The New Subjective Medicine: Understanding the Patient’s Worry Improves Shared Decision Making and Increases Compliance

Monica Ortendahl
Uppsala, Sweden

Physicians may not value different outcomes in the same way as patients. Therefore, a new more subjective medicine taking the patient’s point of view on health care and health should include cognitive as well as emotional components. Health was viewed as an objective biological fact in the past. However, it has increasingly been argued that patient values must be respected in health care decisions with an increased interest in the subjective health [1].

The task of the health provider is to consider the probability of obtaining certain health outcomes, and weigh the value of an outcome by the probability with which it will occur; this information forms a basis for decision making for both the patient and the provider.

Recent research into health [2] has focused upon values with perceptions of pros and cons of health. However, a broader view of health also mandates the inclusion of beliefs about health-related issues. The assessment of health beliefs may help providers to understand their patients’ treatment behavior and facilitate treatment engagement and compliance.

Beliefs about the likely outcome of different treatments might vary among doctors and patients. Incorporating patients’ beliefs about these outcomes into decisions is thus of importance. Health beliefs are sometimes related directly to perceived risk and sometimes to worry [3]. Perceived level of risk calls for a more intellectual judgment, and worry refers to emotional reactions. Experts often argue that when no or very small risks are involved, people are still worried and that a possible reason for this is lack of trust.

However, worry has not been focused upon to the same extent as level of risk.

Decision counseling may clarify personal preferences related to health behavior choices and thus facilitate achievement of the ideals of informed and shared decision making.

Examples of decision counseling on risks in the medical context, as described by Myers [4] and others, include cancer prevention and control where provider and patient identify personal values associated with decision alternatives. Another example is the treatment of rheumatoid arthritis, which implies a succession of single or multiple drugs with decision points when the next drug is chosen [5]. Therefore, risks and worry must be considered repeatedly. Rheumatoid arthritis gives different symptoms including pain and disability.

Should the worry about pain or disability, or both, constitute the basis for the process of the decision and the assessment of outcomes? What is the estimate of probability that one or both of the symptoms will decrease with the treatment chosen? How are pain and disability experienced subjectively by the patient? For the doctor disability is more apparent and objective, whereas the pain, which is subjectively experienced by the patient, might be more difficult to assess. Another example is the patient...
with a pain in the throat and fever who may also be worried and demand treatment with antibiotics. If tests show no bacterial infection, the patient only needs to be advised not to worry and to rest.

In our era of chronic illness with uncertainty and risk in treatment options, decision making by patient and physician is frequently influenced in a significant manner by the principles and practice of risk taking. These principles, and some of their contradictions, have been a neglected area of study. The modes of clinical reasoning described in many studies have frequently been found to be oversimplified [6]. No single model can be expected to describe decision processes because the effects of risk and worry probably vary with individuals and also with different contexts. Illness behaviors and worry related to illness may vary depending on social, cultural, demographic, psychological and economic factors. Another major variation is present in terms of whether the illness is acute or chronic, and whether it is life-threatening or not. Some major models of illness behavior and compliance, like the Health Belief Model, are based on the evaluation by the patient of the gain or loss implicit in certain actions (or lack of actions) pertaining to the illness situation [7]. A more diversified use and critical appraisal of these concepts in medicine becomes more important as we attempt to refine decision models.

To be effective, the clinician must gain an understanding of the patient’s perspective of his or her illness. Patient concerns can be wide-ranging, including fear of disability and pain.

This author considers it as especially valuable to continue the studies on medical decision making, both from the perspective of the doctor and the patient, with special reference to risk and worry. This has been a neglected area, and probably many of the problems of lack of compliance could be explained by the subjective experience of these two factors. The further incorporation of patient subjectivity should carry us well beyond informed consent.

References