

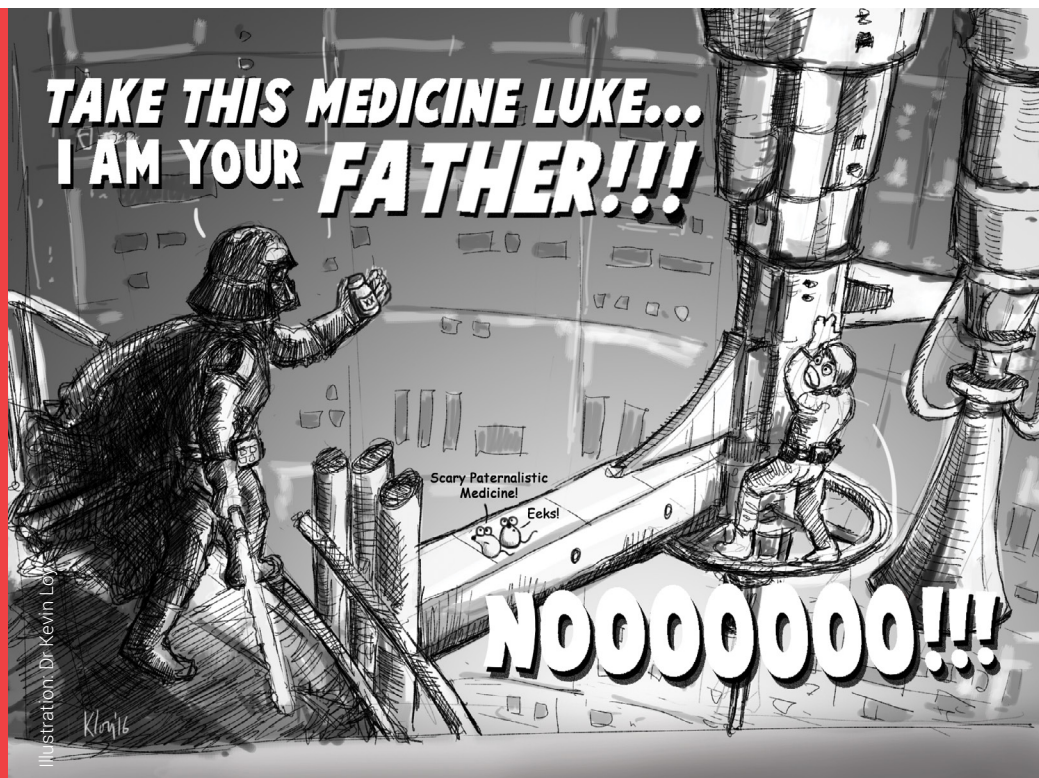
PROFILE



TEXT BY

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INFORMED CONSENT (PART 2) —

SHARED DECISION-MAKING

Informed consent is about helping patients make the right choices for their medical treatment.

The Singapore Medical Council's Ethical Code and Ethical Guidelines exhorts doctors to ensure that their patients are adequately informed and are able to participate in the decision-making process.

"It is a doctor's responsibility to ensure that a patient under his care is adequately informed about his medical condition and options for treatment

so that he is able to participate in decisions about his treatment. If a procedure needs to be performed, the patient shall be made aware of the benefits, risks and possible complications of the procedure and any alternatives available to him."

I wrote about the problem of having too much choice in the November 2015 issue of *SMA News* (<https://goo.gl/5LLNL2>). In the modern era of advancing technology, the treatment options for any medical condition are innumerable and can be bewildering.

Patients not only receive information from doctors, but from many different sources as well, including both print and social media, and the Internet. How does a doctor ensure that a patient is able to comprehend all "the benefits, risks and possible complications of a procedure and any alternatives available"?

In this issue of *SMA news*, we have a timely article by Ms Mak Wei Munn and Ms Jasmine Tham (see page 18) on the legal aspects of informed consent, including some recent developments in Singapore.

Informed consent is where the patient makes the choice or agrees to undergo treatment without coercion. The role of the doctor is to provide information and to educate the patient, while patients need to actively participate in the process in an open manner. Getting the context right is important and the doctor must take into account the patient's social, occupational and family circumstances. This means that the process of informed consent is one that is **individualised**. Different patients have varying threshold for risk and would respond to their options for medical intervention accordingly.

From a legal perspective, what was deemed acceptable practice in informed consent is now shifting. The previous gold standard that “as long as it was acceptable by a body of doctors” (Bolam), has now shifted to one that makes it imperative to take into account individual, patient-centric preferences (Montgomery).

SHARED DECISION-MAKING

Atul Gawande's book *Being Mortal: Medicine and What Matters in the End* has been making its rounds in the medical community's list of must-reads recently. Gawande is a surgeon working in Boston and he wrote about the harsh realities of ageing and confronting mortality, the harm of over-medicalisation, the depersonalisation of institutional confinement and the hard conversations with one's loved ones in order to understand what their true wishes were at the end of their lives.

The book also carries an insightful discussion on shared decision-making where the author wrote about the challenges his family faced after his father was diagnosed with cancer. Even though both he and his parents were doctors, they found it difficult to follow the discussion with his father's oncologist. They were presented with all the data by the expert and were asked to make a choice, but there were simply too many options and each had its set of risks and benefits to consider. He lamented that the conversation never got to what his father really cared about, which was to maintain a life that was still worthwhile.

This tendency of doctors to do more was perhaps unsurprising. In Gawande's opinion, “the only mistake clinicians seem to fear is doing too little” but they don't realise that doing too much could be devastating as well. There is clearly a need for doctors to have a deeper understanding of what their patient's goals are, and to be able to work out the best course of action together with the patient.

GUARDIAN, TECHNICIAN, COUNSELLOR, FRIEND

Gawande referred to the work of medical ethicists, Ezekiel and Linda Emanuel, who proposed four models of the doctor-patient relationship.¹ They described these models as paternalistic, informative, interpretive and deliberative, echoing the earlier classic works of Eric Berne's transactional analysis model describing the parent, adult and child ego states.

The paternalistic model of care is the traditional model with the doctor as the guardian of medical knowledge and whose authority cannot be challenged, as he knows what is best for the patient and therefore makes the critical decisions. The doctor has the obligation to place the patient's best interest above his own, and the patient has to trust and even be thankful for the decisions made on his behalf.

The informative model of care is one where the doctor is a technical expert who provides the facts, data and options, but leaves the final decision to the patient. This shift to the other extreme reflects the rising trend of a consumerist culture where patients are deemed as clients and doctors as providers. Patients are given the information, the freedom and the control.

The interpretive model of care is one where the doctor acts as a counsellor to guide the patient in their medical journey and help the patient determine what is in their best interest based on their individual values. The patient may be confused and conflicted at first and it is up to the doctor to assist the patient in realising his or her own goals, leading to self-understanding. The choice of treatment is aimed at realising these values.

The fourth model is the deliberative model of care where the doctor acts as a friend, not only to provide information and guide the patient, but also to educate and provide his or her own insights and values during the decision-making process. Not only does the doctor indicate what the patient *could* do, the doctor advises what the patient *should* do, based on his intimate

knowledge of the patient's values. These four models operate in the doctors' daily interaction with their patients and may be used for different patients in different settings, based on the situation. However, medical paternalism is roundly criticised and best avoided, as it does not support the notion of patient autonomy and self-determination in medical ethics. It is easy for patients to blame doctors when something goes wrong, especially when they were not consulted prior to a procedure.

The informative model can be employed for straightforward uncomplicated consultations where the patient has maximum choice and is knowledgeable enough to make decisions about their own care. The interpretive and deliberative models apply when the subject matter is more complex, with treatment results that may be unpredictable. Patients may feel confused and conflicted, and may appear vague and unable to express their goals during the consultation process. When this occurs, the doctor needs to spend time to elicit the patient's ideas, concerns and expectations, and then guide the patient towards a decision best suited for his individual circumstance.

This process of open discussion and understanding, with the exchange of ideas and values where both parties contribute and collaborate, is the process of shared decision-making. ♦

SUMMARY

- Informed consent is not about asking the patient to sign a form. It is a process.
- Informed consent is not about explaining every option. It is individualised and contextualised.
- Informed consent is about getting to know the patient.
- Informed consent is shared decision-making

References

1. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. *Jama* 1992; 267(16):2221-6.