based on medical evidence and suited to the goals, values and preferences of the patient.

The institutional goal imposes preconditions for the argumentative exchanges between physicians and patients. An important constraint applies to the freedom of whether or not to engage in an argumentative discussion about a particular point of view. The ideal model of a critical discussion grants such freedom to discussants. Because ideally the discussants are voluntarily engaged in a critical discussion about a certain standpoint, arguers in an argumentative confrontation have the option of retracting standpoints and expressions of doubt (van Eemeren and Grootendorst, 1984: p. 101).⁵ However, in order to further the achievement of the institutional goal and to act in accordance to norms of institutional rationality, such freedom needs to be restricted. Ideally, a physician needs to present all the treatment options that are relevant to the patient, and provide evidence in favor or against each of these options. As a result, the physician cannot for example assume that there is no difference of opinion concerning the issue of whether or not the treatment option proposed is suitable for the patient, nor concerning the issue of whether or not there are alternative treatment options. As soon as a physician presents a particular treatment option, it can be assumed that differences of opinion about these two issues exist, and that he is expected to argue in defense of the point of view he adopts. Otherwise, the physician will fail in acting in accordance with the institutional norms of the exchange, which require him to anticipate this difference and try to discuss it by discussing the pros and cons of the treatment option at issue.⁶

As we have seen, in the process of shared decision making physicians are expected to act in accordance with two types of norms. In the first place, they are expected to be reasonable discussants and defend their proposals in line with the ideal model of a critical discussion, i.e. they are expected to act in accordance with norms of reasonable argumentation. In the second place, they are also expected to act in accordance with the ideal of medical shared decision making, i.e. they are expected to act in accordance with norms of institutional rationality and do their best in order to make the best possible treatment choice based on medical evidence and suited to the goals, values and preferences of the patient. Apart from

adhering to these two norms, physicians may also be expected to try to steer the discussion to a favorable outcome, namely to convince the patient that the treatment option they favor is the best medically speaking. Even though the pursuit of this rhetorical goal is often in tension with the pursuit of reasonable argumentation, the two are in principle reconcilable. Likewise, the pursuit of the rhetorical goal is in principle in line with the ideal model of shared decision making, in which physicians are expected not just to give information to the patient, but also to state their own preferences, even though the pursuit of this goal can endanger the shared decision making process. 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).

In what follows we will examine ways in which physicians can present their recommendations strategically without openly violating the norms of reasonableness, both argumentative and institutional.

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

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. Physicians may for example select the evidence that is most likely to appeal to the preferences of the patient as they defend the treatment option that is favorable to them, and patients may strategically refer to the opinion of other doctors or to their own experiences to compensate for the lack of medical expertise. 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 so-called "micro-certainty, macro-uncertainty phenomenon" (Bauman, Deber & Thompson 1991): While physicians frequently disagree among themselves about the efficacy of a given treatment, they are typically quite confident that their individual treatment decisions are the best for the patient. 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 strategic 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 be more involved in treatment decisions have more favorable patient outcomes, especially in the case of long-term decisions, as in the case of chronic diseases (Joosten et al. 2008: 224).

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, without the patient being openly denied this right.

As a follow-up to this research, we shall briefly discuss some ways in which physicians may in practice attempt to give the impression that they are adhering to the following 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.

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

3.1 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. In reality this may not necessarily be 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 it, 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.

In this case, the doctor's attempt to convince the patient of taking steroids as a treatment option is not in accordance with the ideal of shared-decision making. The physician avoids the discussion of the suitability of the treatment option and proceeds directly to the discussion of the technicalities of the treatment. Furthermore, the physician violates the norms of a critical discussion also as he falsely assumes that the patient accepts that taking steroids is a suitable treatment option. The assumption violates the pragma-dialectical starting-point rule, according to which "discussants may not falsely present something as an accepted starting point or falsely deny that something is an accepted starting point" (van Eemeren & Grootendorst, 2004: p. 193).

3.2 Presenting the available treatment options in such a way that the treatment preferred by the doctor seems to be the most 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 the most 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 midwives 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 anemia and hepatitis, 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: 2004: 458). By falsely portraying the antenatal screening as a routine test, the physician violates both the rules of a critical discussion and the principles of shared decision making. Starting from the assumption that the antenatal screening is a routine test, which the physician falsely presents as a commonly accepted starting point, the physician avoids the discussion of the availability of other suitable treatment options, in this case, not doing the screening. The latter is a violation of the institutional norms of shared decision making, too, since the physician is under the institutional obligation of discussing the various treatment options that are available to the patient.

Example 2 is given by Rubinelli and Schulz (2006, p. 370). The exchange might also be analyzed 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)

In cases such as the above, physicians can be seen to fail to act in accordance with the ideal of shared-decision making as they exclude the possibility of a difference of opinion about the suitability of the treatment option they propose. Furthermore, the use of the plural in referring to the treatment option, as something that physicians ‘always’ do, can restrict the freedom of patients to doubt the suitability of the treatment option proposed, and thereby violates the freedom rule of a critical discussion, according to which “discussants may not prevent each other from advancing standpoints or from calling standpoints into question” (van Eemeren & Grootendorst, 2004: p. 190).

3.3 Presenting the recommendation in such a way that it looks as if the decision is completely up to the patient

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, so that the impression is preserved that the decision is completely up to the patient.

Physicians may for instance only mention undesirable consequences of a particular treatment, without explicitly advising against it. Or they may just mention favorable consequences of a treatment without explicitly recommending it. In this way, the physician makes it seem as if it is completely up to the patient 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 factor of > 1 in 200 or less: < (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 completely up to the expectant mother.

By not explicitly recommending the treatment that is implicitly promoted, the physician can be seen to fail to act reasonably on both institutional and argumentative levels. On the institutional level, the physician does not present the patient with evidence about the pros and cons of the treatment options available.⁷ On the argumentative level, that translates into a violation of the pragma-dialectical

burden of proof rule according to which a discussant who has advanced a standpoint has the obligation to defend the standpoint if asked to do so (van Eemeren and Grootendorst, 2004: 138–140). As we have argued earlier, even if the physician does not explicitly advance a standpoint about a particular treatment option, his responsibility in the institutional context of the medical encounter justifies the attribution of such a standpoint and of the obligation to defend it.

4. Conclusion

The examples analyzed above suggest that the institutional goal of shared decision making, namely to try to establish the best possible treatment option based on medical evidence and suited to the goals, values and preferences of the patient, is compatible with the aim of a critical discussion to critically test the points of view concerning the different available treatment options. As the exchanges analyzed show, failure to adhere to the ideal of shared decision making was accompanied with a violation of the rules for a critical discussion. Even though the ideal model of shared decision making and the ideal model of a critical discussion are designed to further two different goals, following the rules of a critical discussion seems to be instrumental for the process of shared decision making.

But how do the basic principles of shared decision making relate to the rules for a critical discussion? That the patient must be able to participate in the decision making is not only a principle of shared decision making but 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. However, from the perspective of a critical discussion, this requirement can be translated as an institutional burden of proof, i.e. a commonly accepted procedural starting point that needs to be followed in order for the discussion to be reasonable. 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; it is a legal right of the patient. Just like the institutional burden of proof, this legal right can be considered a commonly accepted procedural starting point that needs to be observed by the patients and the doctors who wish to argue reasonably.

In principle, it can be completely acceptable, both dialectically and institutionally 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. As the cases that we have discussed show, fallacious strategic maneuvering endangers not only the critical testing procedure, but also the shared decision making procedure.

Notes

1. In practice, of course, there may be circumstances which make it impossible to put the ideal of shared decision making into practice or which make doing so undesirable, for instance, because a patient is unable or does not wish to participate fully in the decision making process.
2. Goodnight (2006: 81) arrives at a similar conclusion: “it is the doctor who must meet the burden of proof and satisfy the patient’s doubts.” Goodnight points out that in infrequent occasions this position could be reversed, if for instance the patient proposes to have a treatment that the doctor thinks has too little likelihood of success.
3. The anticipation of a difference of opinion concerning the treatment option that the doctor proposes is essential for a medical consultation to be conducted in accordance with the ideal model of shared decision-making. That is not to say that shared decision making requires doctors and patients to engage in peer-to-peer discussions. It is rather to say that the model requires doctors to anticipate any doubts that patients might have and justify the choices of treatment they make in anticipation of these doubts. In other words, doctors are required to justify treatment options without patients having to express any disagreement about these options.
4. See van Eemeren and Grootendorst (1984, 1992) for more details about multiple disputes.
5. See Krabbe (2001), for an elaborate discussion of the (un-)reasonableness of retracting one’s commitments in the different stages of resolving differences of opinion.
6. The institutional requirement that a doctor discusses the pros and cons of possible treatment options imposes constraints on the structure of argumentation a doctor can use in defending his points of view. In defending the point of view that a particular treatment option is suitable, for example, the doctor needs to employ what van Eemeren, Grootendorst, and Snoeck Henkemans distinguish as a coordinative argumentation structure (2002: pp. 63–78). In this structure both the arguments in favour of the treatment option and those against it are presented, and the former are presented as being stronger.
7. In fact, in the case above, the physician presents only the treatment option. Even though the doctor does not explicitly recommend it, he does not discuss the possibility of another option either.

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