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Research Paper

Eliciting patient preferences in shared decision-making (SDM): Comparing conversation analysis and SDM measurements

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ABSTRACT

Objective: To explore how physicians bring up patient preferences, and how it aligns with assessments of shared decision-making.
Methods: Qualitative conversation analysis of physicians formulating hypotheses about the patient's treatment preference was compared with quantitative scores on SDM and 'patient preferences' using OPTION(5) and MAPPIN'SDM.
Results: Physicians occasionally formulate hypotheses about patients' preferences and then present a treatment option on the basis of that ("if you think X + we can do Y"). This practice may promote SDM in that the decisions are treated as contingent on patient preferences. However, the way these hypotheses are formulated, simultaneously constrains the patient's freedom of choice and exerts a pressure to accept the physician's recommendation. These opposing effects may in part explain cases where different assessment instruments yield large variations in SDM measures.
Conclusion: Eliciting patient preferences is a complex phenomenon that can be difficult to reduce into an accurate number. Detailed analysis can shed light on *how* patient preferences are elicited, and its consequences for patient involvement. Comparing CA and SDM measurements can contribute to specifying communicative actions that SDM scores are based on.
Practice implications: Our findings have implications for SDM communication skills training and further development of SDM measurements.

1. Introduction

Modern medicine is under increasing influence by the public and ethical imperative for shared decision-making (SDM) [1,2]. In Norway, legislation mandates patients' "right to participate in choosing between available and medically sound methods of examination and treatment" [3]. However, in practice, SDM has shown to be a complex concept to define, implement, and assess [4–6], and a recent review concludes that a "major gap in knowledge is whether and how shared decision making works" [7].

Recently, a small body of conversation analytic studies has started to empirically specify how patient involvement and SDM actually play out in authentic encounters; For instance, how patients are offered choice [8–10] and how patient preferences are dealt with [11,12]. Our study develops this line of research further, by comparing conversation analysis (CA) with SDM measurements of the same data.

This study identifies and explores a conditional construction, a variant of 'hypothetical questions' [13], by which physicians formulate a hypothesis about the patient's preference and then present a treatment option on the basis of that, taking the following basic form: "if you think X + we/you can do Y". By preference we refer to patients' view or stance on the desirability of some particular treatment or examination option. These hypothetical constructions make claims about the recipient's epistemic domain, and such statements are shown to elicit (dis)confirmation from the recipient in response (so-called 'statements about B-events') [14–16]. Thus, making claims about others' inner views and thoughts is a well-documented resource for eliciting this,

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which, as in this case, can be one way of eliciting patients' treatment pReferences

The aim of this study is: (1) to describe how physicians formulate hypothetical patient preferences and the interactional consequences of this practice for patient involvement in decision-making, (2) compare qualitative analysis of this practice with quantitative assessments of the item 'patient preferences' and overall mean scores from two SDM measurements, and (3) discuss how this practice aligns with guidelines and objectives of the SDM component 'patient preferences'.

2. Methods

2.1. Material and selection of data for the present study

147 video-recorded encounters from various non-psychiatric settings in a Norwegian Teaching Hospital, drawn from a larger dataset of 380 encounters [17], have been reviewed by the first two authors in relation with previous studies [18,19]. The 147 encounters constitute a strategic, inductive sample aimed to include cases from disciplines in which patient participation seemed to be more prevalent. Decision-making sequences in 27 encounters, in which patients were actively involved, were identified and analyzed in detail [18]. The physicians in some of the encounters were trained in patient-centered communication skills, but not in SDM specifically. In a recent study [6], the same 27 encounters were part of a material coded with two validated SDM instruments, namely Option(5) [20] and MAPPIN'SDM [21].

2.2. Methods

The qualitative analysis adopts a conversation analytic (CA) methodology [22], whereby instances of recurring interactional practices are collected and analyzed in depth in order to uncover the participants' underlying norms and conventions for accomplishing the practice in question.

All instances where physicians elicited patients' stances towards treatment have been identified. Only a few instances involved open inquiries into what the patients preferred. In the majority of cases, the physicians instead presented claims about the patients' preferences for the patients to confirm or reject [12,15]. One type of these claims is the formulation of a hypothesis about the patients' preference. More than 20 instances have been identified in 13 of the 27 encounters. In this article, four typical examples from three encounters will be presented.

Aiming to compare the CA with quantitative measures of SDM and patient preference elicitation, we assessed MAPPIN'SDM and OPTION(5) codings of our material from a prior study [6]. Both measures aim to quantify the level of shared decision-making from an observer's perspective, but as Table 1 indicates, the differences between the measures are substantial [6]. While OPTION(5) consist of five items assessing observed physician behavior, MAPPIN'SDM consist of nine items assessing SDM from three perspectives: observed physician and patient behavior and the patient-physician dyad. Both MAPPIN'SDM and OPTION(5) grade items from 0 ("no effort is made") to '4' ("exemplary effort"), which are calculated into percentage scores (4 = 100%, 3 = 75%, 2 = 50%,

Table 1
OPTION(5) and MAPPIN'SDM item by item (items shaded with grey corresponds to such an extent that comparison is meaningful).

OPTION(5)	MAPPIN'SDM
No equivalent	**Item 1:** defining the problem
No equivalent	**Item 2:** key message
Item 1: Stating that options exist	No equivalent
Item 2: Promising support to patient	No equivalent
No equivalent	**Item 3a:** Options (structure)
Item 3: Information about options	**Item 3b:** Options (content)
	Item 8: Evaluating patient's understanding
No equivalent	**Item 3c:** Options (information quality)
Item 4: Eliciting preferences	**Item 4:** Expectations & worries
No equivalent	**Item 5:** Indicate decision
No equivalent	**Item 6:** Follow up arrangements
Item 5: Integrating preferences	No equivalent
No equivalent	**Item 7:** Negotiating communication approach
No equivalent	**Item 9:** Evaluating doctor's understanding
Option(5) mean score	**MAPPIN'SDM$_{dyad}$ mean score**

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