



Medical Decision Making

Temporal characteristics of decisions in hospital encounters: A threshold for shared decision making? A qualitative study

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ABSTRACT

Objective: To identify and characterize physicians' statements that contained evidence of clinically relevant decisions in encounters with patients in different hospital settings.**Methods:** Qualitative analysis of 50 videotaped encounters from wards, the emergency room (ER) and outpatient clinics in a department of internal medicine at a Norwegian university hospital.**Results:** Clinical decisions could be grouped in a temporal order: decisions which had already been made, and were brought into the encounter by the physician (performed decisions), decisions made in the present (here-and-now decisions), and decisions prescribing future actions given a certain course of events (conditional decisions). Performed decisions were a hallmark in the ward and conditional decisions a main feature of ER encounters.**Conclusion:** Clinical decisions related to a patient–physician encounter spanned a time frame exceeding the duration of the encounter. While a distribution of decisions over time and space fosters sharing and dilution of responsibility between providers, it makes the decision making process hard to access for patients.**Practice implications:** In order to plan when and how to involve patients in decisions, physicians need increased awareness of when clinical decisions are made, who usually makes them, and who should make them.

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1. Introduction

Patient-centered care has been promoted for decades [1–4]. One of its prime requisites is the involvement of patients in medical decisions, a principle built on an ethical imperative [5,6].

Change has come about slowly [7,8] and one of the major barriers to patient involvement in decisions is the inherent asymmetry of the patient–physician relationship [9–11]. Nowhere is this asymmetry greater than in hospitals, where patients are more seriously ill, and physicians are part of a complex, hierarchical, and technically diversified culture. Hospitals are also the cradle of basic physician training and socialization. We hypothesized that scrutiny of patient–physician encounters in

hospitals could provide insight into the conditions under which physicians adopt and practice their skills in clinical reasoning and patient communication, hopefully illuminating why shared decision making still has not covered much ground.

Attempts to strengthen patients' active involvement in medical decisions has been studied and promoted with two conceptually different approaches. Informed decision making (IDM) [12,13] has evolved within bioethics as an attempt to improve on informed consent. Shared decision making (SDM) [14–18], developed largely in general practice, aims to support patients in deliberation and determination around decisions entailing equipoise. With almost no exceptions, research on SDM and IDM targets single decisions related to a specified, predetermined topic [19–22], focusing on difficult decisions with two or more options, where medical evidence provides no clear guidance. However, most clinical encounters deal with several problems and produce several decisions, as illustrated by the work of Braddock et al. They defined a decision as “a verbal statement committing to a

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particular course of action” [12]. In two separate outpatient studies using this definition, an average of more than three decisions per encounter was found [12,13], concerning prescriptions, diagnostic tests, referrals and instructions regarding diet and physical activity. While the Braddock definition is broad, it still omits decisions that govern the subsequent courses of action, such as evaluations of findings and tests, and interpretations concerning diagnosis, prognosis and etiology.

Deber has made a distinction between “problem solving” – the physician’s search for a single “correct” solution, and “decision making” – the choice of one among several alternatives [23]. Yet medical “problem solving” often involves “decision making” on the path to a conclusion. Contrary to what we might wish, diagnostic conclusions seldom reveal themselves [24]. Most of the time, these processes present options that require decision making and leave room for interpretation because of medical and contextual complexity [25]. In confronting the uncertainties of diagnostics and treatment, the term “decision” tends to be used restrictively for situations where it is possible to calculate the probabilities of outcomes [26–29]. A more inclusive approach [30] could shed light on the range of decisions that are made in relation to patient–physician encounters. An increased understanding of the full decisional content of clinical encounters may inform a discussion about when and how patients should be involved in decision making.

In health care institutions, many clinical decisions involve input and reflection from several professionals in deliberative processes where patients are not present [31–33]. While such processes are commonplace in hospitals, the only studies on the nature and frequency of decisions in medical encounters originate from primary care or outpatient clinics [12,13,34]. The aim of this inductive study was to identify and characterize all clinically relevant decisions that emerged when physicians interacted with patients in different hospital settings. Halfway through the process, which initially focused on the definition and topical characteristics of decisions, a temporal aspect of clinical decisions emerged. In this paper we describe the details of this temporal dimension and discuss its implications on SDM.

2. Methods

We used an exploratory qualitative approach to identify and characterize decisions in videotaped hospital encounters.

2.1. Study participants

This is a secondary analysis of 50 of 130 available videotapes from the Department of Internal Medicine in a Norwegian general teaching hospital. The tapes were collected and primarily analyzed as part of a randomized controlled trial to evaluate the effects of a 20-h communication skills course [35] and included 95 outpatient, 25 ward round and 10 emergency room (ER) encounters. The average duration was 26 min (SD 16).

The first 30 videotapes used in the analysis were randomly selected. The last 20 videos were selected in clusters of five, ensuring variation in physician and patient age and sex, clinical subspecialties and hospital settings.

The videos were available following broad consent from participating physicians and patients to use the tapes for further studies of their encounters. Our study was approved by the Regional Ethics Committee for Medical Research of South-East Norway. Participating physicians were a random sample of all eligible physicians under 60 years of age working in the department. Patients were recruited consecutively on the days the physicians were available, and 94% agreed to have their encounter filmed [36]. The physician was a consultant in 52% and a

resident in 48%, a male in 61% and a female in 39% of the encounters. 55% of the patients were male, 45% female. Patients were on average 55 years old (SD 19), physicians 41 (SD 9).

2.2. Study group and preconceptions

In order to identify and characterize medical decisions, we brought together an expert group to assess the videotaped consultations. The research group consisted of a resident internist/research fellow (EHO), a neurologist/professor (JCF), a general practitioner/professor (ES) and a professor of health services research/previously a general practitioner and a public health officer (PG). Being physicians, the study group members were capable of analyzing the medical content of the material, the constraints of the health care system, the pros and cons of diagnostic tools and therapeutic interventions, and the language and ethos of clinical medicine.

Critical awareness of the potential biases generated by the shared medical perspective [37] was a continuous focus of attention as we immersed ourselves in observation, reflections and classifications of the material. To contrast the medical perspective, we included a social psychologist/communication specialist (RMF) in the analytic phase of the study.

2.3. Analysis

We used two of Miller and Crabtree’s three prototypical qualitative strategies in our analysis [38], starting with immersion/crystallization. The two fundamental questions describing the method’s core process coincide with our research questions (in brackets);

- What are the content and constituent elements (of clinically relevant decisions)?
- When does it (a clinically relevant decision) begin?

Our immersion process began in 2010. We independently watched videos from the three different clinical contexts and transcribed events resembling decisions. Findings were brought to the group for discussion. Subsequently, each analyst returned to the material, in an iterative fashion during the course of seven group meetings. The group had extensive discussions about where to set the threshold for claiming that an observed statement or action signified a decision. This discussion included the communicative function of statements, e.g. the physician interrupting the patient, the physician complementing the patient’s haircut or the physician comforting the patient. Such broadening of the discussion gave us a wide scope of statements to consider and was crucial to the process of narrowing in on a definition of clinically relevant decisions.

In addition to the Braddock definition of “particular courses of action”, our definition included statements that carried meaning and weight because they were made by the responsible physician. In order to be defined as decisions, physician statements had to be clinically relevant (“I will prescribe some pills that will lower your blood pressure” versus “We will order you a taxi”) and had to be about the particular patient; not a sharing of medical knowledge in general (“I think you got cancer due to smoking” versus “A lot of people get cancer due to smoking”). We defined a clinically relevant decision as; “a verbal statement committing to a particular course of clinically relevant action and/or statement concerning the patient’s health that carries meaning and weight because it is stated by a medical expert”.

Halfway through the process the transcribed events of the first 30 encounters were sorted and categorized using an editing analysis style [38]. These 242 transcribed statements were

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