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Research Paper

Is patient behavior during consultation associated with shared decision-making? A study of patients' questions, cues and concerns in relation to observed shared decision-making in a cancer outpatient clinic

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ABSTRACT

Objectives: To explore how cancer patients actively participate in consultations by asking questions and expressing emotional cues/concerns and to what extent this is associated with physician shared decision making (SDM) behavior.
Methods: This observational study included audio recordings of 31 primary consultation with patients at the Oncology Outpatient Clinic at the University Hospital of North Norway. The content (topics) and frequency of health related questions from patients/caregivers were registered along with emotional cues and concerns (VR-CoDES) and observed shared decision-making (OPTION). Patient reported outcomes were measured before and one week after the consultation.
Results: On average, 17 (SD 15) questions were asked, and 1.9 (SD 1.9) emotional cues and concerns were expressed by patients per consultation. The questions mainly pertained to treatment and practical issues. The mean OPTION score was 12 (SD 7.9) and was neither associated with questions nor emotional cues and concerns from patients.
Conclusion: Although patients were active by asking questions, observed physician SDM behavior measured by OPTION was low and not associated with patient **behavior** during consultation.
Practice implications: Further research on patients' influence on physician SDM behavior is needed.
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1. Introduction

Patient centered care is widely acknowledged as a central element of high-quality health care [1] and effective physician-patient communication is associated with improved health outcomes like reduced levels of anxiety [2,3]. Norwegian health care legislation has guaranteed patients the right to receive information and to be involved in decisions regarding their own health [4]. One of the assumptions underlying shared decision making (SDM) is that the provided information must be comprehensible and adapted to the individual patient [5]. Asking questions is an effective way for patients to receive information customized to meet their needs.

In a UK study of 2331 cancer patients, the majority preferred to have as much information as possible, both the good and the bad [6]. Patients' highest information need has been found to be in the time period close to when receiving the diagnosis [7]. Hagerty et al. reported that 98% of patients wanted their doctor to be realistic, provide opportunities to ask questions, and acknowledge them as individuals when discussing prognosis [8]. There is also evidence of today's patients being more active participants in the medical encounter when it comes to asking questions [9].

The frequency of questions asked by patients varies across cultures and settings [10–12]. Whether or not the individual patient raise questions during their consultations with the physician also depends on a complex interplay between individual factors of the patient and the physician, as well as the context of the consultation. Previous research has found question asking associated with patient**s'** educational level [13] and level of anxiety [10]. Supportive talk and a partnership-building

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communication style by the doctor may facilitate patient involvement, as well as patients expressions of worries and concerns.

Cancer patients may experience emotional distress during the entire course of treatment [14–18]. Worries may be expressed explicitly as questions or concerns, but also implicitly as hints or cues [19]. Physicians' recognition of patients distress may reduce anxiety and increase satisfaction [20]. However, doctors tend to be less responsive to patients' emotions than to their informational needs [19].

SDM has been defined by Charles et al. as a set of principles, involving at least the clinician and patient [21]: Both parties share information, both parties take steps to build a consensus about the preferred treatment and an agreement is reached on the treatment to implement. No gold standard exists for objectively measuring SDM. There is evidence that patients asking targeted questions can influence physician behavior towards more SDM [22]. To our knowledge, no previous study has explored patient's natural verbal behavior in the form of question asking and expression of cues and concerns in relation to observed SDM. However, it can be assumed that there might be a relationship between patients being active participant**s** in the consultation and the level of physician SDM behavior. The purpose of this study was to examine how Norwegian cancer patients actively participate in consultations by asking questions and expressing cues and concerns and what patient characteristics determine this behavior. Furthermore, to explore to what extent this behavior is associated with SDM. We hypothesized that more active patients (asking questions and expressing cues and concerns) were more involved in SDM than less active patients.

2. Method

This study was part of a project exploring the effect of communication aids on question asking, SDM and patient reported outcomes (anxiety/depression/quality of life) and includes data from the control group.

2.1. Sample

Physicians and patients were recruited from the Cancer Outpatient Clinic at the University Hospital of North Norway (UNN). This outpatient clinic receives patients with various cancer diagnos**e**s from the three northernmost counties in Norway, admitted for assessment of oncological treatment (chemotherapy, radiotherapy etc.).

2.1.1. Physicians

Physicians at the Oncology Department at UNN receive a minimum of one year of clinical training before seeing newly admitted patients at the Outpatient Clinic. Physicians who fulfilled this requirement were invited to participate and written informed consent was obtained. Physicians involved in the design and implementation of the research project were excluded (four senior physicians).

2.1.2. Patients

We aimed to have 30 participating patients. Newly admitted patients were recruited from the participating physicians' outpatient lists in the period from April to June 2014. Eligibility criteria included: Age 18 to 75, Norwegian speaking, and able to complete questionnaires.

Author AA identified patients, and eligible patients received a written invitation approximately one week prior to their appointment. Those who agreed to participate when phoned by the study nurse, met with her before the consultation to sign a written informed consent and complete the pre-consultation questionnaire. The subsequent consultation with the physician was audio recorded. One week after the consultation, the patient received the post-consultation questionnaire by mail.

2.2. Analysis of audio records of consultation

The audio files were transcribed verbatim and the following elements were coded from the transcripts: Questions from patient/caregiver, emotional cues and concerns expressed by the patients along with physicians' responses and to what extent physician SDM behavior occurred. Coding was performed by two psychology students.

2.2.1. Questions from patients/caregiver

A manual was developed to ensure coding agreement. Patient and caregivers questions were coded into 14 categories.

Table 1 displays the 14 categories of topics questions were coded into.

One of the two coders coded questions in each consultation. Physicians' invitation to ask questions was coded as either absent, basic or extended, and whether it happened in the first/middle/last part of the consultation. Basic endorsement was coded when the physician asked if the patient had any questions. Extended endorsement was coded when the physician additionally emphasized the importance of asking questions.

2.2.2. Emotional cues and concerns

Patients' emotional cues and concerns, and physicians' responses were coded from the transcripts according to the Verona coding definition of emotional sequences (VR-CoDES) [23] and provider response (VR-CoDES-P) [24]. Author KL coded the transcripts after completing training with training material provided at the International Association for Communication in Healthcares' website (www.each.eu). Training was supervised by a member of the group of developers of the VRCoDES (SB). Coding of each exercise was successively discussed with the supervisor until the coding was in accordance with the recommended values in the training material. During the coding process, the coder and supervisor met regularly and reviewed the coding and discussed cases of uncertainties.

Due to the limited sample of consultations and the relatively low frequency of emotional cues and concerns, the subtypes of cues were not coded (only the frequency of events). In the carefully monitored coding process, the majority of consultations were based on a coder and supervisor consensus, and inter rater reliability was considered not applicable.

2.2.3. SDM

The OPTION scale measures to what extent physicians involves patients in SDM [25]. The scale includes 12 items evaluating

Table 1
Displays the 14 coding categories questions were coded into.

1.	When and how to ask questions
2.	Diagnosis
3.	Tests
4.	Prognosis
5.	Optimal care
6.	Multidisciplinary team
7.	Treatment options
8.	Treatment
9.	Costs
10.	Sources of information
11.	Relatives
12.	Life style
13.	Practical
14.	Other

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