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The doctor-patient relationship as a toolkit for uncertain clinical decisions

Lauren Diamond-Brown

Boston College, Sociology Department, 426 Mcguinn Hall, 140 Commonwealth Avenue, Chestnut Hill, MA, 02467-3807, USA

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ABSTRACT

Medical uncertainty is a well-recognized problem in healthcare, yet how doctors make decisions in the face of uncertainty remains to be understood. This article draws on interdisciplinary literature on uncertainty and physician decision-making to examine a specific physician response to uncertainty: using the doctor-patient relationship as a toolkit. Additionally, I ask what happens to this process when the doctor-patient relationship becomes fragmented. I answer these questions by examining obstetrician-gynecologists' narratives regarding how they make decisions when faced with uncertainty in childbirth. Between 2013 and 2014, I performed 21 semi-structured interviews with obstetricians in the United States. Obstetricians were selected to maximize variation in relevant physician, hospital, and practice characteristics. I began with grounded theory and moved to analytical coding of themes in relation to relevant literature. My analysis renders it evident that some physicians use the doctor-patient relationship as a toolkit for dealing with uncertainty. I analyze how this process varies for physicians in different models of care by comparing doctors' experiences in models with continuous versus fragmented doctor-patient relationships. My key findings are that obstetricians in both models appealed to the ideal of patient-centered decision-making to cope with uncertain decisions, but in practice physicians in fragmented care faced a number of challenges to using the doctor-patient relationship as a toolkit for decision-making. These challenges led to additional uncertainties and in some cases to poor outcomes for doctors and/or patients; they also raised concerns about the reproduction of inequality. Thus organization of care delivery mitigates the efficacy of doctors' use of the doctor-patient relationship toolkit for uncertain decisions. These findings have implications for theorizing about decision-making under conditions of medical uncertainty, for understanding how the doctor-patient relationship and model of care affect physician decision-making, and for forming policy on the optimal structure of medical work.

1. Introduction

> One thing about OB [obstetrics] is it's so hard to know … and there is this expectation that you are never going to let anything bad happen. It's tricky right, you're not supposed to let anything bad happen, and that's hard, because your predictive powers are poor.

The obstetrician in the opening quote describes having "poor predictive powers" in situations of medical uncertainty, where the consequences of potential actions or inaction are not supported by strong scientific or experiential evidence. Medical uncertainty is a well-recognized problem in health care and a major topic in medical sociology (Atkinson, 1984; Fox, 1957, 1980; Gerrity et al., 1992; Light, 1979; Timmermans and Angell, 2001). Yet much of the foundational work on uncertainty was based on doctors in training (Atkinson, 1984; Light, 1979; Fox, 1957). There is a lack of research about how practicing physicians understand and react to uncertainty. A notable exception is Gerrity et al.'s (1992) study, which confirms the existence of physicians' subjective awareness of medical uncertainty and measures doctors' reactions to it. Gerrity et al. (1992) identified obstetrics and gynecology as 5th out of 14 specialties for physicians' perceptions of the amount of uncertainty in their daily work (p.1038). Additionally, a renaissance of North American midwifery and the women's health movement have challenged obstetricians' authoritative knowledge and created a climate with diverse opinions of best practices (Simonds, Rothman

E-mail address: brownyj@bc.edu.

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and Norman, 2007) and patient preferences (Declercq et al., 2013; Miller and Shriver, 2012). Even within obstetrics there is great variability in physician philosophy, style and skill (Luthy et al., 2003). Indeed my research reveals obstetricians' narratives of decision-making in birth are riddled with uncertainty.

This study draws on interdisciplinary literature on uncertainty and physician decision-making to examine a specific physician response to uncertainty: using the doctor-patient relationship as a toolkit. The doctor-patient relationship is featured in studies of clinical decision-making, but I move beyond descriptive studies of interaction to examine its role in physician decision-making under conditions of uncertainty. Additionally, I ask what happens to this process when the doctor-patient relationship is fragmented. I engage with work that studies how organizational frameworks shape decision-making by focusing on how model of care shapes the doctor-patient relationship and thus the interactive knowledge doctors use for uncertain decisions.

To investigate this, I conducted semi-structured interviews with 21 obstetricians about decision-making in labor and delivery. Obstetric decision-making in childbirth is a compelling case for this study because of the high degree of medical uncertainty and variation in model of care. The traditional private practice on-call model for labor and delivery is increasingly being replaced with shift work models in large groups practices (ACOG, 2013; Rayburn, 2011); presently both exist, which allows for comparison within one specialty and one clinical moment. This remains understudied, but it is important to know because of the move towards large group practices and shift work, which fragments the once continuous doctor-patient relationship.

My analysis renders it evident that some physicians use the doctor-patient relationship as a toolkit for dealing with medical uncertainty. I argue doctors working in fragmented care face challenges when relying on the doctor-patient relationship to cope with uncertain decisions. These challenges lead to additional uncertainties and in some cases to poor outcomes for doctors and/or patients. The findings of this paper raise concerns about the reproduction of inequality and have implications for theorizing about decision-making under conditions of medical uncertainty, for understanding how the doctor-patient relationship and model of care affect physician decision-making, and for forming policy on the optimal structure of medical work.

1.1. The nature of uncertainty and physician response

Renee Fox's (1957, 1980) foundational work suggests uncertainty is endemic to medicine and recursive. She argues uncertainty is a moral existential problem that medical students reflexively struggle with as they train to become physicians. Fox is challenged by Light (1979) who argues doctors avoid uncertainty by adopting a particular 'school of thought' that provides certainty based on clinical experience and professional norms. Atkinson (1984) also challenges Fox's characterization of doctors as reflexive scientists and argues medical training socializes physicians to control uncertainty through reductive modes of explanation that allow doctors to make decisions with trust in their 'thinking as usual'.

Although there is debate in medical sociology about how doctors-in-training are socialized to deal with uncertainty, research shows some practicing physicians do acknowledge uncertainty in clinical work (Gerrity et al., 1992). The questions then become: what is the nature of the uncertainty and how do doctors respond? Interdisciplinary research offers clarification on the nature of uncertainty (Brashers, 2001; Han et al., 2011). Of particular use to this paper is Babrow's (2001) distinction between ontological (indeterminacy of causes) and epistemological uncertainty (nature of knowledge), and Vos, Anthony & O'Hair's (2014) third type, axiological uncertainty: uncertainty about the moral implications of an event (p. 874). In my study obstetricians experience all three types of uncertainty but not in the same way. The variation in their experience of and response to uncertainty has to do with differences in the social context of practice.

Gerrity et al. (1992) present five factors of the social context that shape physician response to uncertainty: the patient, the medical problem, physician characteristics, test and treatment characteristics, and organizational structure (p. 1030). Their findings are limited to mainly physician-level characteristics as predictive factors. They find extensive variation in physician response and disparities between doctors' beliefs about what they should do in the face of uncertainty, versus what they actually do. They suggest we need "comparative studies done on attitudes, intentions, and actual behaviors of physicians in different settings operating under different organizational and financial constraints and incentives" (p.1044).

One organizational change to medicine relevant to uncertainty is the evidence-based medicine (EBM) movement. EBM, and what Tanenbaum (1999) refers to as the outcomes movement more generally, is in part a response to uncertainty and variation in medical practice. These seek to replace doctors' subjective knowledge in decision-making (clinical experience, the doctor-patient relationship, professional norms) with probability-based statistical evidence (Ghosh, 2004; Lambert et al., 2006; Mykhalovskiy and Weir, 2004). Research on how EBM is actually used by physicians shows that EBM is integrated into tacit knowledge within doctors' networks (Gabbay and le May, 2004) and combines with rather than replaces subjective knowledge (Armstrong, 2002; Timmermans and Angell, 2001). The attempt to reduce uncertainty through promoting rationalized knowledge has not removed ontological uncertainty, and in some cases creates new epistemological uncertainties.

1.2. The doctor-patient relationship and physician decision-making

While we have limited data on physicians' responses to uncertainty, literature on clinical decision-making more broadly identifies the doctor-patient relationship and organizational structure of care as central components of the decision-making process (Clark et al., 1991; Eisenberg, 1979). The doctor-patient relationship figures heavily into studies of decision-making; research focuses on the roles each party takes in communication and decision-making, analyzing who sets goals of the encounter and the status of patients' values (Heritage and Maynard, 2006). As patient-centered care and shared decision-making have become new standards of practice, much work has focused on these models in the medical encounter. Bensing (2000) conceptualizes patient-centered care by distinguishing between the content and control of a doctor-patient encounter. The content of the consultation may be 'patient-centered' or 'disease-centered', the former focuses on patients' needs from a biopsychosocial model, and the latter is strictly biomedical. Control has to do with who sets the agenda and maintains power in the decision-making process. The focus on power has been analyzed by many, such as Collins, Drew, Watt & Entwistle's (2005) bilateral vs. unilateral approach, Emanual and Emanuel's (1992) paternalistic, mutual, and consumerist relationships, and Charles, Gafni & Wheelan's (1997, 1999) model of shared decision-making, which includes "the exchange of both information and treatment preferences by both physician and patient and agreement by both parties on the treatment to implement" (1997, p. 682). These studies clarify differences in types of doctor-patient interaction, but we do not know how these change in response to uncertainty, or how structure of care mitigates a doctor's approach.

Through moving the discussion into an organizational