THE PHYSICIAN–PATIENT ENCOUNTER: THE PHYSICIAN AS A PERFECT AGENT FOR THE PATIENT VERSUS THE INFORMED TREATMENT DECISION-MAKING MODEL

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Abstract—Assuming a goal of arriving at a treatment decision which is based on the physician’s knowledge and the patient’s preferences, we discuss the feasibility of implementing two treatment decision-making models: (1) the physician as a perfect agent for the patient, and (2) the informed treatment decision-making models. Both models fall under the rubric of agency models, however, the requirements from the physician and the patient are different. An important distinction between the two models is that in the former the patient delegates authority to her doctor to make medical decisions and thus the challenge is to encourage the physician to find out the patient’s preferences. In the latter, the patient retains the authority to make medical decisions and the physician role is that of information transfer. The challenge here is to encourage the physician to transfer the knowledge in a clear and nonbiased way. We argue that the choice of model depends among other things on the ease of implementation (e.g., is it simpler to transfer patient’s preferences to doctors or to transfer technical knowledge to patients?). Also the choice of treatment decision-making model is likely to have an impact on the type of incentives or regulations (i.e., contracts) needed to promote the chosen model.

We show that in theory both models result in the same outcome. We argue that the approach of transferring information to the patient is easier (but not easy) and, hence, more feasible than transferring each patient’s preferences to the physician in each medical encounter. We also argue that because better “technology” exists to transfer medical information to patients and time costs are involved in both tasks (i.e. transferring preferences or information), it is more feasible to design contracts to motivate physicians to transfer information to patients than to design contracts to motivate physicians to find out their patients’ utility functions. We illustrate our arguments using a clinical example of the choice of adjuvant chemotherapy versus no adjuvant chemotherapy for women with early stage breast cancer. We also discuss issues relating to the current realities of clinical practice and their potential implications for the way that economists model physician–patient clinical encounters. © 1998 Elsevier Science Ltd. All rights reserved.

Key words—agency models, physician–patient encounter, informed decision-making

INTRODUCTION

A conceptual approach that is often used in health economics to describe the physician–patient relationship is the physician as agent for the patient (e.g., Feldstein, 1974; Evans, 1984; Phelps, 1992). This type of relationship in which a principal (the patient) delegates authority to an agent (the doctor) to take action (e.g., make medical treatment decisions) for the principal (who defines the contract), is justified as a direct consequence of the asymmetry of information between the patient and the doctor. The doctor possesses the knowledge needed for making a treatment decision regarding the patient’s illness and for assessing the expected effectiveness of health care interventions in improving the patient’s health status. The hope is that “[I]f this agency relationship were complete, the professional would take on entirely the patient’s point of view and act as if she were the patient” (Evans, 1984, p. 75). The model described is one where the physician acts as a perfect agent for the patient, i.e., using her extensive knowledge to make the treatment decision for the patient taking the patient’s point of view.

Modelling the relationship between doctors and their patients as an agency relationship is very appealing to economists because of the vast body of literature in economics dealing with the agency paradigm (Levinthal, 1988; Bamberg and Spremann, 1989). Health economists have long recognized, however, that perfect agency relationships do not exist. It is important thus to emphasize that most (if not all) health economists see this model as a benchmark from which one can study the departure from that model in a useful way.
Agency theory recognizes that what makes the agency relationship complex is the principal's uncertainty as to the agent's actions and characteristics. Agency theory holds that the uncertainty problem is best addressed through contract design. In other words, the challenge is to design a contractual agreement that will turn all doctors into perfect agents: A practical question is whether such a contract can be designed in the context of health (e.g., Dranove and White, 1987; McLean, 1989; Rochais, 1989; Blomqvist, 1991; Mooney and Ryan, 1993; Lee, 1995; Pontes, 1995).

Depicting the physician as the perfect agent for the patient stems from the attempt to preserve the idea that the consumer is the best judge of the value to herself of different commodities or states in this case, different health outcomes. This model also preserves a central principle to economic analysis—the sovereignty of consumer choice. Even though it might be the doctor who makes the treatment choice, it is the same choice that the patient would have made if she had the knowledge and information that her doctor has. Retaining the goal of arriving at a treatment decision which is based on the physician's knowledge and the patient's preferences, we discuss the feasibility of the task. More specifically, we compare two models, which share this goal, the physician as a perfect agent to her patient and the informed decision-making model.

Both models fall under the rubric of agency model (i.e., an action is undertaken by an agent for a principal who defines the contract), however the requirements from the physician and the patient are different. An important distinction between the two models is that in the former the patient delegates authority to her doctor to make medical decisions and the challenge is to encourage the physician to find out the patient's preferences. In the latter, the patient retains the authority to make the treatment decision and the physician's role is that of information exchange, communicating the needed technical or scientific knowledge to the patient. The challenge here is to encourage the physician to transfer the knowledge to the patient. The patient then informs the physician about her treatment choice. The challenge here is to encourage the physician to transfer the knowledge in a clear and non-biased way. The choice of model depends among other things on the ease of implementation (e.g. is it simpler to transfer patients' preferences to doctors or to transfer technical knowledge to patients?). Furthermore, the choice of a model is likely to have an impact on the type of incentives or regulations needed (i.e., contracts) to promote it. Hence the choice of model is likely to depend on whether it is easier to create contracts that motivate physicians to find out their patients' treatment preferences versus motivate physicians to provide technical information to their patients.

The comparison between these two models is made in context of a physician–patient treatment decision-making encounter. To illustrate our points we chose a specific clinical example—the case of adjuvant chemotherapy versus no adjuvant chemotherapy for women with early stage breast cancer. We also discuss issues relating to the current realities of clinical practice and their potential implications for the way economists model physician–patient clinical encounters.

**THE TREATMENT DECISION-MAKING CONTEXT**

Adjuvant chemotherapy may be used postoperatively in women with axillary-node-negative breast cancer. Results of clinical trials have shown that adjuvant chemotherapy decreases cancer recurrence. However, the risk of recurrence (i.e., the cancer coming back) is small and adjuvant chemotherapy can have a large adverse effect on the patient's quality of life during treatment (Levine et al., 1992). In this situation there is no right or wrong treatment choice from a clinical perspective; the choice involves making a trade-off between potential morbidity and disability now (due to therapy, if chosen) versus potential reduction in both morbidity and inconvenience later (due to the recurrence of the disease). In this example there is also asymmetry of information between the doctor and the patient. The physician possesses technical knowledge about the disease and the expected outcome of each course of action (i.e., treatment versus no treatment) that the patient typically does not have. The patient on the other hand, is the only person who can judge how changes in her health status will affect her well being.

The general problem can be restated as follows. In order to make a treatment decision which involves trade-offs (such as those described in our clinical example) two components are required: full knowledge about the risks and benefits of each course of action as well as their costs, when relevant (i.e., the knowledge component), and each individual's utility function (i.e., the preference component). In many other real life situations, both components are found in the same person. However, in the case of treatment decision-making, often the knowledge exists in one person (i.e., the doctor) and the "preference mapping system" (i.e., the utility function) exists in another body (i.e., the patient). Thus, in order to make a treatment decision which is based on the physician's knowledge and the patient's preferences we have to bring the two components together. This means either transferring the patient's "preference mapping system" to the physician (i.e., choosing the model of the physician as perfect agent) or transferring the technical knowledge to the patient (i.e., choosing the informed decision-making model).
In an ideal world, where both physicians and patients share the goal of a treatment decision which is based on both the physician’s knowledge and the patient’s preferences and no difficulties are encountered in either transferring the patient’s preferences to her physician or in transferring the physician’s knowledge to the patient, there should be no difference between these two approaches in terms of the treatment choice made in any given patient–doctor encounter. In reality, however, the implementation of each approach is far from being perfect and easy; hence, the choice of treatment might differ based on the decision-making approach chosen. Which approach is preferred depends, in part, on the feasibility of implementation and how close the outcome can be to the ideal case. In the following sections we examine this issue further.

THE PHYSICIAN AS A PERFECT AGENT MODEL

The model of physician as a perfect agent corresponds with the approach in which the patient’s preferences are transferred to the physician. For simplicity, we discuss first the case of a physician who would like to act as a perfect agent for her patients. For such a physician we do not have to deal with the question of how to design a contractual agreement that will turn this doctor into a perfect agent. Later, we relax this assumption. In the context of our clinical example, for the physician to act as a perfect agent for his/her patients s/he needs to know each patient’s utility function. In the absence of evidence that all patients have the same utility function it means that for each patient–physician encounter the physician needs to determine the utility function of that specific patient.

This is not a simple task. First, the number of potential utility functions is unlimited. Second, there is no way (known to us) to find a patient’s utility function without an empirical enquiry. This enquiry again is not an easy task and is time consuming. Simple questions like how do you feel about potential hair loss or the cancer recurring are not sufficient to determine what would have been the patient’s choice of treatment if she had the physician’s knowledge. This is because such simple questions are unlikely to capture the complexity of the decision-making context (i.e., all trade-offs involved as well as the patient’s ranking of all the potential combinations of outcomes and their likelihood of occurrence). In other words, such a process will not result in transferring the richness of a patient’s preference mapping system (i.e., her utility function) to the physician.

One practical method to transfer the patient’s utility function (or preference mapping system) to the physician is the use of a decision tree type analysis at a clinical level. In this approach the assumption is that the patient prefers the treatment that provides the best expected utility. The physician has the knowledge (i.e., the decision trees) and the patient provides his/her “preference mapping system” in the form of utility scores assigned to various potential outcomes. The physician uses this input and “folds back the decision tree” to identify the treatment option which is most desirable form the patient’s perspective (i.e., with the greatest expected utility). This option is then recommended to the patient. This type of interaction is highly recommended by some clinicians and has been tried in the context of real doctor–patient interactions (e.g., Fleming et al., 1987; Moskowitz and Pauker, 1989; Hagen et al., 1989).

A problem arises when the patient’s preferences do not correspond to the underlying assumptions of expected utility theory. In this case the physician might be recommending a treatment option which is inferior from the patient’s perspective (e.g., Gafni, 1990). In other words, by forcing the patient to subscribe to a specific type of utility theory assumptions, the physician does not respect the patient’s sovereignty and hence does not play the role of a perfect agent for the patient. It is important to note that empirical studies have found that people do not behave in a manner consistent with the axioms of expected utility theory, and when asked to reconcile their actual behaviour with the axioms, many preferred not to change their original behaviour (e.g., Fishburn, 1988; Karnie and Schmiedler, 1991; Machina, 1987). Furthermore, in many cases the type of analysis performed (e.g., the use of a Markov tree type analysis) calls for additional assumptions (i.e., in addition to the vNM axioms) which do not have any empirical or normative support (Gafni et al., 1993). To the best of our knowledge, those who use this approach in practice do not check to see whether their patients do subscribe to these assumptions. Yet this is essential if one believes in patient sovereignty. To ensure patient sovereignty the physician would need to describe the suggested approach (i.e., the expected utility maximization approach) to the patient, explain the implications of the assumptions underlying this approach and allow the patient to accept or reject it. This, to our knowledge, is not being done in practice.

Finally, the complexity of making treatment decisions by doctors for their patients is illustrated in a paper by Mehrez and Gafni (1987). The paper shows that even in the case of an expected utility maximizing individual, in which the physician is aware of the structure of the patient’s utility function, the physician, who wants to act as a perfect agent, and her informed patient can reach different conclusions about the optimal treatment option. This might be a result, for example, of the use of population probabilities by the physician versus subjective probabilities (i.e., a subjective interpretation of the population based probabilities) by patients to determine the likelihood of each poten-
tial outcome. This potential discrepancy between the professional view and patient’s view of information is also acknowledged by Lee (1995).

Relaxing the assumption that the physician would like to pursue only the patient’s objective makes things more complex. This is the typical (and more realistic) case of conflicting goals of the principal and agent which is the focus of classical agency theory. This is the case where an incentive system (i.e., a contract) is called for in order to ensure that the agent will act in the best interests of the principal (Levinthal, 1988). However, as explained earlier, the choice of optimal treatment for each patient, in most cases, is a preference judgement. In most clinical cases, as in our breast cancer example, there is a trade-off between benefits and risks in the choice of different interventions. In such cases, there is no right or wrong choice (i.e., there is no one optimal treatment for all patients). Because it is recognized that each patient’s preferences are not known in advance to her doctor (e.g., Pauly, 1980), a physician cannot act as a perfect agent to her patient without knowing each patient’s “preference mapping system” (i.e., utility function). Hence, the role of the contract is to convince or motivate the physician to find out for each physician–patient encounter what the patient’s utility function is.

The above demonstrate that while the agency approach might provide a useful tool for theoretical investigations, its practical applicability is very limited. It is not surprising that at this point “...we have not yet discovered a contractual agreement that turns all doctors into perfect agents” (Phelps, 1992, p. 215). The problem that we have not solved yet is how can a doctor, who wants to act as perfect agent for her patient, finds out the “preference mapping system” of each patient. Without a feasible solution to this problem there is no way to design a contract that will encourage physicians to become perfect agents (or even better agents). It is thus not surprising to find that those who want to use this model make strong assumptions about both the patient’s and the doctor’s utility functions.

The fact that strong assumptions about the physicians’ and patients’ utility function are being used in the literature on agency model in health care is well known. As a result, Mooney and Ryan (1993) argue that “... more research is needed into the nature of both the patient’s and the doctor’s utility functions. Only then can we begin to devise optimal incentive structures to encourage doctors to take adequate account of patient preferences” (p. 125). We agree that better understanding of patients’ and doctors’ utility functions can help. But, this does not solve the practical issue of how a doctor is to know, for each specific patient, what her utility function is. Unless we find out that all patients have the same utility function this practical issue will be a major obstacle, in our opinion, for doctors to act as perfect (or even better) agent for their patients.

THE INFORMED DECISION-MAKING MODEL

The informed decision-making model corresponds with the approach where the information is transferred by a provider, e.g., the physician, to a patient. The latter then decides about the optimal treatment option from her perspective. Again for simplicity, we start with a physician who wants to participate in an informed decision-making process. For such a physician the question is: Can a doctor transfer complex medical information at the point of decision-making in a clear, easy to understand and unbiased way?

In recent years the issue of transferring information to patients to enable the informed patient to make treatment decisions has received a lot of attention. Decision aids designed to inform patients about treatment options have been developed ranging in type from high cost interactive videos (e.g., Deber, 1994; Deber, 1996) to low cost decision boards (e.g., Levine et al., 1992). It is beyond the scope of this paper to discuss the advantages and disadvantages of each mode of physician–patient communication suggested in the literature. We choose instead to explain how this concept works in practice using a decision board as illustration. We describe briefly below the decision board developed by Levine et al. (1992) because it relates to the presentation of treatment options (i.e., adjuvant chemotherapy versus no further treatment) to women with early stage breast cancer, which is the clinical example used in this paper.

Research has shown that in the cancer area, communication between physicians and patients suffers from major problems (e.g., Siminoff et al., 1989; Mackillop et al., 1988). This communication breakdown has led to interest in developing methods whereby information derived from clinical trials and the clinic experience on the risks and benefits of adjuvant chemotherapy versus no treatment can be presented to an individual patient in a clear, nonthreatening, and unbiased a fashion as possible*, and to develop a simple process whereby the informed patient can voice a treatment preference. The Levine et al. (1992) decision board (DB) was designed and tested on real patients at the point of treatment decision making. It is a visual aid which helps clinicians present the relevant information needed by patients to decide about the optimal treatment in an efficient and standardized way.

This decision board has been used since 1991 in the Hamilton regional cancer clinic which serves a population of about 1.5 million people. It is pre-

*It is important to emphasize that an unbiased presentation of information does not exist. The goal is to minimize the bias in the process of developing such tools.
sented to the patient by either the physician or an expert oncology nurse. After the presentation the patient receives a take-home version (i.e., a Xerox copy of the completed board). The patient is asked to think about her choice of preferred treatment option at home. The experience with the DB concept has been positive from both sides (i.e., patients and clinicians). Other decision boards have also been developed in the cancer area (e.g., Whelan et al., 1995; Sebban et al., 1995; Elit et al., 1996).

It is important to emphasize that the decision board represents only one method of transferring information to patients. Other methods have been developed and found to be satisfactory in different cases. The most commonly used method today is the computer-based interactive video and supporting written materials to provide patients with information about their medical condition and the benefits and harms of alternative treatment options. This method was first developed by Wennberg and colleagues for the case of benign prostatic hyperplasia and since then has been further developed into a program (i.e., The Shared Decision-Making Program (SDP)) by the U.S.—based foundation for Informed Decision-Making (Kasper et al., 1992). The videos include interviews with patients and medical experts to set out the choices. The medical information is derived from clinical trials, systematic overviews and other outcome studies. Details of the patient’s medical history are entered into the computer which calculates for each patient the probabilities of a range of outcomes based on available research evidence. Again, preliminary studies have shown that the interactive video is well received by patients and clinicians (e.g., Barry et al., 1995).

It seems that the answer to our question (i.e., can we transfer complex information to patients in a clear and standardized way) is a qualified yes. Using our clinical example, information about possible treatment options for cancer patients is complex and typically the patient is stressed and frightened, which adds complexity to the interaction. Yet the use of decision aids, like the decision board, enables the physician to transfer the knowledge needed to make a treatment decision to the patient. We do not want to create the impression that the ideal instrument has been developed or that the process of transferring information is a simple one. The point that we want to emphasize is that practical ways to communicate complex medical information to patients do exist.

It is also important to emphasize that there are time costs involved in the process of information transfer. This might be seen as an obstacle to the implementation of the informed decision-making model. But, there are also time costs involved in the process of transferring the patient’s utility function to the physician (i.e., the physician trying to learn the “preference mapping system” of the patient).

We do not know of any empirical evidence to suggest which time cost component is greater. Based on our experience with both procedures, trying to measure the patient’s utility function, even under some strong assumptions (i.e., that the patient follows the vNM axioms) is more difficult and more time consuming. Hence, for a physician who wants to arrive at a treatment decision which is based on the physician’s knowledge and the patient’s preference, the time costs involved in transferring the information should not be seen as an obstacle when compared with the alternative approach.

Finally, when choosing the approach of transferring information to patients, one would like to provide individualized information (i.e., information which is relevant to the specific patient). Unfortunately, doctors cannot predict what will happen to a specific patient. The knowledge (or information) that doctors have is only about groups of patients. The task of the doctor is to fit the patient to a “clinical group” and then describe the information on treatment benefits and risks to the patient. In other words “[W]hat sets patient analyses apart from generic clinical decision models are the accommodations they contain for the unique characteristics of the individual. Such analyses consider the constellations of co-morbid conditions that characterize the individual and limit the benefit he or she may derive from diagnostic and therapeutic interventions” (Moskowitz and Pauker, 1989, p. 29A).

The number of different clinical groups that a specific patient with a specific problem can be matched with is much smaller than the number of different possible utility functions that patients can have. Also these clinical groups are known in advance while there is no way to know in advance the utility function of a specific patient. This is a practical advantage. For example, in the adjuvant chemotherapy decision board, the only difference in the presentation of the treatment options for women who belong to different clinical groups is in the probability of recurrence. (There is no way to predict for each woman an individualized probability of each potential treatment side effect.) As a result there is no need to use different boards for different physician–patient encounters. The generic board is used but with different cards that are prepared in advance which describe the different potential values of the probability of recurrence, for each specific patient. So, for a common treatment decision problem that many women face we have one board that enables the physician to transfer the information to all patients. Alternatively, if the avenue of transferring preferences was chosen, the physician would have to find out, in each encounter, what is the patient’s utility function in order to play the role of a perfect agent.
Relaxing the assumption that the physician would like to participate in an informed decision-making process implies designing a contract to motivate the physician to behave in a way consistent with this approach. One area that the contract will have to deal with is the possibility that the physician may use the information transfer process to advance his own goals (e.g., might present the information in a biased way to convince the patient to choose a treatment that the physician might also benefit from). How to design a contract that will prevent or reduce such events is not an easy task. However, it is important to point out that all the methods known to us (e.g., decision board, video) involve leaving written information with the patient. Hence, if there was a deliberate attempt to bias the presentation it is easier to detect it (i.e., easier than in the case where there is no written record of the process). It is thus not surprising to us that developers of such tools attempt to use the highest quality information available when developing these instruments.

The quality of the medical information used by the physician is not just an issue in the case of the informed treatment decision-making approach; it is an issue also in the case of the physician as perfect agent model. This model is about a doctor who uses her knowledge to make treatment decisions for the patient taking the patient’s point of view. But the model does not specify the quality of that knowledge. The difference is that in the latter, the physician does not have to disclose to the patient the information that she is using. This creates another challenge for the contract between the principal and the agent—how to make sure that the physician is using the best available information. Shopping for a second opinion was suggested as a way to force doctors to become a better agents (Rochaix, 1989). Unfortunately, the phenomenon of searching for information by shopping for multiple opinions is more complex than described by Rochaix and there is not always a positive value to obtaining a second opinion (Mehrez et al., 1995).

**DISCUSSION**

In this paper we have dealt primarily with the practical question of whether it is easier to transfer information to patients, or to transfer patients’ preferences to physicians in a context of a physician–patient encounter when the goal is to arrive at a treatment decision which is based on the physician’s knowledge and the patient’s preferences. Our conclusion is that transferring information to the patient is easier (but not easy) and, hence, more feasible than transferring each patient’s preferences to the physician in each medical encounter. This is because the “technology” to measure patients’ preferences without making strong assumptions is much less developed (and many will argue does not exist) than the “technology” to transfer complex medical information to patients. Thus, transferring information to patients is likely to result in an outcome which is closer to the ideal—a choice based on the knowledge of the physician and the patient’s preferences. It also has an added psychological advantage to the patient in that it is the patient who declares the treatment choice rather than the physician.

Both models fall under the rubric of agency model. An important distinction between the two models is in the nature of the contract to be designed. In the case of the perfect agent model the challenge is to create a contract that motivates physicians to find out their patients’ true utility function. In the case of the informed decision-making approach the challenge is to create a contract that motivates physicians to provide information to their patients. Again, we feel that because better technology exists to transfer medical information, and time costs are involved in both tasks (i.e., transferring preferences or information) that it is more feasible to design contracts to motivate physicians to transfer information than to learn what are their patients’ preferences. As a matter of fact, in many countries physicians are already required by law to disclose all medical information and treatment options in an unbiased way to their patients.

In this paper we dealt with the case of treatment decision-making that involves only one doctor and one patient. Treatment decision-making, however, frequently involves more than one “patient” and one physician in a single and/or sequential medical encounter(s). For example, research on physician and elderly patient medical encounters increasingly focuses on triad rather than dyad relationships in recognitions that many elderly patients bring a relative or friend to the physician’s office (Rosow, 1981; Coe and Prendergast, 1987; Adelman et al., 1987; Haug and Ory, 1987; Beisecker, 1988; Haug, 1994). Also, in many cases, several physicians participate in the process of decision-making. A breast cancer patient, for example, may have a family physician, a surgeon, a radiation oncologist and a medical oncologist, all of whom may have specific treatment preferences for the patient (Charles et al., 1997). In these situations, the physician as a perfect agent model encounters other problems: it is not clear who is the agent (i.e., which physician) and whose preferences should be represented and how. The practice of informed treatment decision-making in this context also becomes more complex to implement because it requires, for example, much more co-ordination of activities.

While both the informed decision-making approach and the physician as a perfect agent approach represent two normative models of decision-making, patients’ actual preferences for the role they want to play in the decision-making process are neither uniform nor stable. A fairly exten-
sive body of research, much of it in the cancer area, suggests that while most patients have high preferences for information about their disease, treatment alternatives and prognosis, their preferences for participation in the treatment decision-making process are more variably distributed (e.g., Cassileth et al., 1980; Blanchard et al., 1988; Beisecker, 1988; Sutherland et al., 1989; Ende et al., 1989; Beisecker and Beisecker, 1990; Degner and Sloan, 1992; Deber, 1994). With respect to physicians’ preferences for a treatment decision-making model, very little research has been undertaken (i.e., we were unable to locate only one Italian study [Liberati et al., 1990]). However, this is an important component because physician support is necessary to enable any of these models to occur in practice (Dranove and White, 1987; Ong et al., 1995; Charles et al., 1997).

What is clear from this empirical evidence is that limiting the conceptualization of physician–patient to any one model of decision-making (e.g., the physician as perfect agent for the patient) does not reflect the current realities of clinical practice in many (if not most) cases. The question is where do we go from here? For those who support (from a normative perspective) the goal of choosing treatment options based on the physician’s technical knowledge and the patient’s preferences for outcome, we have argued that the informed treatment decision-making approach is a more practical and, thus, preferable alternative to the physician as perfect-agent model. However, for those who believe that “[A]s a profession we do ourselves a disfavour by clinging to a model that is based on how we want consumers to behave, rather than on what they really do” (Rice, 1993, p. 211) it is clear that more work is required to be able to develop models which better reflect the current realities of clinical practice.

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