Whose Life Is It Anyway?

ALTHOUGH THE article by Volk et al[1] in this issue of the ARCHIVES is based on a pilot study of only 10 men and their spouses, the general approach of this research is interesting and meritorious for application to family medicine. One future application may be to explore a fundamental health care question: "Whose life is it anyway?"

The fascinating differences the authors observed between the utilities that men, women, and couples, as well as physicians, assign to prostate cancer screening and subsequent decision options if screening reveals positive results not only suggest diversities in how individuals value different outcomes but also underscore a clinically common philosophical issue: "Whose life is it anyway?" Volk et al found, for instance, that wives would rather have their husbands live longer and experience such complications as incontinence and impotence that might result from therapy for prostate cancer than live shortened lives and not risk complications of treatment. And just as interesting was the observation that the value of the utilities that wives placed on these complications was significantly higher than utilities ascribed by 3 different physician-expert studies.

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When 2 partners gather to reach consensus on an issue, a certain degree of bargaining is expected. In medical decision making, we know little of the process of the inherent negotiations and what directs the final combined decision of a couple. We might suspect, for instance, that most of a couple's decisions might favor the dominant spouse's opinions. Knowing something about that process may be clinically useful.

When a physician needs to facilitate a health care decision process, what information is available that could be used to predict a couple's decision? Can health care decisions be predicted, although undoubtedly not perfectly so, from past decisions and their processes, from past health or life experiences, or from psychological or sociological characteristics? Around what issues or in what situations are the strong partner's opinions not likely to prevail? Are there, in fact, certain issues in which one spouse is more likely to acquiesce to the other's opinion regardless of past unrelated decisions?

Can decision outcomes be predicted by sex differences of each partner, especially when dealing with sex-related health care issues such as prostate, breast, ovarian, and uterine disorders? Are the outcomes of the couple's bargaining likely to depend on the potential severity of the outcomes of moderately symptomatic prostatic hypertrophy vs prostate carcinoma, for example? What factors other than the sex of each partner might influence the predictability of couples' decisions? Would these factors assist in predicting same-sex couple decisions? So many questions!

The central issue is whose life is it anyway? I would claim that this simple question is highly relevant to modern clinical practice and will become increasingly so as health care services become more rationed or restricted. Every physician has an obligation to assist a patient in making an informed decision when presented with several therapeutic options. The family physician has a special and complex obligation to consider the family's needs in making an informed decision. Volk et al reminds us of this obligation and its complexity. Especially for family physicians, the issue of agency becomes relevant in assisting couples to reach decisions. Is the physician the agent of the person's whose health is most directly to be influenced by a given decision? Whose utility is it that determines the person "most directly influenced"? When does the physician become an agent of the spouse or of other family members? Can the physician be an agent of degree—that is partly the agent of 1 partner, and partly that of the other?

How should the physician's assigned utility of a problem enter into the decision process? Certainly it does enter and often weights heavily in patient decision making. How common is it for a physicians to have been on the "wrong side" of the decision?

There are many approaches to understanding the process of making medical decisions. One topology lists 5 common strategies: distilled clinical judgment, the conservative approach, maximizing expected utilities, the "go for broke," and the significance approaches.[2] In addition, Reust and Mattingly[3] recently identified 3 roles of family involvement in medical decision making: supporting the patient, being affected by the decision, and advocating for autonomy. Marvel et al[4] remind us of the various levels that physicians may be involved with patients and their families, including physician-centered medical issues, collaborative information exchange, dealing with affect, brief psychosocial intervention, and more extensive individual or family therapy.

Consider the following scenario. A healthy, 65-year-old man independently from his spouse reaches a well-reasoned decision not to pursue screening for prostate cancer. He reaches this decision in large part because he has also researched, contemplated, and decided against any therapy should prostate cancer develop in him. Why screen for an illness if no therapy will be accepted? He has read the literature and carefully considered the pros and cons of therapy. He also has weighed many other factors in developing his opinion such as quality of life should he de-

velop the disease, his age, and financial status for his family should he become ill or die in the near future. He has reached a decision that he is most comfortable with and, believing in his "conservative approach," strongly does not want any therapy if prostate cancer should develop in him.

Now his spouse develops an opinion perhaps through a similar process of reading; discussion with friends, physicians, and others; and contemplation. Her analysis, perhaps or perhaps not tempered with consideration of additional factors such as the potential to be widowed or missing her mate, decides on the go-for-broke approach and values therapeutic trials as opposed to doing nothing if prostate cancer develops in her husband.

In a clinical situation in which the patient's wishes regarding prostate cancer treatment arise, the family physician himself has no clear "best option" using formal decision analysis, as Volk et al discuss, one that would "maximize the expected utility." This is because of a current controversy as to what is the best therapeutic option to recommend to a relatively young man with early prostate cancer. But the usual way physicians have made decisions is by distilled clinical judgment or global introspection. It is simply not clear, at this time, if a minimalistic wait-and-see approach, is as good or better than more aggressive surgical, pharmacological, or radiation therapies. Distilled clinical judgment is not a good strategy—utility analysis is better; but whose utilities should be factored into the decision? The family physician must decide how much of his own personal bias and interpretation of the data should influence the patient's decision. For this argument, we will assume that the family physician adopts a policy of going with the "family's decision" (ie, his utility decision will be similar to the couple's) and provides information only, not intending to have his own personal value or utility contribute to the decision process. (How likely is this scenario and what are the predictors of this interaction would be additional fascinating and important research.)

Now, what if the couple is interviewed together by the family physician. Well meaning, the family physician entertains the separate views of both partners. In his interest of bringing closure to the discussion, he asks the couple for a decision on the issue of future therapy. The husband acquiesces to his wife's opinion, but perhaps not because he values her opinion over his own, but perhaps because it is his pattern to avoid confrontation in the presence of a third party he respects, his family physician. The wife seems satisfied—her opinion prevails; the husband appears satisfied—anyway, he is the one who "gave in" or compromised; and the family physician is satisfied because he negotiated a settlement agreed on by all.

But what if the man only appeared satisfied and actually is quiet disgruntled by the process? He views the vote as 2 to 1, and he gave in to avoid further conflict until he reflects on the whose-life-is-it-anyway issue and decides it is his! On the way home from the physician's office, he discusses what has transpired. Obviously, if the observations of Volk et al are generalizable, his wife feels the answer to the whose-life-is-it-anyway issue is as much hers, maybe more, than his.

What will the physician think when he or she prescribes further therapy? What if in the future the family physician arranges prostate cancer therapy for this man without the full knowledge of what transpires in the couple's decision process? Could the physician become an accessory to battery should the patient undergo surgery that was not wanted or experience a poor outcome or significant disability? Would the family physician be morally absolved of any charges since one could argue that it is the patient's obligation to decline therapy not in his own best interest? But for the patient to determine his own best interest, does not that mean that he must have been offered the opportunity of informed consent? Was the patient's consent given under family duress, assisted by the family physician?

Perhaps you find the clinical scenario plausible, although somewhat strained. It is unlikely that the gentleman in this scenario would have brought legal action if he has a poor outcome, but are not the issues valid ones? Are not these issues a significant part of many of our daily medical decisions?

The article by Volk et al underscores the need for us to understand better the process and implications of decision making not only for us as physicians but our patients. Over the last decade, our ability to examine medical decision making has gradually increased, but it remains imperfect and far from complete. Considering the utility of decisions and their options has been helpful to us and our patients. While probability assignments (the significance approach),[5] utility discounting, and decision-tree analysis are useful techniques in understanding the process, they have not reduced the complexity of the decision process.

Family physicians have been among the first, as a specialty, to feel comfortable about the concept of patient-centered medicine. Slowly, the rest of American medical culture seems to be evolving in that direction to consider the individual in medical decisions.[6] For family physicians, the added complications to the decision-making process exist when we consider couples. Several orders of magnitude are added to the complexity of health care decisions when, in addition to the opinions of couples, the wishes and concerns of other family members become factored in. We all confront this most graphically at the gravely ill patient's bedside. Daddy is too weak or obtundent to give his own opinion. The family with the family physician gather to decide if and when to let daddy go. Whose life is it anyway?

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