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Measuring shared decision making processes in psychiatry: Skills versus patient satisfaction

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Abstract

Objective: To measure to what extent clinicians in a psychiatry department involve patients in decision making about treatment choice and to compare these data with patients' satisfaction rates about clinician communication behaviours.
Methods: Communication was analyzed by scoring 61 audio taped consultations with a validated instrument (OPTION). Patients scored satisfaction on the same OPTION behaviours. Eight clinicians were involved, as were 61 patients.
Results: The clinicians scored on average 43 points at overall 'shared decision making', on a scale of 0–100. Clinicians performed well in asking if patients had any questions. They scored low on meta-items about the decision making process: checking the preferred approach of the patient to receive information, or checking the preferred level of involvement in decision making. Satisfaction scores of a group of 29 patients showed no concern about these low scores.
Conclusion: The clinicians in this study did not ask meta questions about participation in decision making. An explanation given was that they intuitively 'feel' if a patient wants to be involved or not. Patients did not express great concern about this. More experiments with clinicians openly checking desired participation levels of patients are needed, in order to learn more about possibilities in meta communication, and possible biases of clinicians.
Practice implications: Our starting point was that clinicians need to become experts in all roles of their profession, as communicator as well as medical expert. Providing mirror information by assessing decision making behaviours will help to improve performance. Clinicians should be able to perform these SDM behaviours, even if patients are not asking for participation. Claims that clinicians do empathically feel if patients are able to involve in decision making, should be checked by scientific experiments.

Keywords: Shared decision making; Patient–physician communication; Professionalism; Patient satisfaction

1. Introduction

Paradigmes about quality of the behaviour and attitude of physicians are shifting [1]. Besides being medical experts, physicians are expected to perform well in other roles, such as communicator, collaborator, reflector, and organizer [2]. Some non-medical skills are learned during medical studies. Mostly however, they are to be learned afterwards. Goals for improvement of communication skills may be: performing bad news meetings, handling aggressive behaviour or communication with patients from different ethnic backgrounds. Patient involvement in treatment decisions is a goal that became more popular the last years [3–9].

From the available models to measure quality of clinical communication, the model of shared decision making (SDM) is a prominent one [10]. In SDM, the clinician is encouraged to explore preferences and values of patients with respect to treatment choice, information provision, and level of participation in decision making. By presenting enough and accurate information about treatment options and by asking if and how the patient wants to participate, clinicians aim for increased patient satisfaction and treatment compliance [3,11]. Some claim that even clinical outcomes will improve by higher SDM levels [12]. Improvements are also expected for clinicians: those using a patient-oriented communication style report more satisfaction and less work-related stress [13].

Not everyone is positive. De Haes described that shared decision making is not applicable in all clinical situations: equipoise seems a condition for success [14]. Neither do all patients feel comfortable about having a choice: patients with

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less education, a worse prognosis or a higher level of anxiety, may be likely to have less pronounced preference for involvement [11,15,16]. The consequence is that performing shared decision making skills will not be appropriate in all circumstances. Communication about the communication process itself becomes more important then: to what extent does this patient want to be involved at this moment? What are the values of this patient about involvement and about receiving information? And to what extent can these questions be asked explicitly, or is an intuitive judgement by the clinician more appropriate?

To find out more about this checking of values on involvement of patients in psychiatry we performed a study in which quality of shared decision making skills are assessed. This study addresses the question if an instrument developed to measure shared decision making skills in general practice can be used in psychiatry as well. Untill now no studies on shared decision making with the OPTION instrument were found in the field of psychiatry.The skill performance data are contrasted with patients' satisfaction on involvement.

2. Methods

2.1. Participants

In order to assess the shared decision making behaviours of clinicians, 61 consultation meetings between 8 clinicians and their patients were recorded on audiotape. All psychiatrists in education of this department were involved. They were not instructed about the topic of the training and not trained in shared decision making. They met a convenience sample of 61 patients, who attended the outpatient psychiatry clinic of the academic ErasmusMC Hospital. All patients visiting for intake were approached during 12 months. When a clinician recorded eight meetings, we stopped collecting data. Patients received a letter before the meeting, asking for informed consent. In all meetings decisions about treatment were made. Patients with acure symptoms, with brain damage, and with severe language problems were not approached. Of the 65 patients that were approached, 4 refused.

2.2. The instruments

The communication skills of the clinicians were scored with the Observing Patient Involvement in Treatment Choices instrument (OPTION)[17]. Although the developers claim the instrument describes 'shared decision making', a better description would have been 'patient involvement in decision making', since patient behaviours are not measured. The OPTION scale measures observable skills and aims to achieve an overall 'involvement' scale at clinician level, provided there are at least five consultations available at clinician level. A weakness of the instrument is that it only describes clinician behaviours. In the situation that a patient is very actively asking and participating in decision making, the OPTION score may appear to be low, while a high level of sheared decision making was reached. A strength of the instrument is that it gives not only an indication of the quality of involvement skills of clinicians, but also provides clear indications for improvement of the skills (see Box 1).

A trained researcher scored behaviours as described in Box 1. The researcher scored behaviours as follows: 0 = the behaviour is not observed; 1 = a minimal attempt is made to exhibit the behaviour; 2 = the behaviour is observed and a minimum skill level achieved; 3 = the behaviour is exhibited to a good standard; 4 = the behaviour is exhibited to a very high standard. A total OPTION score could be accounted at a range of 0–100. Data was analyzed at overall score and at item level.

The researcher was trained by an instruction manual and video. She scored several test consultations and compared results. No second researcher scored the material and therefore no inter-rater reliability could be performed.

To measure patients' satisfaction about communication, a questionnaire was given at the end of the meeting with the same items (Box 1). In the satisfaction questionnaire scores were presented in a Likert format, from 0 (very unsatisfied), 1 (not satisfied), 2 (neutral), 3 (satisfied) and 4 (very satisfied).

2.3. Data analysis

Data was analyzed with SPSS, Version 13. We used *T*-test, one-way ANOVA and Bonferroni test for statistical testing. Significance level of 0.05 was used. For psychometric analysis of the scale we used Reliability statistics and for the factor analysis we used the Varimax method with Kaiser Normalization.

3. Results

3.1. Characteristics of study sample and meetings

The average age of clinicians was 31 years. Four of the eight clinicians were males.

Box 1. Items on the OPTION instrument

1. The clinician draws attention to an identified problem.
2. The clinician states that there is more than one way to deal with the identified problem.
3. The clinician assesses the patient's preferred approach to receiving information.
4. The clinician lists options.
5. The clinician explains the pros and cons.
6. The clinician explores the patient's expectations.
7. The clinician explores the patient's concerns.
8. The clinician checks that the patient has understood the information.
9. The clinician offers the patient explicit opportunities to ask questions.
10. The clinician elicits the patient's preferred level of involvement.
11. The clinician indicates the need for a decision making (or deferring) stage.
12. The clinician indicates the need to review the decision (or deferment).