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Talking to your Patients



“What would you do if you were in my shoes?”

A Question of Values

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When patients ask: “What would you do in my shoes?” they may be:

- Asking for help because they do not, and will not, understand the choices or their consequences.
- Expressing utmost respect for the clinician.
- Assuming their clinician knows them enough to be able to think about their values and preferences in conjunction with research evidence.

Clinicians may wrongly interpret this question as: “What would you do in my shoes *if I had your values and preferences?*” This misinterpretation would not be problematic if clinicians and patients shared the same values and preferences. However, at least two arguments challenge this assumption.

First, consider the adage “First, do no harm.” If clinicians abide by this adage, they may want to avoid using warfarin in patients at high risk of bleeding. Conversely, patients with atrial fibrillation may

The Case of Mr. Babel

Mr. Babel, 74, had been gaining weight over the last three years. Six months ago, his doctor diagnosed him with impaired fasting glucose and suggested a low-calorie diet and a 30-minute walk every day. Mr. Babel returned to the office having gained an additional 5 kg. His glucose was 7 mmol/L and his hemoglobin A1c was 5.5%. His family doctor presented the choice of starting metformin or continuing with diet and exercise to try to prevent diabetes. As his doctor began to explain the pros and cons of the choices, Mr. Babel interrupted and asked, “Doctor, what would you do if you were in my shoes?”

For a followup on Mr. Babel, see page 32.

place a relatively higher value on using warfarin to prevent a disabling or fatal stroke and a lower value on the inconvenience, cost, and side-effects (bleeding) of taking warfarin. Thus, “First, do no harm” may place the clinician at conflict with the patient.

Second, patients and clinicians may come from different cultural backgrounds or belong to different generations. This, in part, may explain the difficulties in achieving concordance with plans aimed at preventing disease.

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Table 1

Helpful Web sites

Institution	Web site
The Society for Medical Decision-Making	www.smdm.org
The Ottawa Health Decision Centre	www.ohri.ca/programs/clinical_epidemiology/OHDEC/default.asp
The University of Michigan Program for Improving Health-Care Decisions	http://www.med.umich.edu/pihcd/
Society for Judgement and Decision-Making	http://www.sjdm.org/
American Academy of Family Physicians Counselling Tools	http://www.aafp.org/x19497.xml

What to do?

Although appointments are usually brief and focused, family physicians can exchange information across multiple visits. Physicians should find out patients' favoured decision-making model, the amount of information they desire, and their ideal degree of involvement in deliberation and decision-making. Clinicians should also be aware these preferences might vary with the nature of the decision and the outcomes.

Not all decisions require thorough discussion and elicitation of patient preferences. In general, important decisions, with unclear trade-offs between benefits, risks, and permanent consequences, should include as much involvement as the patient is willing to invest.

Finally, clinicians should be aware of the best available evidence from clinical research, so as to help patients make decisions by determining the range of choices available and the likely outcomes of these choices.

Unanswered questions

Many challenges remain. How can patients who wish not to engage in decision-making protect themselves from clinical decisions that are not consistent with their values and preferences? How can clinicians assess that patients are truly informed and that their preferences reflect their understanding and values? When is information harmful and when is it necessary for decision-making? What tools can we use to

engage in shared decision-making with our patients in a 10-minute consultation? While researchers find answers to these questions, practicing clinicians should try their best to make sure important decisions remain as consistent as possible with the values and preferences of informed patients (Table 1). [Dx](#)

References available upon request—contact *The Canadian Journal of Diagnosis* at diagnosis@sta.ca.

A followup on Mr. Babel

The clinician chose to stop presenting information and to ask the patient how much involvement he would like to have in this decision. The patient wanted to be involved, but also wanted to have the clinician's input. Mr. Babel expressed clearly his strong preferences for avoiding diabetes and avoiding taking pills. The clinician mentioned briefly the Diabetes Prevention Program, which supported choosing lifestyle modification over pills. Mr. Babel was less enthusiastic about adhering to a strict diet, but was willing to work closely with a dietitian to improve his eating habits. They brainstormed about opportunities to increase daily activity and they agreed on a followup phone call in four weeks to evaluate how the plan was going.