



Confusion in and about shared decision making in hospital outpatient encounters



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ABSTRACT

Objective: To explore how physician efforts to involve patients in medical decisions align with established core elements of shared decision making (SDM).

Methods: Detailed video analysis of two hospital outpatient encounters, selected because the physicians exhibited much effort to involve the patients in decision making, and because the final decisions were not what the physicians had initially recommended. The analysis was supplied by physician, patient, and observer-rated data from a total of 497 encounters collected during the same original study. The observer-rated data confirmed that these physicians demonstrated above average patient-centred skills in this material.

Results: Behaviours of these two not trained physicians demonstrated confusion about how to perform SDM. Information provided to the patients was imprecise and ambiguous. Insufficient patient involvement did not prompt the physicians to change strategy. Physician and patient reports indicated awareness of suboptimal communication.

Conclusion: Inadequate SDM in hospital encounters may introduce confusion. Quantitative evaluations by patients and observers may reflect much effort rather than process quality.

Practice implications: SDM may be discredited because the medical community has not acquired the necessary skills to perform it, even if it is ethically and legally mandated. Training and supervision should follow regulations and guidelines.

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1. Introduction

Patient-centred medicine [1] has emerged over the last four decades and has gained widespread popularity. Founded on an ethical imperative [2], and consonant with the demands of an increasingly informed population [3], it now represents the dominating principle underlying medical communication curricula in Western societies [4]. One important feature of patient-centred medicine is the involvement of patients in decisions about treatment (shared decision making (SDM)) [5–10]. Patient-centred medicine and SDM have been embraced politically [11], and in Norway, the Law on patients' rights mandates these principles [12].

There is no shared definition of SDM [7]. Recently, Elwyn et al. developed a simplified description with a sequential structure; (1) justification of the discussion and team-building, (2) information about alternatives and options, (3) elicitation of patient preferences, and (4) integration to form a shared decision [10,13]. Clayman et al. have provided a similar scheme for coding SDM with a more detailed structure [14]. This work recognizes the difficulty of coding systems to reflect the complexity of SDM, particularly where several decisions are made and not often in a clear order.

Several authors have discussed dilemmas and challenges in SDM [15–17]. The sociologist Per Måseide, while acknowledging that the physicians' power in the asymmetrical relationship to the patient can represent a problem, argues that this power is also necessary and constitutive for adequate medical practice [18]. Furthermore, even under optimal circumstances, patients will be less informed than the physician. Their consequent reliance on the physician's advice and recommendations displays trust in the physician's competence and benevolence [19]. Medical competence includes balancing the powers and risks of treatment.

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According to Grimen [20], SDM may disrupt this strong connection between power, trust, and risk, creating uncertainty [21]. Such considerations, and the ample evidence showing SDM is not widespread in medical practice, have led critics to question the principle [22].

Patients' opinions about SDM differ individually, somewhat but not fully explained by factors such as cognitive abilities, health literacy, the complexity of the decision, or frailty [16,23,24]. In hospitals, where patients are more seriously ill, they may feel the additional effect of institutional power [24], which also influences staff physicians reducing their freedom to shift from paternalistic to patient-centred medicine [18].

The principle of SDM is regulated by law in Norway and must be implemented in hospitals; however, it is fairly new to medical practice and may challenge the traditional physician-patient relationship. Thus there is a need to study how SDM works in practice. We aimed to explore SDM in real hospital outpatient encounters in order to understand how efforts of patient involvement in medical decisions align with recent descriptions of SDM elements.

2. Methods

2.1. Material

We present a detailed analysis of two videotaped encounters in a dataset comprising patient and physician self-completed questionnaire data from 497 videotaped encounters involving 71 physicians, made in non-psychiatric settings in a large teaching hospital in Norway in 2007–2008 [25]. In addition, we had observer ratings from all encounters. The physicians in these encounters had not been trained in SDM.

Patients reported global satisfaction [26], description of the physician's communication and information behaviour [27], and their affect before and after the encounter [28]. Physicians reported their evaluation of the encounter and their liking of the patient [29]. Experienced psychology students trained for 18 h, rated the videotapes using the Four Habits Coding Scheme [30,31]. This coding scheme includes some SDM elements, but is designed to measure patient-centred behaviour more generally.

2.2. Analytic approach

The analysis presented here forms part of a large research programme on physician-patient encounters in specialist health-care, with focus on information exchange and how decisions are made. We have scrutinized 250 videotapes for any kind of clinical decisions, and have developed a classification system for decisions [32] using qualitative analysis according to Miller and Crabtree [33]. Also, in a study aimed to describe negotiations about treatment with conversation analytic principles [34], we have scanned 140 videotapes for active attempts from the physicians to involve patients in decisions. On request from the first author, the three coauthors, who were blinded to observer, physician, and patient reported data, provided a selection of cases where (1) the physicians exhibited much effort to involve the patient and (2) the final decision differed from the physician's primary recommendation. Such combinations were rare and hence easy to identify, the selection was made independently by the coauthors from their detailed knowledge of the material. We expected these encounters to be potentially fruitful for understanding successful shared decision making. For detailed analysis, we selected two encounters that all four authors agreed represented clearly much effort to involve the patient, and they were transcribed according to conversation analytic conventions [35] (see the Appendix A). Norwegian transcripts are available on request.

The authors represent three different fields of knowledge; linguistics and conversation analysis (AML), psychology and microanalysis of communication (JJG), and medicine and medical decision making (EHO, PG). The analysis is a joint interpretation of the selected videotapes. Consensus was reached without any major disagreement.

3. Results

3.1. Case no. 1—Surgery or tablets?

Case no. 1 is an 81-year-old man who had minor prostate surgery nine and two years ago, now visiting a urologist. The patient and physician do not know each other. The urologist greets the patient and his partner warmly and mentions the referral letter. He takes the history quickly, mostly by listening. Following the examination, the urologist, now sitting, initiates the discussion about treatment before the patient has sat down:

(Excerpt 1-1)

5.25 D: ((sits down)) ye:s, (0.6) there is much prostate left to: (1.8)

5.29 P: remove?

5.30 D: remove if one wants that. ((patient walking towards his chair))

(0.5)

5.32 D: and that is what maybe (.) I rather would recommend that we operate you once more.

(2.5) ((patient sits down))

5.39 D: what do you s:ay about that?

(0.8)

5.41 P: yeah wHa::t what happens?

(1.0)

5.44 D: nt.h well, either we can operate on you? e:m like through the urinary tract like we did the last time? ((urologist's beeper makes a sound)), or e:: ((urologist picks up beeper and looks at it while he continues)) one could try with some t- ((voice from beeper)) with some tablets. (0.4) that's also possible.

(0.5) ((urologist touches beeper))

5.57 P: yea.h,

(1.0) ((urologist puts beeper back in pocket))

5.58 D: I don't know how yo:u look at it.

(2.5) ((the patient who has put his hand in his right pocket while the urologist spoke, picks up what seems to be a pack of tablets and gives it to his partner, the urologist gazes briefly at the handover))

6.02 P: put this in your bag.

(0.5)

6.04 D: do you use e:: much nitroglycerin, then ((turn continues))

The urologist's pause after the words *left to* (5.25) allows the patient to collaboratively complete the utterance with a required verb [36]. Then, in less than 10 s (5.30) the urologist (a) shows there are alternatives and that the patient has a say (*if one wants*), (b) gives a mitigated (*maybe, rather*) recommendation, and c) asks for the patient's opinion. The patient reacts with hesitation, and a question signalling uncertainty (5.41). This leads the urologist to explain the surgical procedure and link it to previous experiences of the patient, to mention the alternative, and to reformulate an invitation (5.58). The urologist does not pursue the patient's lacking response and continues instead to take a cardiac history. The patient says he had a successful coronary angioplasty last year and the urologist reformulates his question:

(Excerpt 1-2)

6.21 D: but for the urination are you so bothered that you:: would let yourself be operated if that's possible? or (0.8) or what-or else there are drugs that we could [try:?]

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