4 Patient Consent: Issues in the Legal Regulation of a Client-Professional Relationship

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PATIENT CONSENT: ISSUES IN THE LEGAL REGULATION OF A CLIENT-PROFESSIONAL RELATIONSHIP

Role relationships in modern societies tend towards increasing formalization, as noted in many of the classic works in sociology. Formalization is characterized by replacing social bonds based on personal attachment and diffuse obligations with impersonal, contractual ones based upon specific rights and obligations. Role performances, furthermore, are to be accountable to certain technical standards (Durkheim, 1964; Parsons, 1939; Simmel, 1950: 317-29; Weber, 1958: 196-244). Recent changes in the legal status of patient rights within physician-patient interchanges are a further manifestation of this tendency towards formalization and rationalization in modern societies (Betz and O'Connell, 1983; Matek, 1977).

Structural changes in the medical context have left patients open to various forms of exploitation and neglect. This situation provides the background for the development of legally mandated patient consent procedures as a step towards greater formalization of the doctor-patient relation. The paper addresses the limitations of law to transform the nature of the social transactions between doctors and patients. This paper shows that implementation of legally prescribed procedures is mediated by the cognitive understandings of actors and the social conditions within which encounters take place. The paper concludes with suggestions for alternative approaches to protecting the interests of patients.

In 1983 a new law was signed in the State of Hawaii to require all physicians treating breast cancer patients to present a standardized patient education form about alternative treatments. Following its passage, the author explored the possibility of undertaking research on the effects of this law. The research proved infeasible, but informal interviews were conducted with physicians with major responsibility for treating patients with breast cancer in four of the major medical centers in Honolulu, including two surgeons, one oncologist and one nuclear radiologist. This paper is based on material from these interviews along with experiences of the author as a member of the research committee of one of the medical centers in Honolulu.

TRANSFORMATION OF DOCTOR-PATIENT RELATIONSHIPS

The analysis of patient consent must begin with an understanding of the nature of the traditional professional relationship between doctors and patients and the factors which have impacted doctor-patient encounters in the last several decades.

The Professional Model

The traditional doctor-patient relationship was characterized by Parsons as one of paternalism, where the patient assumes a role analogous to that of a dependent child (Parsons, 1951: 428-79). The concept of the sick role developed by Parsons further emphasized the passive-dependency of the patient, including the obligation to cooperate with medical treatment. Doctor-patient transactions are presumed to take place in a framework of patient confidence in the expertise of physician decision-making and trust that the physician will attend to the well-being of the patient.

The professional model, most thoroughly presented by Freidson (1970b), further elaborated the basis for patient trust in the physician. Medicine is granted the status of profession because physicians have mastered an esoteric body of knowledge which underlies their right to autonomy in medical decision-making. The profession, furthermore, is guided by a service ethic and a conception of "medical responsibility" for the well-being of the patient. The profession is also responsible for monitoring the actions of its members.

Doctors and Patients in the Medical Marketplace

Whether or not patients were ever as trusting or physicians as disinterested as these formulations suggest, the context of medical practice has undergone radical transformations in recent decades which have seriously undermined such a simplistic model. These developments have been detailed by other social scientists (e.g. Starr, 1982). Only a brief overview will be given here.

First, the bureaucratization of the medical context has reduced the quality of doctor-patient encounters. Physicians increasingly practice in groups settings; patient contacts have been shortened in order to manage large case loads; and relationships have become fragmentary and transitory as patients are referred to specialists for specific problems. Despite the technical advantages of group medicine, physicians rarely know much about their patients apart from their specific medical complaints, and patients are skeptical that physicians understand their problems or care about them (Mechanic, 1976a; 1976b).

Second, patients have become commodities in a medical-industrial complex consisting of large medical centers, staffed by teams of specialists and supplied by medical equipment and pharmaceutical interests. These entities have vested interests in promoting particular kinds of treatments. Health is assumed to be an entity which can be sold and purchased, and patients themselves have exchange value as economic commodities in the health care market (Carlson, 1975; Illich, 1976). Medical decisions are not purely neutral, technical means to assure patient well-being. They also entail benefits which accrue to members of this industrial-medical complex. Medicine is big business (McKinlay, 1977; Waitzkin, 1974).

Third, physicians are becoming "proletarianized," as they cease to own the means of their productive activity. Physicians are increasingly employed by or at least under the control of third-parties. The dangers of third-party medicine as a threat to the professional autonomy of physicians has long been recognized (Field, 1961; Mechanic, 1976a). During the past decade, the concern with cost-containment has resulted in an explosion of health maintenance organizations, preferred-provider contracts, cost-ceilings on hospitals, quotas on medical testing and prescriptions, and other forms of medical rationing. Changes in the reimbursement practices, especially institution of payment schedules based on the use of Diagnostic Related Groups, also impact on medical practice. Medical decisions are not based solely on medical science and concern for the well-being of patients, but increasingly the financial self-interests of the organizations for which physicians work or insurance programs which pay their fees (Mechanic, 1985).

The Problematic Consequences of Medical Technology

In addition to changes in the organization and political economy of medical practice, a final set of changes within the technical sphere of medical practice must also be acknowledged as critical to the emergence of patient consent procedures. These changes regard the special consequences of new developments in medical technology.

Expanding medical technology confronts physicians with more problematic decisions. The normal mode of medical decision-making is one of diagnostic classification, based on the presenting complaints and physical examination of the patient, followed by the "normal course of treatment," suggested by the prevailing medical understanding of the diagnosed condition. Medical technology, however, has complicated such decisions by increasing the available diagnostic measures and treatment modes, thus making possible alternative courses of action. Many of these measures, however, have uncertain outcomes with risks of significant negative side-effects (Thomas, 1977).

An additional problem stems from the trade-off between medical outcomes and non-medical values. For example, in some cases medical technology permits the extension of life under conditions which severely limit the quality of life. What may be an acceptable outcome in purely medical terms, may be unacceptable to the patient. While medical science may enable physicians to make purely medical judgments based on scientific criteria, medical expertise is insufficient as a basis to determine the appropriateness or desirability of treatments as they affect non-medical, quality of life outcomes for their patients (Wulff, 1981; Shingleton and Shingleton, 1980; Shain, 1980).

THE DEVELOPMENT OF PATIENT CONSENT AS A LEGAL RIGHT

The changes in the organization and practice of medicine reviewed above make it clear that it is simplistic to assume that medical decision-making is a purely technical matter, where a physician, whose interest is the well-being of the patient, undertakes a scientifically-based intervention. In addition to the fact that evidence may be ambiguous regarding the most effective treatment, the decision must take into account competing values. Physicians furthermore are subject to external pressures by third parties, and they have vested interests in undertaking particular treatments in terms of the possibilities for obtaining financial, research, career development and other goals.

While the general public may not understand the details of these developments, there is a general recognition that doctor-patient relationships have changed. Physicians are often suspected of subordinating interest in the well-being of the patient to their financial and professional goals. The explosion of malpractice suits and the emergence of a consumers movement aimed at reassuring patients their rights in medical transactions can be seen as a consequence of this distrust and the breakdown of the traditional emotional ties between doctors and patients (Mechanic, 1976b; Betz and O'Connell, 1983).

One means by which physicians are able to make decisions in their own interests, is through the control of information. Not only do patients lack medical knowledge by which to evaluate alternative modes of treatment, but they are often deliberately kept ignorant regarding their own conditions and prognosis (Davis, 1966; Waitzkin and Stoeckle, 1976; Fisher, 1984).

During the past two decades, the rights of patients to information and to participation in medical decision-making affecting their well-being has been established through a large number of court decisions as well as through new laws enacted through legislation.

These rights are most conspicuously embodied in patient consent procedures, which include informing the patient about the nature of the treatment, possible side-effects, the risk of these side-effects, and the availability of alternative treatments. Patient consent is usually implemented through a doctor-patient transaction, during which the physician obtains the signature of the patient on a patient consent document. In cases where the patient is a child or is physically or mentally incapable of making decisions, a family member or other person may represent the patient.

Litigation has continued as courts have faced the task of clarifying the meaning of what constitutes acceptable patient consent. Some courts have ruled that merely obtaining a patient's signature does not fulfill the requirement unless the patient has a "reasonable" understanding and that "significant" risks and other facts "material" to the decision-making are disclosed (Edelman and Edelman, 1977).

Legal Developments in Hawaii

In the face of the growing number of court judgments extending the legal rights of patients and the crisis created by the escalating cost of malpractice insurance, state legislatures have enacted additional laws to tighten patient consent procedures. The State of Hawaii passed a general law in 1976 requiring the Board of Medical Examiners to establish reasonable standards of disclosure of information to patients and to require the written consent of patients for medical procedures (Hawaii, 1976). Similar laws now exist in most other states.

Special attention has been given to the treatment of breast cancer. Breast cancer is one of the most significant life-threatening risks for women. Treatment decisions are problematic due to a proliferation of alternative treatments, including the surgical procedures of medical mastectomy, simple mastectomy, and lumpectomy, and these may be combined with radiation therapy and various forms of chemotherapy. In some cases there is also a decision to prophylactically remove the other breast and/or perform a hysterectomy. There are continuing ambiguities over appropriate criteria and the relative risks of available alternatives, including risk to life, residual disability, and emotional trauma due to perceived aesthetic and sexual implications of treatment (Shain, 1980; Moetzinger and Dauber, 1982).

In 1983, the State of Hawaii passed a new law specifically addressing the decision-making for breast cancer based on a similar law passed the previous year in California (California State Department of Health, 1983; Hawaii, 1983). The Medical Board of Examiners was instructed to develop a standard form to be employed by physicians which would provide patients with information

regarding the alternative treatments available for breast cancer, along with descriptions of the possible consequences and risks associated with each treatment.

The new law is intended to increase the patient's role in the decision-making process. It goes beyond the more general requirement for patient consent in that it standardizes what information the patient is given and how it is provided. Thus this law formalizes the encounter between doctor and patient and attempts to establish patient control of decisions as a contract for specific medical services. From this perspective, doctor-patient transactions are placed within the context of a larger body of legal opinion concerning consumer rights. A patient is a responsible agent and a contractor for medical services and therefore has a right to decisions about those services.

LIMITATIONS IN IMPLEMENTING PATIENT CONSENT

Patient consent requirements have the potential to shift significantly the power of medical decision-making from the physician to the patient. However, the usual implementation of patient consent is designed as a formality which does not alter traditional doctor-patient roles. Despite legally mandated consent procedures, physicians have consistently resisted increasing patient participation in medical decision-making, and few patients exercise their rights to such participation (McIntosh; 1974; Haug and Levin, 1981; Faden, et al., 1981; Laforet, 1976; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1982).

The remainder of this paper is devoted to understanding the limitations of legal efforts to actually increase patient control. These remarks are based on the author's interviews with several physicians with major responsibility for the treatment of breast cancer as well as observations as a member of the Research Committee of a major medical center. The limited success in changing doctor-patient transactions rests on 1) the professional understanding of medical responsibility shared by physicians and 2) the conditions of the doctor-patient encounter.

The Physician Conception of Medical Responsibility

Physicians perceive a dilemma between the emerging legal rights of patients and what they regard as the legal and moral responsibility they have as physicians for the well-being of their patients (Laforet, 1976; Edelman and Edelman, 1977). There are three components to this concern: physician control; medical criteria for success, and avoidance of patient harm.

Physician control. First, and most fundamentally, physicians are legally responsible for appropriate medical decisions which affect their patients. Patients lacking in expertise and clinical experience presumably are incapable of making good judgments about the efficacy of medical treatments (Laforet, 1976; Aring, 1974).

To illustrate, the new law in Hawaii expands the information patients receive about alternative treatments for breast cancer. One physician feared that the effect of the new law would be to tempt patients, based on wishful thinking, to insist on the least drastic mode of treatment. In some cases, this alternative could prove to be inadequate and result in death. He rhetorically asked, who was responsible for making the correct decision? Wouldn't the patient or the patient's family subsequently blame the physician? Thus physicians perceive themselves as legally and morally accountable for medical decisions. Deferring to the judgement of patients would place them in a potentially vulnerable position.

At the same time it should be noted that this physician, along with the others interviewed, favored educating patients about the nature of the medical treatment they were to receive and the reasons why that treatment was appropriate. These physicians provide information as a step to building the patient's trust and confidence in the treatment and achieving greater patient satisfaction with the outcome. Their discomfort was based on any attempt to dilute their exclusive responsibility for the medical decision itself.

Thus patient consent in the minds of physicians embodies two separable issues: 1) *patient education* or informed consent, requiring that physicians provide patient with reasonable information about medical procedures, and 2) *patient control*, giving the patient control over medical decision-making. Patient consent procedures accomplishing the first of these purposes were believed to enhance clinical effectiveness. Giving the patient control, however, was perceived as inconsistent with their medical responsibility and was the principal source of opposition to the extension of patient rights.

Medical criteria for success. A second problem regards the criteria for medical judgments. Traditional medical ethics are based on the principle of beneficence -- doing whatever promotes well-being and not doing harm (Shingleton and Shingleton, 1980). Physicians understand their responsibility to do whatever is medically possible to prolong life.

Patient consent procedures threaten to compromise this criterion of medical responsibility to the extent that patients emphasize values other than longevity. Thus a medically responsible decision cannot accommodate the case

of a woman who out of concern for appearance should refuse a mastectomy. Physicians are troubled by the increasing dilemma posed by patient objections to the possibility of prolonging life through new technology but at highly reduced human capacities and quality of life.

New models of decision analysis have been proposed for situations offering alternative treatment modalities which would incorporate the values of patients (Eraker and Politser, 1982). However formal decision analysis as a replacement for professional clinical judgement has been resisted by physicians (Schwartz, 1979; Brett, 1981). The logic-in-use in clinical situations continues to be predicated on a view of medical decisions as objective and scientific rather than incorporating patient values.

The author observed many instances of this problem in the deliberations of a hospital research committee. Experimental cancer treatments, for example, typically rely upon highly toxic drug regimens which carry high risk of permanent organ damage and high levels of discomfort and disfigurement for the patient. At best, the life of the patient may be extended a few weeks or months, but at great sacrifice of quality, and possibly also at great financial expense to the family. While members of the committee were aware of the problematic aspects of such treatments, they seldom raised them in the context of evaluating specific research proposals. Discussion was usually confined to the specific medical procedures, possible effects on the tumor, soundness of research methodology, completion of forms, and possible liability for the hospital.

On one occasion, a chemotherapy program was described for a specific cancer which had particularly severe side-effects, including nausea and permanent liver and kidney damage. The patients eligible for this program in fact had advanced forms of their disease, which meant that their survival was unlikely in any event. When asked by the author whether such patients might be better off without such a treatment, the physician proposing the program responded, "Other treatments have already failed with these patients. This represents one more treatment which we can try."

The response of this physician is indicative of what Scheff (1963) has described as the operating decision-rule in medicine: when in doubt treat. It is the duty of the physician to treat so long as a treatment is available. Physicians believe they should not destroy the hope of the patient and the patient's family. Indeed, patients and family members, initially and without much reflection, typically express the desire that every measure be taken. Nevertheless, increasing information about alternatives and giving patient's more control over decisions would likely undermine the sole concern with medical outcomes since,

upon greater reflection, patients are likely to consider outcomes in the light of other values.

Avoiding patient harm. Third, legally-mandated informed consent procedures are viewed as contrary to the physician's medical responsibility to avoid harm. Several physicians noted that complete disclosure of the possible negative side-effects of treatments, even if these are low risk possibilities, may heighten the patient's anxiety and may be therefore detrimental to the well-being of some patients. A complete disclosure of information may result in unnecessary psychological distress, a refusal to undergo needed procedures, and even suicide.

Indeed, studies have found that there are important differences among patients in their desire for and reaction to information (McIntosh, 1974; Shain, 1980). Some patients experience confidence and a greater sense of control by knowing the details of their disease and the nature of treatment procedures. Other patients, however, respond negatively to such information and prefer simple comfort and reassurance from the physician. These patients place their trust in the doctor's medical judgement. Legally mandating consent procedures undermines the clinical judgement of the physician regarding how to approach patients who differ radically in their desire for information and ability to cope with the complexities and ambiguities of medical decisions.

Several of the physicians interviewed about the new consent procedures for breast cancer patients noted that even many well-educated women had asked them to omit the details and simply "do what you feel needs to be done." Discussing their disease and the nature of medical procedures was highly distressing for these patients and from their perspective unnecessary, since they trusted the physician to make the best judgement.

Aside from increasing patient anxiety, physicians believe that the new requirements to provide detailed information about alternative treatments, have the potential to undermine patient confidence in physicians and thereby threaten good medical care and patient well-being. The fact of legal regulation itself implies that somehow physicians cannot be trusted to make decisions which are in the best welfare of their patients. Furthermore, forcing patients to participate in medical decision-making risks undermining the belief in physician competence and the efficacy of treatment. While medical decisions often entail a degree of uncertainty, physicians believe that the patient is better off maintaining trust that the doctor is in fact doing what is medically most appropriate in the situation (Aring, 1974; Laforet, 1976).

The Doctor-Patient Encounter

The above discussion shows that physicians have serious reservations about patient consent procedures which threaten their medical authority. However, the conditions of the doctor-patient encounter have greatly limited the impact of legal efforts to establish the rights of patients and increase their control over decisions. The structure of doctor-patient transactions is such that physicians are able to effectively constrain the level of patient participation in decision-making.

Physician control of the clinical encounter. Physicians control medical encounters with patients through verbal and non-verbal conditions in the situation. One obvious set of factors involves the high level of expertise of the physician relative to the patient and the esoteric nature of the medical language which disadvantages the patient from meaningful participation. In addition, the physician controls many other features of the situation, such as the imposition of time constraints on the interaction and the general syntax of doctor-patient discourse. Physicians exercise control over initiating the various phases of the encounter, turn-taking, and interactional opportunities for the patients. As a consequence patients have highly constrained opportunities for contributing information and for raising questions (Drass, 1982; Fisher, 1984).

The typical manner of presenting the patient consent form forecloses patient control over decisions. Despite the requirement that consent forms be comprehensible, they are often 4 to 6 pages long and contain highly technical descriptions of procedures and their possible consequences. Patients are given little chance to examine the details, besides which they are highly anxious and not in the frame of mind to carefully weigh the alternatives. The forms indicate the general availability of other treatments but provide no details about alternatives or specifics about the actual differences among them. The option of obtaining no further treatment is virtually never seriously presented to patients. Physicians usually present their intended treatment before presenting the consent form to patients; and indeed, sometimes the patients are already hospitalized before being asked to sign the consent form (Presidents Commission, 1982).

Thus, patient consent procedures are typically presented so as to carry out the requirement of informing the patient, while denying the patient an opportunity for making meaningful choices. The procedure minimizes patient questions and input, precluding serious patient consideration of alternatives, and thereby preserves the effective control of physicians over treatment decisions.

Patient background expectations. Physician dominance in the clinical context also rests upon the general frame of such encounters. As reviewed

earlier, the traditional doctor-patient relationship is based on a model of paternalism, analogous to the emotional dependency which a child experiences in relation to a parent, who is caring, knowledgeable, and in charge.

New models of the doctor-patient relationship have been proposed as more appropriate. Freidson (1970a) has suggested a conflict-negotiation model, based on the assumption that physicians and patients in some measure always have different interests at stake in the medical encounter. Health care reformers have suggested a collaborative model, especially for the management of chronic illnesses, where the physician and patient develop a joint strategy for managing disease (Szaz and Hollender, 1956; Shain, 1980).

The courts have adopted the role of consumer advocate to view patients as engaging in a contractual relationship with physicians where a potential conflict of interest exists between buyers and sellers (Betz and O'Connell, 1983; Reeder, 1972). This consumer model, however, rests on the assumptions that health is a commodity which can be sold in a market and health care consists of atomistic units provided by a seller of services. Such a mechanistic view of healing is fallacious and ignores the significance of the intrinsic emotional quality of the doctor-patient relationship (Aring, 1974; Carlson, 1975; Illich, 1976).

Research shows that the typical clinical situation remains closest to the traditional paternalistic model. Most patients enter the medical context highly anxious and desiring reassurance and comfort. They also hold background expectations that physicians have the exclusive expertise to make medical judgments and that a patient has a duty to passively cooperate. Patients expect the physician to make decisions, and they refrain from asking questions or challenging judgments. Only a small proportion of patients, typically those who are better educated, younger, and those with certain chronic conditions, actively question physicians and expect to participate in medical decisions (Haug and Lavin, 1981; Fisher, 1984; Lorber 1975) Furthermore, the emotional quality of the doctor-patient relationship is the principal basis on which patients evaluate their care (Ben-Sira, 1980).

In Honolulu, efforts to increase patient control in the medical context is likely to be especially difficult. Non-Haole ethnic groups generally have a traditional respect for authority figures and a desire to avoid face-to-face confrontations (Robillard, et al., 1983; Howard,1974). It may also be the case that non-Haole physicians perceive patients who ask questions and actively seek information to be aggressive. A more democratic and participatory model of doctor-patient encounters imposed by legal mandate is likely to fail in a context which violates cultural orientations deeply held by both patients and physicians.

DISCUSSION AND CONCLUSION

Formal patient consent procedures are now routinely implemented in medical settings. Physicians embrace patient consent procedures in so far as providing information to patients increases their trust in the physician. However, steps to increase patient participation in decision-making are perceived as threatening the medical responsibility of the physician and are vigorously opposed by the medical profession.

In fact, the widespread acceptance of patient consent procedures does not rest on an extension of *patient control* but on a rationale of *physician legitimation* (Betz and O'Connell, 1983). Medical malpractice suits and malpractice insurance constitute major costs to medical institutions and individual physicians. Patients are less likely to be able to mount credible malpractice suits if there is documentation that the patient was informed of the possible risks attending medical treatment and yet provided consent. Thus obtaining consent constitutes an act of patient submission to the authority and medical care of the physician.

In contrast, recent court decisions and legislation have attempted to formalize and extend patient rights. Legal requirements for patient consent have been intended to increase the control of patients as consumers over medical decisions which affect their lives. They constitute an extension of the general tendency towards greater formalization of social relationships in modern societies by rationalizing medical encounters into a contract between physicians and patients.

These developments are a reaction to recent changes in medical care which have undermined traditional social bonds based on diffuse obligations. The bureaucratization of medical contexts, the commodification of health care and patients, and the "proletarianization" of physicians have introduced many considerations into medical decision-making apart from the well-being of the patient. Developments in medical technology, furthermore, call into question the assumption that medical decisions are solely a matter of expertise and scientific neutrality. Alternative modes of treatment exist for many conditions, each associated with certain risks and drawbacks, and successful medical outcomes may have unacceptable results from the standpoint of non-medical values held by the patient.

Nevertheless, the evidence seems clear that legal efforts to increase patient control of medical decisions have had little actual effect on physician-patient transactions. Physicians are indoctrinated to assume the legal and moral responsibility to make the best medical decisions on behalf of their patients. In

addition, the clinical situation preserves the dominance of the physician. Due to their esoteric knowledge, physicians are able to control their transactions with patients and believe it is proper for them to do so in order that the most appropriate decisions be made. Their advantage in controlling the situation enables physicians to implement consent procedures in a manner consistent with their own interests and perspective.

The attempt to rationalize doctor-patient transactions, however, has also failed for a more fundamental reason. Doctor-patient relationships do not conform to an impersonal contractual relationship, where the consumer is in charge. Patients enter medical encounters in a state of high anxiety, seeking relief from someone whom they believe has special expertise and capabilities. While individual patients differ in their circumstances, desires and expectations, many feel a deep emotional dependency on their physician. Healing is not a mechanistic exercise, but entails important processes embedded in the relationship between healers and sufferers (Frank, 1961). Thus, legal requirements based on a contractual, consumer model of client-professional relationships, try to formalize and standardize what is inherently highly personal.

Viable Approaches to Protecting the Patient

This paper has presented a skeptical view of the ability for legal measures requiring informed consent to regulate doctor-patient encounters in a manner acceptable to the perspectives of physicians or suitable to the needs of patients. Nevertheless, the intention has not been to suggest patients should not have a more active role in decisions which affect them. Indeed, the conditions of modern medical practice offer great risk to biasing medical decisions against the well-being of patients.

As an alternative to patient consent procedures, efforts to more directly change the structure of doctor-patient encounters may offer more promise in protecting the rights of patients to quality care and to a voice in the decisions which affect them.

Two well-known procedures provide some control over the quality of medical care. First, second opinions should be required from disinterested medical professionals prior to invasive medical procedures. Second, a fair amount of experience suggests that monitoring the quality of care by external bodies through the review of medical records, prescription records, lab samples, and so forth, does affect medical decision-making in favor of better patient care.

Two less widely implemented procedures have the potential to increase the participation of patients in decision-making by moving doctor-patient

transactions in the direction of greater collaboration. First, new nursing roles as patient educators and patient advocates can serve as a help to patients in formulating and articulating their values and concerns. Second, formal models of decision analysis can serve as a medium for physician-patient collaboration which would utilize both the medical expertise of the physician and the values and psychological concerns of the patients as input for making medical decisions.

Steps along these lines, may be more successful than patient consent procedures to build greater communication and trust between physicians and patients, because they do not try to impose an impersonal, contractual model of physician-patient relationships which is contrary to the desires of both physicians and patients.

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