

Discussing Treatment Options and Risks With Medical Patients Who Have Psychiatric Problems

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Discussing medical treatment options and risks becomes a more complicated task when patients have psychiatric problems. Such patients may perceive risk and judge options differently from usual, they may raise special issues about informed consent and competency, and they may present special needs and stresses in the physician-patient relationship. This article addresses how to approach such treatment discussions within the framework of 3 content areas of the medical interview (medical decision making, informed consent, and the physician-patient relationship) and 2 formal techniques of the interview (exploration and assertion). Clinical research regarding how psychiatric problems may affect each of these areas of concern is reviewed. Ultimately, the goal of understanding such variations—and of possessing methods to address them in discussing treatment options and risks—is to help the patient be as free as possible from the burden of biases or distortions in making his or her decisions and to promote the best fit between the patient's wishes and the physician's medical judgment.

She smiled again, raised her eyes to the doctor, and looked at him so sorrowfully, so intelligently; and it seemed to him that she trusted him, and that she wanted to speak frankly to him. . . . But she was silent, perhaps waiting for him to speak.

And he knew what to say to her. It was clear to him that she needed as quickly as possible to give up the five buildings and the million if she had it. . . .

But he did not know how to say it. How? One is shy of asking men under sentence what they have been sentenced for. . . .

"How is one to say it?" Korolyov wondered. "And is it necessary to speak?"

And he said what he meant in a roundabout way.

*"A Doctor's Visit" in The Short Stories of
Anton Chekhov*

Discussions between physician and patient about treatment are often complex and emotion-laden processes. They are

shaped by different social and personal concerns on the parts of the physician and patient, may show awkward efforts to understand the other's meaning and to communicate one's own, and exhibit the back-and-forth displays of power or compromise that typify any negotiation. Ideally, the outcome of this complex dialogue is a treatment plan reflective of the physician's medical judgment and the patient's wishes.

Such ideal agreements are difficult to reach in practice and are subject to many interferences. One of these is the possible distortion of a patient's thinking and emotions that may be caused by psychiatric problems. Although the extant literature offers suggestions about discussing risk with medical patients¹ and with psychiatric patients,² it offers little guidance about how to discuss treatment options and risks with medical patients who have psychiatric problems. This article aims to suggest approaches, based on the framework of the medical interview and on a review of relevant clinical research.

As background, 3 essential areas bear on the interview: scientific (medical de-

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Matrix of Elements in Discussion of Treatment Options and Risks

Exploration	Example	Assertion	Example
Medical Decision Making			
Assess decisional biases due to framing, risk aversion, wishful thinking, etc	"What makes you so sure that radiation will cure your cancer for good?"	Counterbalance, frame alternately, address denial or other distortions	"You don't want to even try chemotherapy. Does that mean you are giving up without any fight?"
Legal			
Evaluate competence: understanding of choices, quality of reasoning	"Are you really convinced that I'm prescribing tamoxifen because I want to experiment on you like a guinea pig?"	Inform and educate; help to obtain guardianship for surrogate decision making if needed	"I'm going to tell you the risks of angioplasty, then ask you some questions to see whether you have understood."
Physician-Patient Relationship			
Assess views about relationship with caregivers	"It sounds like you just want to hand all of your medical decisions over to me without even asking any questions. Why?"	Balance empathy with assertiveness in negotiating a treatment plan	"I understand that you like to try herbal medicines first. Could we get back together in 1 month to see how things are, and then do some standard tests if your fatigue still isn't better?"

cision making), legal (informed consent and competency), and interpersonal or emotional (the physician-patient relationship). As in all such dialogue, there is a dialectical shifting on the physician's part between forms of exploration (of the other's views) and assertion (of one's own). Therefore, the dialogue may be viewed as a matrix of 6 components, each one incorporating an element of content and an element of form. This is illustrated with examples in the **Table**.

With this framework in mind, we explore how the physician may adapt his or her interview technique to help correct for the distortion in decision making that may result from a patient's psychiatric problems. Ethically, to suggest that the physician should compensate for the patient's lapsed judgment may sound like a regression to medical paternalism. However, the goal is not to substitute for the patient's own decision; it is to help the patient to open himself or herself to the full range of medical and personal concerns, with a minimum of defensiveness or distortion. Furthermore, the process is not one-sided; equally important is the physician's internal processing of biases and distorted judgments that may result from personal anxieties, overly rigid adherence to medical

protocol, or a disdain for psychiatric patients.

Illustrative dialogue is used that is based on composites of actual cases but is changed to disguise the identities of patients and to highlight technical points.

PSYCHIATRIC PROBLEMS AND MEDICAL DECISION MAKING

Effect of Psychopathologic Conditions on Judgment

Normal judgment about uncertain risk or benefit differs in predictable ways from rational calculation. For example, the perception of risk is heightened by irrational fears, including those of unfamiliar technology, perceived dread and lack of control, and the prospect of hidden or delayed harm.³

Furthermore, the judgments of physicians and patients about probabilities (such as the likelihood that a given disease is present or that a particular treatment will be effective) are systematically affected by a set of psychological biases. These include the effect of recent experience (the availability bias),⁴ wishful thinking in the face of fears,⁵ and how choices are framed.⁶ If the probabilities are identical, people tend to avoid taking a risk when the chance

is framed as a potential loss, they tend to take the risk when the chance is framed as a potential gain, and they prefer a certain choice (even if this is illusory) rather than a probabilistically better chance.^{7,8}

Strategies to compensate for such biases include educating patients (and physicians) to be aware of their presence, presenting choices in terms of 2 or more alternative frameworks (eg, chance of dying and chance of survival),⁹ and expressing probabilities in familiar terms (eg, "1 in 20 000 corresponds to the chance that a person will live longer than 100 years").

How might psychiatric conditions alter judgment above and beyond these normal biases? How might they affect the discussion of treatment options and risks?

Depression. Depression may cause cognitive deficits independent of the disturbed affect; thus, negativistic or passive attitudes about treatment may reflect deficits in learning, recall, problem solving, and the ability to select among relevant hypotheses.¹⁰⁻¹² Patients with severe depression may overestimate the risks and underestimate the benefits of treatment for medical conditions, independent of symptoms such as apathy or delusionality.¹³ Among patients with cancer who are terminally ill and depressed, hopelessness itself contributes to a desire for hastened death.¹⁴ These findings imply that patients may not be able to correct for negativism merely by trying to override depressive emotions.

Emotional and Neuropsychiatric Factors. Denial or magical thinking may undermine one's appreciation of the illness and one's reasoning about treatment options.¹⁵⁻¹⁸ Obsessionalism may skew the judgment of probability.¹⁹ Hypochondriasis is associated with an exaggerated view of vulnerability to disease and of risk.²⁰ Neuropsychiatric conditions, such as damage to the prefrontal cortex, may inhibit the associations with reward and punishment that underlie decision making, thereby affecting insight and judgment.²¹

Psychosis. Patients with delusions tend to request less information be-

fore reaching an inferential decision and to focus less on their hypotheses in response to feedback.^{22,23} On the other hand, some patients with delusional schizophrenia differ little from normal control subjects in their use of logic on tasks of syllogistic reasoning, probability judgment, and conditional reasoning.²⁴ These findings suggest a need to probe the patient's reasoning and not simply to assume that delusionality distorts judgment.

Although psychiatric problems may affect judgment, the clinician must avoid inferring bias or, worse, inferring incompetence solely because a patient's autonomous decision goes against medical advice.²⁵ Many nonpsychiatric patients exhibit decision-making biases and many psychiatric patients do not. Too, many patients exhibit irrational decision making that is not biased or incompetent.²⁶ Physicians themselves are susceptible to decisional biases,²⁷ our outlook is often bound by our medical culture,²⁸ and we use our rituals to bind the anxiety that attends risk.²⁹ These considerations suggest the need for caution and humility on the physician's part in assessing for bias.

In summary, psychiatric problems may be associated with specific cognitive deficits, but these deficits do not necessarily mirror the exact character of the primary psychopathologic condition. They may affect patients' judgments about the probable outcome of medical treatments.

Implications for Discussing Treatment

In the dialectical interview framework, exploration may be used to elicit the patient's view of risk and to assess for possible skewing of judgment, while assertion, or counterbalancing, may be the physician's attempt to redress the skewed judgment by advocating from a more neutral position. This technique is illustrated in the dialogue in case 1.

Case 1

A 35-year-old woman with diabetes mellitus was referred by her primary care physician back to an endocrinologist for evaluation and to

consider an insulin pump. Progressive symptoms included chronic fatigue, pain in the extremities, and early retinopathy. She was also depressed, and although her symptoms had improved with antidepressant medication and counseling, she remained demoralized about her illness. In fact, for a year she had resisted the idea of revisiting the endocrinologist.

On interview, the endocrinologist found her irritable and sullen. When he endorsed the idea of an insulin pump, expecting a positive response, the patient instead snapped: "This is my husband's idea. I don't need more problems than I already have. If anyone would get infected or get ketoacidosis from a pump, it would be me. No thanks."

Physician: You sound sure that you will get an infection from the insulin pump. Are you really convinced about this? [probing depressive and negativistic beliefs: in its extreme, the latter would constitute a depressive delusion]

Patient: I told you, this pump means more trouble for me.

Physician: Your depression could be making everything seem hopeless to you even if the pump might help. [counterbalancing, by pushing her to discount her depression-induced negativism]

What can I tell you about the pump to help you make the best decision for yourself? [fostering discussion about the pros and cons]

Patient: It's not just my depression. Everything that happens to me worsens my problems.

Physician: Really? What has gotten worse? [expressing curiosity about the patient's life, probing for pessimism]

Patient: My boss has turned against me.

Physician: How do you know that?

Patient: He tells the other workers in the library that I can't be counted on to work a whole day.

Physician: Have you kept on working every day in spite of feeling depressed? [assessing level of depression]

Patient: Yes, but it's been hard.

Physician: It sounds like your boss might actually be trying to be supportive. [assessing sense of re-

ality and ability to consider alternatives]

Patient: Well, maybe. He hasn't actually asked me to leave.

Physician: So, what about the insulin pump?

Patient: If I had to take time off because I got an infection or got hospitalized, I would lose my job.

Physician: Couldn't it work the other way? I would hope that the pump might give better control of your sugar and let you feel healthier. [counterbalancing]

Patient: How do I know that it will be better instead of worse? [demonstrating her ability to weigh alternatives]

Physician: I wish that I could assure you of that. [empathizing and admitting uncertainty]

This hypothetical dialogue illustrates the dialectic of exploring vs advocating. The interview is grounded by nonjudgmental questions that elicit the patient's views of herself and her illness, while the physician advocates against depressive (biased) thinking as he tries to negotiate an agreement to pursue beneficial therapy. This flexible style of interviewing allows themes to emerge and prevents premature closure about the ultimate decision, while empathizing with the patient.³⁰

PSYCHIATRIC PROBLEMS AND INFORMED CONSENT

Legal Implications of Psychiatric Status

Informed consent doctrine governs much of how physicians discuss treatment options and risks with patients. The 3 elements of informed consent are (1) disclosure of information, (2) voluntariness of the patient's decision, and (3) competence to make that decision. The disclosed information must include the risks, benefits, and alternatives to recommended treatment that a prudent patient would wish to know to make an intelligent and rational acceptance or refusal.^{31,32(pp7-11)}

Disclosure. Experts have advocated for a process that not only discloses information but also maximizes physician-patient collaboration, in ac-

cord with the legal and humanistic intent to foster patient autonomy.³³ However, courts have specified little about the exact type of communication that should occur, and they have said less about how the approach should be modified for patients who have mental problems.³⁴

Voluntariness. Voluntariness may too often be abrogated with patients who have psychiatric problems, eg, when they are coerced into consenting to hospitalization under threat of institutional commitment or are compelled to agree to procedures by well-meaning (but sometimes overcontrolling) family members or caregivers. Legal psychiatric commitment, even if it is understood to have been necessary, may leave a residue of resentment on the patient's part.³⁵

Competence. By far, the most common concern in discussing treatment with patients who have psychiatric problems, particularly dementia, is whether they are competent to consent to treatment or to refuse it. If they are not, they may need to be considered for guardianship. (Strictly speaking, what the clinician assesses is decisional abilities; competence is a legal determination by a court.) Competence is usually assumed, but in case of doubt, it needs to be assessed. Not only cognitive deficits can interfere with decisional capacity but also delusionality, manic grandiosity, depressive negativism, denial, and more subtle symptoms.³⁶ Competency may fluctuate and may need to be reassessed periodically during treatment,³⁷ particularly in the case of delirium.³⁸ Contrary to the frequent assumption that competency standards should be the same for acceptance of a procedure as for refusal, the threshold for competence varies according to the risk-benefit ratio of what is being decided (ie, a lower threshold pertains to competency to accept a high benefit–low risk procedure than to refuse this same procedure).^{32(pp24-26)}

There is an extensive literature on medicolegal competency standards in psychiatric patients,³⁹⁻⁴¹ and there exist unofficial guidelines for clinical work and research.^{42,43} All of

these address the patient's ability to recall relevant information and to reason about treatment choices. These abilities are assessed by questions such as: "What do you understand about your condition and the proposed treatment?" "What would happen if you were to refuse treatment?" and "Can you explain how you came to your decision about (not) wanting treatment?"⁴⁴ In practice, at least in the case of dementia, physicians' criteria and judgments regarding competency are variable.⁴⁵ The literature reviewed in the following subsections bears on the decisional capacity of psychiatric patients.

Age and Dementia. In one study,⁴⁶ older patients showed poorer comprehension of hypothetical informed consent items than did younger patients; yet, they made equally reasonable decisions. In a later study,⁴⁷ patients with early to moderate Alzheimer disease showed impaired comprehension of consent information about an actual drug treatment and could not fully explain their reasoning; yet, they showed no impairment in the actual quality of reasoning about risk vs benefit. The authors caution that usual competency standards are dependent on conscious, explicit, verbal processes (ie, the ability to explain) but that these may not accurately represent how normal people arrive at such decisions. In summary, neither age alone nor a mild degree of dementia by itself necessarily signifies an impairment in decisional ability, although these suggest that the clinician be cautious.^{48,49} As dementia progresses, it affects more of the neuropsychological functions that comprise competence.⁵⁰

Affective Disorders. Outpatients with a moderate degree of depression have shown no significant impairment in comprehension or reasoning about treatment.⁵¹ The ability to reason about risk vs benefit may, however, be significantly impaired by pseudodementia accompanying more severe depression; by cognitive factors; or by depressive hopelessness, diminished attention to self-interest, guilt, an attitude of

"deserving punishment," or a wish for "silent suicide."⁵²⁻⁵⁴

Emotional and Neuropsychological Factors. Fearfulness may impair the ability to absorb and use information.⁵⁵ In patients with schizophrenia, fear may exacerbate delusions and lead to treatment refusal.⁵⁶ Severe denial may block the basic recognition of a problem and the ability to hear a physician's advice and cautions.^{57,58} Acute illness, response to trauma, or other severe emotional stress may impair the individual's judgment for a limited time.

Schizophrenia. Thought disorder may correlate with a diminished comprehension of informed consent issues.^{59,60} Paranoia may obviously interfere.⁶¹ Because psychotic ambivalence may lead a patient to protest against treatment verbally but accept it behaviorally, the patient's true judgment may be difficult to determine. Cognitively, patients with schizophrenia may show impairment in attention, memory, abstract reasoning, and problem solving.^{62,63} They also show some curious deficits in awareness about abnormal body movements, a type of deficit that could diminish the ability to apprehend medical choices.^{64,65} Decisional impairment in patients with schizophrenia may improve markedly with education.⁶⁶⁻⁶⁹

In summary, the relationship between psychiatric problems and problems with competency is complex. Deficits may involve emotional and neuropsychological effects. The patient's capacity to understand and to decide may change over time, and deficits may be amenable to educational or therapeutic measures.

Implications for Discussing Treatment

The requirements of informed consent imply an interview that shifts between educating the patient about the options and risks of treatment alternatives (assertion) and testing how well he or she understands and thinks about the choices (exploration).

Patients who are competent should be able to ask pertinent and appropriately self-protective questions about treatment options and risks and to focus clearly on the issue to be decided.⁷⁰ Cognitive abilities express themselves not only in the content of answers (topical focus, logic, and richness of detail) but also in the manner of communication (fluency, immediacy, and attentiveness to the interviewer). Replies that seem incomprehending, vague, confused, illogical, or evasive should raise suspicion of a cognitive or other psychiatric disorder.⁷¹

Not uncommonly, clinicians fail to appreciate impaired cognition because they rely on their impression of fluency in the patient's speech, while neglecting to use standard tests, such as digit span, naming, and object recall, and tests of abstracting and executive ability, such as similarities, proverbs, and clock drawing.^{72,73} The Mini-Mental State Examination and other tests may be used to help assess the extent of cognitive deficit.^{74,75}

On the other hand, clinicians may overdiagnose cognitive impairment if they mistake a patient's transient anxiety, sedation, or medical distress—all of which can amplify a mild underlying cognitive deficit—for a fixed condition.

For patients in whom impaired cognition is a concern, evaluation might include the following: (1) Use verbal calming, mild sedation, or perhaps simply a brief waiting period to decrease interference by anxiety; (2) Explain the procedure in language that suits the patient's educational background, using illustrations if necessary (effective even for patients with learning disability⁷⁶); (3) Elicit the patient's understanding and questions about the procedure (eg, "What would you like to know about this test to help you make your decision?"); (4) Shift into a structured mental status examination if the patient's replies suggest cognitive impairment; (5) Obtain information about the patient's history and cognitive and behavioral functioning from relatives and caregivers; and (6) Try to educate the patient over time to see whether comprehension improves.

Case 2

A 70-year-old man was hospitalized after a neighbor found him lying on the floor in his apartment. He was dirty and he appeared not to have eaten or drunk recently. He had gangrene in one foot. After being medically stabilized with ample fluid and nutrition, he was approached about undergoing a below-knee amputation. He understood that he had been hospitalized because of a fall at home and that physicians were recommending amputation of the foot, but he said that he did not want to lose his foot and he had to think a lot about this.

On mental status examination, he was attentive and oriented. He could recall 2 of 3 items at 3 minutes but could neither recall nor recognize the third one. He showed mild perseveration and confusion on cognitive challenges, such as serial 3 subtractions and clock drawing.

The following hypothetical dialogue illustrates the interview format of educating and testing. For the sake of clarity, an unequivocal choice is presented, but the same principles would apply to discussing less clear-cut choices.

Physician: Mr T, do you understand why we are suggesting that you let us amputate your foot? [testing]

Patient: Because I have an infection.

Physician: That's right. If we don't amputate the foot, your infection will spread. [informing the patient in simple language, one item at a time]

Patient: I don't need an amputation.

Physician: I can understand that you might be afraid of the infection and of losing your foot. That is a big loss. [addressing underlying fear]

Patient: I don't need an amputation. [perseverative, unelaborated response]

Physician: There are bacteria in your foot that will make the infection spread. Do you understand what might happen if we do not amputate your foot? [assessing patient's understanding of consequences]

Patient: I guess I could die.

Physician: Unfortunately, that's true. I know that you don't want to lose your foot. It's not an emer-

gency today, but we want to prevent the infection from spreading and killing you. What do you think about having the amputation?

Patient: I don't need it.

Physician: You just said that you could die without an amputation. Please explain to me how you can say that you could die without an amputation but you also say that you don't need it to be done. [assessing logic and the ability to integrate information that has been registered]

This brief dialogue is intended to show the back-and-forth shifting in the interview between educating (a form of advocacy or informed consent) and probing (a form of exploration or assessment of decisional capacity). The dialogue illustrates a complex legal and clinical situation that is beyond the scope of this article to discuss in detail but that resembles many common clinical encounters. This patient's illogical and unelaborated answers indicate a need for further assessment, history, and efforts at education to complete the informed consent process, including the evaluation of competence.

Psychiatric Problems and the Physician-Patient Relationship

With patients now having many sources of information and influence about their medical care (health maintenance organizations, Internet data, advocacy groups, etc), the physician no longer acts as a sole authority; some commentators view the physician's role more as that of an advocate or collaborator in decision making.^{77,78} Across cultures, there may be markedly different views about the roles of physician and patient and about the personal value of autonomy.⁷⁹

Nevertheless, the central focus in the recent history of the physician-patient relationship centers on its evolution from physician paternalism to greater patient autonomy. Physicians have often been criticized for dominating clinical interviews by using medical jargon, controlling the flow of questions and discourse, and suppressing patients' expression of personal concerns.^{80,81} However, some experienced clinicians, looking at patients'

emotional and decisional needs for an appropriate authority figure, have pointed out the harm that may come from a physician's being too passive or deferential about treatment decisions and from failing to act assertively when patients deny the presence of serious illness, sabotage or undermine treatment, or cannot give up control.^{82,83}

The discussion of treatment options and risks occupies a central role in this tension between autonomy and medical authority, because it is an occasion when the patient is, in some sense, on equal terms and may negotiate about treatment with the physician. Negotiation may imply a power differential and a conflict, but it also connotes a process of exploring each other's points of view and reconciling differences.⁸⁴⁻⁸⁶

How might psychiatric problems affect the physician-patient relationship and prompt the clinician to modify the approach to discussing treatment options and risks?

Depression. Severe depression casts a pall of discouragement over discussions about treatment and over the physician-patient relationship. A common reaction is for the physician to mirror the patient's sense of helplessness and apathy, eg, by delegating decisions to family members. Patients often do not realize that their pessimism is in itself a symptom. The physician should advocate assertively for treatment against the patient's negativism and should encourage the patient to stay as active as possible in decision making and in recovery, without expecting too much too soon.

Schizophrenia. The inner world of the patient with schizophrenia is fragmented, his or her grasp of reality is impaired, and emotions are blunted. For these reasons, the physician-patient relationship with such a patient often feels vague and strange. If the patient is paranoid, he or she may appear to be mistrustful, grandiose, challenging, or threatening. "Psychotic ambivalence" may be confusing because the patient may make vehement verbal objections to treatment, while nevertheless com-

plying with it behaviorally. The physician should try to maintain a steady relatedness and to be factual and honest about treatment choices. Above all, he or she should try to engage the part of the patient's psyche that remains reality-based and able to collaborate.

Personality Disorder. Patients with pathologic narcissism, borderline personality disorder, and other personality problems may act needy, demanding, confrontational, histrionic, fickle, or angry. Instances of severe personality disorder are uncommon, but they take a disproportionate amount of attention and time in medical practices. In the extreme, relationships with medical staff may become vicious cycles of anger and avoidance and turn discussions about treatment into power struggles.^{87,88}

Such problems must be differentiated from substance abuse or withdrawal, mania, acute distress reactions, antisocial or factitious behavior, and other disorders that may manifest as aggression, manipulativeness, entitlement, or provocativeness. It is also important to determine whether hospital or office staff are exacerbating the vicious cycle with angry responses that further provoke the patient.

A useful strategy with such patients—common across the board with a range of psychopathologic conditions and severities—is to address their feelings through empathy and then to negotiate an agreement about the treatment plan. The clinician should try to depersonalize the discussion of treatment options and risks, ie, to separate it from the patient's issues of personal anger, mistreatment, and feelings of inadequacy or injury. Limit setting on any abusive behavior by the patient is crucial. In cases of severe personality disorder, psychiatric help and a team approach are needed for clinical management and to help avoid the administrative chaos that such patients can create.

Implications for Discussing Treatment

We have seen in the previous sections that the discussion of treat-

ment may alternate between assessment and advocacy. In this section, the focus of attention is on the physician-patient relationship itself: how the patient views the physician and how those views color the attitude toward treatment (including trust, willingness to accept recommendations, and freedom to question the physician). The dialogue may resemble psychotherapy, with an exploration of the patient's feelings being interspersed with clarifying or interpretive comments by the clinician. The aim is to smooth the way for physician and patient to negotiate a treatment plan, without the distorting effect of interpersonal conflict, overdependency, helplessness, or other relationship problems.

Case 3

A 69-year-old former corporate chief executive with severe coronary artery disease was hospitalized for the fifth time with chest pain and cardiac failure. Divorced and childless, he had insisted on living alone in his own apartment, but he was physically overtaxed there and ignoring dietary restrictions. After his acute cardiac problem was stabilized, the medical and social work staff recommended that he move to a supported living arrangement.

The patient rebuffed this idea with great indignation, proclaiming that he was perfectly capable of managing on his own. With the hospital staff, he acted arrogant and intimidating. Declaring that he had once been cared for by a famous cardiologist, he picked and chose among prescribed cardiac medications, loudly lecturing the residents about adverse effects. At one point, he stole a consultation note from the medical chart to read. As usual, his behavior quickly enraged and alienated the staff, who started to avoid talking with him about any aftercare plans and simply hoped to get him out of the hospital quickly.

Physician: With your knowledge base, you already know a lot about the options for treatment. [acknowledging patient's competence] So, why are you fighting so much with the staff? [identifying the behavioral problem]

Patient: I don't like being ordered around by a bunch of medical elementary students. I don't like being ordered where to live, what to eat, and how to live.

Physician: You're right, we have been telling you a lot of restrictions on your diet and other things in hopes of preventing your heart disease from getting worse. That must be hard to take when you have been independent and in charge your whole life. [empathizing] But this isn't a power struggle. You can take my advice or leave it. The only question is what's best for your health. [trying to deflate the conflict]

Patient: I know the score with physicians. If I don't do what you say, you guys will blackball me. [expecting harsh treatment from others]

Physician: I won't refuse to treat you just because you decide not to take my advice. We are here to help you. [correcting the misimpression, not letting him push the physician away] But I will refuse to treat you if you steal things from your medical chart and you abuse me or the staff. [limit setting]

Patient: So, you're telling me that if I go back to my apartment and I come into the emergency department with congestive failure again, you're not going to ship me to Metropolitan Hospital next time? It's happened before. And believe me, I'll sue.

Physician: You keep trying to make a fight out of this. How about dealing with why you're here. The question is: what are your real choices here, what has worked or failed in the past, and what will protect your health the best right now? [identifying the patient's own belligerence as a defense, motivating the patient to face the distressing problem, while maintaining a helpful stance]

As is true in the earlier examples, the clinician needs to envision a dialectical approach to this type of treatment discussion. The discussion shifts between eliciting the patient's values and emotional concerns and, on the other hand, asserting the clinician's medical judgment.

The physician must do considerable internal work to negotiate

with such patients. A major challenge is to recognize one's anger and to avoid acting it out through hostility, avoidance, or reaction formation (eg, by transmuted one's anger into benevolent indulgence). Another challenge is for the physician to balance medical advocacy with a nonjudgmental attitude toward the patient's personal desires.

CONCLUSIONS

The discussion of treatment options and risks is sometimes conceptualized as a form of information transfer. This article suggests a more complex model, especially as applied to patients with psychiatric problems—a process of probing or exploring the patient's views, alternating with efforts by the physician to counterbalance biased judgments of the patient, to educate, and to address relationship problems. The process includes internal work by the physician to become aware of personal biases and beliefs and to maintain empathy. The optimal result is to expand the patient's freedom to make decisions that best fit his or her personality, social beliefs, and understanding and to promote the best fit between the physician's and the patient's points of view toward treatment decisions.

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REFERENCES

1. Bogardus ST, Holmboe E, Jekel JF. Perils, pitfalls and possibilities in talking about medical risk. *JAMA*. 1999;281:1037-1041.
2. Wisner KL, Zarin DA, Holmboe ES, et al. Risk-benefit decision making for treatment of depression during pregnancy. *Am J Psychiatry*. 2000; 157:1933-1940.
3. Slovic P. Perception of risk. *Science*. 1987;236: 280-285.
4. Tversky A, Kahneman D. Judgment under uncertainty: heuristics and biases. *Science*. 1974;185: 1124-1131.
5. Lee SJ, Fairclough D, Antin JH, Weeks JC. Discrepancies between patient and physician estimates for the success of stem cell transplantation. *JAMA*. 2001;285:1034-1038.
6. Jasper JD, Goel R, Einarson A, et al. Effects of framing on teratogenic risk perception in pregnant women. *Lancet*. 2001;358:1237-1238.
7. Tversky A, Kahneman D. The framing of decisions and the psychology of choice. *Science*. 1981; 211:453-458.
8. Eraker SA, Politser P. How decisions are reached: physician and patient. *Ann Intern Med*. 1982;97: 262-268.
9. McNeil BJ, Pauker SG, Sox HC, Tversky A. On the elicitation of preferences for alternative therapies. *N Engl J Med*. 1982;306:1259-1262.
10. Beck AT. Thinking and depression. *Arch Gen Psychiatry*. 1963;9:324-333.
11. Hartlage S, Alloy LB, Vazquez C, Dykman B. Automatic and effortful processing in depression. *Psychol Bull*. 1993;113:247-278.
12. Baker JE, Channon S. Reasoning in depression: impairment on a concept discrimination learning task. *Cognition Emotion*. 1995;9:579-597.
13. Ganzini L, Lee MA, Heintz RT, Bloom JD, Fenn DS. The effect of depression treatment on elderly patients' preferences for life-sustaining medical therapy. *Am J Psychiatry*. 1994;151:1631-1636.
14. Breitbart W, Rosenfeld B, Pessin H, et al. Depression, hopelessness, and desire for hastened death in terminally ill patients with cancer. *JAMA*. 2000; 284:2907-2911.
15. Duffy JD. The neurology of alcoholic denial. *Can J Psychiatry*. 1995;40:257-262.
16. Miceli M, Castelfranchi C. Denial and its reasoning. *Br J Med Psychol*. 1998;71:139-152.
17. Gillick MR. Talking with patients about risk. *J Gen Intern Med*. 1988;3:166-170.
18. Ness DE, Ende J. Denial in the medical interview: recognition and management. *JAMA*. 1994;272: 1777-1781.
19. Volans PJ. Styles of decision-making and probability appraisal in selected obsessional and phobic patients. *Br J Clin Psychol*. 1976;15:305-317.
20. Barsky AJ, Ahern DK, Bailey ED, Saintfort R, Liu EB, Peekna HM. Hypochondriacal patients' appraisal of health and physical risks. *Am J Psychiatry*. 2001;158:783-787.
21. Bechara A, Damasio H, Tranel D, Damasio AR. Deciding advantageously before knowing the advantageous strategy. *Science*. 1997;275:1293-1295.
22. Huq SF, Garety PA, Hemsley DR. Probabilistic judgments in deluded and non-deluded subjects. *Q J Exp Psychol A*. 1988;40:801-812.
23. Young HF, Bentall RP. Hypothesis testing in patients with persecutory delusions: comparison with depressed and normal subjects. *Br J Clin Psychol*. 1995;34:353-369.
24. Kemp R, Chua S, McKenna P, David A. Reasoning and delusions. *Br J Psychiatry*. 1997;170:398-405.
25. Strain JJ, Rhodes R, Moros DA. Ethical issues in the care of the medically ill. In: Stoudemire A, Fogel BS, Greenberg DB, eds. *Psychiatric Care of the Medical Patient*. 2nd ed. New York, NY: Oxford University Press; 1999:111.
26. Brock DW, Wartman SA. When competent patients make irrational choices. *N Engl J Med*. 1990; 322:1595-1599.
27. Elstein AS. Heuristics and biases: selected errors in clinical reasoning. *Acad Med*. 1999;74: 791-794.
28. Eisenberg JM. Sociologic influences on decision-making by clinicians. *Ann Intern Med*. 1979;90: 957-964.
29. Bosk CL. Occupational rituals in patient management. *N Engl J Med*. 1980;303:71-76.
30. Gutheil TG, Bursztajn H, Brodsky A. Malpractice

- prevention through the sharing of uncertainty: informed consent and the therapeutic alliance. *N Engl J Med*. 1984;311:49-51.
31. Meisel A, Kuczewski M. Legal and ethical myths about informed consent. *Arch Intern Med*. 1996;156:2521-2526.
 32. Grisso TH, Appelbaum PS. *Assessing Competence to Consent to Treatment*. New York, NY: Oxford University Press; 1998:7-11, 24-26.
 33. Lidz CW, Appelbaum PS, Meisel A. Two models of implementing informed consent. *Arch Intern Med*. 1988;148:1385-1389.
 34. Merz JF, Fischhoff B. Informed consent does not mean rational consent: cognitive limitations on decision-making. *J Leg Med*. 1990;11:321-350.
 35. Lidz CW, Hoge SK, Gardner W, et al. Perceived coercion in mental hospital admission: pressures and process. *Arch Gen Psychiatry*. 1995;52:1034-1039.
 36. Gutheil TG, Bursztajn H. Clinicians' guidelines for assessing and presenting subtle forms of patient incompetence in legal settings. *Am J Psychiatry*. 1986;143:1020-1023.
 37. Schwartz HI, Blank K. Shifting competency during hospitalization: a model for informed consent decisions. *Hosp Comm Psychiatry*. 1986;37:1256-1260.
 38. Auerswald KB, Charpentier PA, Inouye SK. The informed consent process in older patients who developed delirium: a clinical epidemiologic study. *Am J Med*. 1997;103:410-418.
 39. Tepper AM, Elwork A. Competence to consent to treatment as a psychological construct. *Law Hum Behav*. 1984;8:205-223.
 40. Grisso T, Appelbaum PS. Comparison of standards for assessing patients' capacities to make treatment decisions. *Am J Psychiatry*. 1995;152:1033-1037.
 41. Michels R. Are research ethics bad for our mental health? *N Engl J Med*. 1999;340:1427-1430.
 42. American Psychiatric Association resources document on principles of informed consent in psychiatry. *J Am Acad Psychiatry Law*. 1997;25:121-125.
 43. American Psychiatric Association guidelines for assessing the decision-making capacities of potential research subjects with cognitive impairment. *Am J Psychiatry*. 1998;155:1649-1650.
 44. Appelbaum PS, Grisso T. Assessing patients' capacities to consent to treatment. *N Engl J Med*. 1988;319:1635-1638.
 45. Marson DC, McInturff B, Hawkins L, Bartolucci A, Harrell LE. Consistency of physician judgments of capacity to consent in mild Alzheimer's disease. *J Am Geriatr Soc*. 1997;45:453-457.
 46. Stanley B, Guido J, Stanley M. The elderly patient and informed consent: empirical findings. *JAMA*. 1984;252:1302-1306.
 47. Stanley B, Stanley M, Guido J, Garvin L. The functional competency of elderly at risk. *Gerontologist*. 1988;28:53-58.
 48. Derse AR. Making decisions about life-sustaining treatment in patients with dementia. *Theor Med*. 1999;20:55-67.
 49. Fellows LK. Competency and consent in dementia. *J Am Geriatr Soc*. 1998;46:922-926.
 50. Marson DC, Chatterjee A, Ingram KK, Harrell LE. Toward a neurologic model of competency: cognitive predictors of capacity to consent in Alzheimer's disease using three different legal standards. *Neurology*. 1996;46:666-672.
 51. Appelbaum PS, Grisso T, Frank E, O'Donnell S, Kupfer DJ. Competence of depressed patients for consent to research. *Am J Psychiatry*. 1999;156:1380-1384.
 52. Bursztajn HJ, Harding HP Jr, Gutheil TG, Brodsky A. Beyond cognition: the role of disordered affective states in impairing competence to consent to treatment. *Bull Am Acad Psychiatry Law*. 1991;19:383-388.
 53. Elliott C. Caring about risks: are severely depressed patients competent to consent to research? *Arch Gen Psychiatry*. 1997;54:113-116.
 54. Simon RI. Silent suicide in the elderly. *Bull Am Acad Psychiatry Law*. 1989;17:83-95.
 55. Montgomery C, Lydon A, Lloyd K. Psychological distress among cancer patients and informed consent. *J Psychosom Res*. 1999;46:241-245.
 56. Appelbaum PS, Roth LH. Clinical issues in the assessment of competency. *Am J Psychiatry*. 1981;138:1462-1467.
 57. Roth LH, Appelbaum PS, Sallee R, Reynolds CF, Huber G. The dilemma of denial in the assessment of competency to refuse treatment. *Am J Psychiatry*. 1982;139:910-913.
 58. Shakin Kunkel EJ, Woods CM, Rodgers C, Myers RE. Consultations for "maladaptive denial of illness" in patients with cancer: psychiatric disorders that result in noncompliance. *Psychooncology*. 1997;6:139-149.
 59. Irwin M, Lovitz A, Marder SR, et al. Psychotic patients' understanding of informed consent. *Am J Psychiatry*. 1985;142:1351-1354.
 60. Schachter D, Kleinman I, Prendergast P, Remington G, Schertzer S. The effect of psychopathology on the ability of schizophrenic patients to give informed consent. *J Nerv Ment Dis*. 1994;182:360-362.
 61. Oxman TE, Rosenberg SD, Tucker GJ. The language of paranoia. *Am J Psychiatry*. 1982;139:275-281.
 62. Gold JM, Harvey PD. Cognitive deficits in schizophrenia. *Psychiatr Clin North Am*. 1993;16:295-312.
 63. Clare L, McKenna PJ, Mortimer AM, Baddeley AD. Memory in schizophrenia: what is impaired and what is preserved? *Neuropsychologia*. 1993;31:1225-1241.
 64. Alexopoulos GS. Lack of complaints in schizophrenics with tardive dyskinesia. *J Nerv Ment Dis*. 1979;167:125-127.
 65. Franck N, Farrer C, Georgieff N, et al. Defective recognition of one's own actions in patients with schizophrenia. *Am J Psychiatry*. 2001;158:454-459.
 66. Carpenter WT, Gold JM, Lahti AC, et al. Decisional capacity for informed consent in schizophrenia research. *Arch Gen Psychiatry*. 2000;57:533-538.
 67. Grisso T, Appelbaum PS. The MacArthur Treatment Competence Study, III: abilities of patients to consent to psychiatric and medical treatments. *Law Hum Behav*. 1995;19:149-174.
 68. Wirshing DA, Wirshing WC, Marder SR, Liberman RP, Mintz J. Informed consent: assessment of comprehension. *Am J Psychiatry*. 1998;155:1508-1511.
 69. Kleinman I, Schachter D, Jeffries J, Goldhamer P. Effectiveness of two methods for informing schizophrenic patients about neuroleptic medication. *Hosp Comm Psychiatry*. 1993;44:1189-1191.
 70. Havens LL. The need for tests of normal functioning in the psychiatric interview. *Am J Psychiatry*. 1984;141:1208-1211.
 71. Jones TV, Williams ME. Rethinking the approach to evaluating mental functioning of older persons: the value of careful observations. *J Am Geriatr Soc*. 1988;36:1128-1134.
 72. Strub RL, Black FW. *The Mental Status Examination in Neurology*. 4th ed. Philadelphia, Pa: FA Davis; 2000.
 73. Freedman M, Leach L, Kaplan E, Winocur G, Shulman KI, Delis DC. *Clock Drawing: A Neuropsychological Analysis*. New York, NY: Oxford University Press; 1994.
 74. Folstein MF, Folstein SE, McHugh PR. "Mini-Mental State": a practical method for grading the cognitive state of patients for the clinician. *J Psychiatr Res*. 1975;12:189-198.
 75. Holzer JC, Gansler DA, Moczynski NP, Folstein MF. Cognitive functions in the informed consent evaluation process: a pilot study. *J Am Acad Psychiatry Law*. 1997;25:531-540.
 76. Arcsott K, Dagnan D, Kroese BS. Assessing the ability of people with a learning disability to give informed consent to treatment. *Psychol Med*. 1999;29:1367-1375.
 77. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. *JAMA*. 1992;267:2221-2226.
 78. Katz J. *The Silent World of Doctor and Patient*. New York, NY: Free Press; 1984.
 79. Solomon MZ. From what's neutral to what's meaningful: reflections on a study of medical interpreters. *J Clin Ethics*. 1997;8:88-93.
 80. Shuy RW. Three types of interference to an effective exchange of information in the medical interview. In: Fisher S, Todd AD, eds. *The Social Organization of Doctor-Patient Communication*. Washington, DC: Center for Applied Linguistics; 1983:189-202.
 81. Mishler EG, Clark JA, Ingelfinger J, Simon MP. The language of attentive patient care: a comparison of two medical interviews. *J Gen Intern Med*. 1989;4:325-335.
 82. Ingelfinger FJ. Arrogance. *N Engl J Med*. 1980;303:1507-1511.
 83. Lerner AM, Luby ED. Error of accommodation in the care of the difficult patient in the 1990's. *J Psychiatry Law*. Summer 1992:191-206.
 84. Coulehan JL, Block MR. *The Medical Interview: Mastering Skills for Clinical Practice*. 4th ed. Philadelphia, Pa: FA Davis; 2001:272-280.
 85. Benarde MA, Mayerson EW. Patient-physician negotiation. *JAMA*. 1978;239:1413-1415.
 86. Scheff TJ. Negotiating reality: notes on power in the assessment of responsibility. In: Stoeckle JD, ed. *Encounters Between Patients and Doctors: An Anthology*. Cambridge, Mass: MIT Press; 1987:193-213.
 87. Groves JE. Taking care of the hateful patient. *N Engl J Med*. 1978;298:883-887.
 88. Stoudemire A, Thompson TL II. The borderline personality in the medical setting. *Ann Intern Med*. 1982;96:76-79.