

Asma Keshtgar, *^{1,2} Susan J. Cunningham,^{1,2} Elinor Jones³ and Fiona S. Ryan,^{1,2}

1 Orthodontics, UCL Eastman Dental Institute, Rockefeller Building, 21 University Street, London, WC1E 6DE, UK

2 Royal National ENT and Eastman Dental Hospitals, University College London Hospitals Foundation Trust, 47–49 Huntley Street, London, WC1E 6DG, UK

3 Statistical Science, University College London, 1-19 Torrington Place, London, WC1E 7HB, UK.

*Correspondence to: Asma Keshtgar, Email address: asma.keshtgar@nhs.net

Abstract

Objectives: To investigate and compare the extent of shared decision making (SDM) in orthodontics from the perspective of patients, clinicians and independent observers.

Design: A cross-sectional, observational study.

Setting: NHS teaching hospital.

Participants: A total of 31 adult patients and their treating clinicians were included in the study.

Methods: The extent of SDM in new patient orthodontic consultations was measured using three versions of a validated instrument: the self-administered patient dyadic-OPTION scale; the self-administered clinician dyadic-OPTION scale; and an independent observer-rated OPTION¹² scale. Patients and clinicians completed the 12-item dyadic-OPTION questionnaire independently at the end of the consultation to rate their perceived levels of SDM. The consultations were also audio-recorded and two calibrated raters independently rated the extent of SDM in these consultations using the OPTION¹² scale.

Results: There was excellent inter-rater reliability between the two independent raters using the OPTION¹² scale (intraclass correlation coefficient (ICC) = 0.909). The mean patient, clinician and independent observer OPTION scores for SDM were 90.4% (SD 9.1%, range 70.8% to 100%), 76.2% (SD 8.95%, range 62.5% to 95.8%) and 42.6% (SD 17.4%, range 13.5% to 68.8%), respectively. There was no significant correlation between the OPTION scores for the three groups (ICC = -0.323).

Conclusions: The results showed that generally high levels of SDM were perceived by patients and clinicians but lower levels of SDM were scored by the independent observers. However, it could be argued that the patient's perception of SDM is the most important measure as it is their care that is affected by their involvement.

Keywords Shared decision making, SDM, patient-centred care, OPTION scale, OPTION¹², dyadic-OPTION

Introduction

Shared decision making (SDM) is a fundamental aspect of high-quality care and can be defined as ‘*a collaborative process through which a clinician supports a patient to reach a decision about their treatment*’ (Department of Health, 2008; NHS England, 2019). The process of SDM relies on the healthcare professional being an expert in presenting the treatment options in terms of effectiveness, risks, and benefits, whilst the patient is an expert in their own values and preferences (Coulter, 2010). As SDM may be more applicable to long term decisions which are deemed less paternalistic than acute decisions relating to healthcare (Joosten et al., 2008), it is highly relevant to orthodontics as elective and long-term decisions are often made.

Major benefits of SDM to patients include more informed decisions being made, improved patient outcomes, better quality of life and respect for the patient’s preferred level of involvement (Légaré et al., 2010; Wilson et al., 2010; Joseph-Williams et al., 2017). Benefits to clinicians include improved efficiency of care, reduced litigation, and better patient adherence to healthcare regimes (Stewart et al., 2000; Légaré et al., 2010; Wilson et al., 2010). Although the main reported barrier to implementing SDM into practice is time pressure (Légaré et al., 2008); interestingly, there is no clear evidence that engagement with SDM is more time consuming than non-SDM care.

Given the benefits of SDM to patient care, SDM is placed as a statutory requirement for healthcare workers in the United Kingdom and is incorporated into legislation and key policy documents, including the Health and Social Care Act and the NHS Constitution (Department of Health, 2012; Department of Health, 2015). Moreover, SDM has established an important presence in healthcare, with dedicated meetings held to improve SDM practices. Action plans identified during the third meeting of the Shared Decision-Making Collaborative included further research and the need to measure and report SDM clearly. Although clinicians are still expected to lead the consultation process, patients should assume a greater role in decision-making, thus empowering patients as they use their personal knowledge to engage in decisions about their own health (National Institute for Health and Care Excellence, 2016).

Not only is the practice of SDM important as part of the delivery of patient care, the measurement of SDM is also key in the commissioning process, clinical improvement strategies, and research (Shared Decision Making Programme, 2012). There are a number of

instruments available to measure SDM, however as this area of research is still relatively new, there is also emergence of new instruments to measure SDM (Scholl et al., 2011; Phillips et al., 2016). While most of the measurement tools are self-report scales which assess the patient's viewpoint on decision making, dyadic tools (i.e., assessed by both the patient and the clinician) and independent observer tools (objectively assessing clinician skills and behaviour by a third party) also exist. Currently, there are no condition or treatment specific measures of SDM.

Despite the existence of a number of scales for measuring SDM, the observer OPTION¹² scale has been reported as the '*most prominent observation instrument*' to measure the extent to which clinicians actively involve patients in SDM (Nicolai et al., 2012). Moreover, the dyadic-OPTION tool was found to be the most promising in measuring essential aspects of patient participation (Phillips et al., 2016). Some studies report that it is more relevant to measure SDM from the patient's perspective, rather than from a clinician or third party perspective, as this is more likely to correlate with patient outcomes, including self-rated health, confidence in the treatment decisions, and satisfaction with care (Stewart et al., 2000; Shay and Lafata, 2015).

In recent years, there has been increased interest in SDM in medicine and dentistry, however relatively little research exists on SDM in orthodontics (Friedlander et al., 2015; Barber, 2019). In particular, a research gap exists in assessing correlations between observed and perceived scores of SDM (Barr et al., 2015). It has been recommended that triangulation of observer measures with patient and clinician reported measures of SDM potentially offers a unique perspective also (Vortel et al., 2016). The current study aims to address this area of knowledge deficit by investigating the extent of SDM in new patient and treatment planning consultations with adult orthodontic patients from the perspective of patients, clinicians, and independent observers.

Materials and methods

This cross-sectional study assessed the extent of SDM in orthodontic new patient and treatment planning consultations with adult patients in a teaching hospital in the UK. The perspective of the patients, clinicians and independent observers was investigated. Ethical approval was granted by the (removed to maintain anonymity, see supplementary file) and Research and Development approval was granted by (removed to maintain anonymity, see

supplementary file). All participants provided written informed consent and the principles of the Declaration of Helsinki were followed.

SDM was measured using three versions of the well tested and validated OPTION instrument: the patient dyadic-OPTION scale, clinician dyadic-OPTION scale (Appendix 1) and OPTION¹² (Appendix 2) scale. These tools have been developed and validated within general medical practice and have been used in studies across medical specialties, to date there are no specific instruments validated for use within an orthodontic setting. Patients and clinicians completed the 12-item dyadic-OPTION questionnaire at the end of the consultation, immediately after patient engagement, to rate the extent of SDM from their individual perspectives. The dyadic-OPTION scale is a 12-item questionnaire which both the patient and treating clinician complete at the end of the consultation to score the perceived level of SDM. Instructions provided to patients and clinicians were those included as part of the questionnaire, the use of this wording is recommended when using the dyadic-OPTION scale to avoid bias. There were no issues highlighted by patients or clinicians in following these instructions.

Whilst performance bias could not be wholly eliminated, this was reduced by only giving clinicians the dyadic-OPTION questionnaire at the end of the consultation to avoid the clinicians reading the scoring criteria before the consultation. The authors acknowledge that risks of performance bias exist for clinicians who had previously used the dyadic-OPTION instrument as they may then have been familiar with the questions and scoring. The OPTION¹² scale requires at least one trained independent observer to score the 12 items on the OPTION scale when assessing a clinical encounter which has been audio or video recorded [insert Table 1.]. As per recommendations on using the OPTION scale, the clinician behaviour in reference to the individual who took the primary role in the consultation process was recorded. The primary adult was always the patient in this study even though some of them were relatively young. Both raters were colleagues of the clinicians included in this study. This could potentially have led to assessment bias. However, both raters were trained and calibrated and rated the consultations using defined pre-determined criteria, thus reducing possible bias.

The 12 items assess behaviours that contribute to SDM, such as whether the patient's concerns have been explored and whether the clinician has ensured that the patient understood the information given. The observer independently scores each item between 0 and 4; a score of 0 indicates that the behaviour described in the item was not observed, whilst a score of 4

indicates the behaviour was exhibited to a very high standard. The total score can therefore range from 0 to 48 and is then converted to a percentage for ease of interpretation. Whilst there are no specific cut off points, low scores indicate poorer SDM and high scores demonstrate high standards of SDM behaviours.

With regards to participant recruitment, the aim was to recruit as many participants as possible in the time frame of the study in order to enhance the generalisability of the results. Data collection was undertaken between 10th October 2019 and 13th March 2020, the data collection period was halted due to the COVID-19 pandemic. Patients were recruited using convenience sampling whereby they were approached by the researcher as they attended either a new patient consultation clinic or a records/consent appointment. Eligible participants included patients aged 16 years of age or older who had not yet consented to, or commenced, orthodontic treatment. Adult patients were investigated as they were making their own treatment decisions, whereas parents often contribute to treatment decisions for adolescent patients. Furthermore, the OPTION¹² scale was originally developed to assess the interaction between the clinician and adult patients (Elwyn et al, 2005). Patients were excluded if they had craniofacial syndromes as the shared decision making process involves a large number of individuals and it would therefore be difficult to choose one clinician to complete the questionnaire and this may affect the overall results. Furthermore, it has been reported that patient experience varies between patients with craniofacial anomalies and those without, and this may have affected the generalisability of the overall results (Singh, 2015). Orthognathic patients were included within the study as there is usually one member of the team who leads the main discussion during the orthognathic consultation and it was therefore feasible to measure the extent of SDM from that clinician's perspective.

The respective orthodontic clinicians of recruited patients were eligible to participate if they consented. New patient and treatment planning consultations were audio-recorded only if both the patient and clinician had consented to participate in the study; the recordings were then rated by two independent calibrated clinicians (an orthodontic specialty registrar and an orthodontic consultant) using the OPTION¹² scale. One rater had previous experience in shared decision making through previous research on this topic and having used the OPITON scale before. Both raters were trained and calibrated by strictly following the calibration process outlined in the OPTION¹² training pack, which involved raters scoring 7 pre-recorded test consultations and comparing scores with the recommended scores (Observing Patient

Involvement in Shared Decision Making, 2005) This training and calibration process was developed and is recommended by the authors of the OPTION scale. During the initial training and calibration of the two raters in using the OPTION¹² scale, it became clear that the scoring criteria for some items in the scale were not directly applicable to the specific nature of orthodontic treatment decision making. Therefore, the two raters agreed a scoring convention specific to the types of encounters commonly occurring in an orthodontic context. This did not involve altering the scoring criteria thus still ensured conservation of the instrument in its original form.

The primary outcome measure was the total OPTION score and the methodology of this study was consistent with other studies using the OPTION scale.

Results

A total of 32 patients and their treating clinicians were recruited. Of the 32 consultations, the quality of one audio recording was not adequate and so was excluded from further analysis. Figure 1 illustrates the recruitment process.

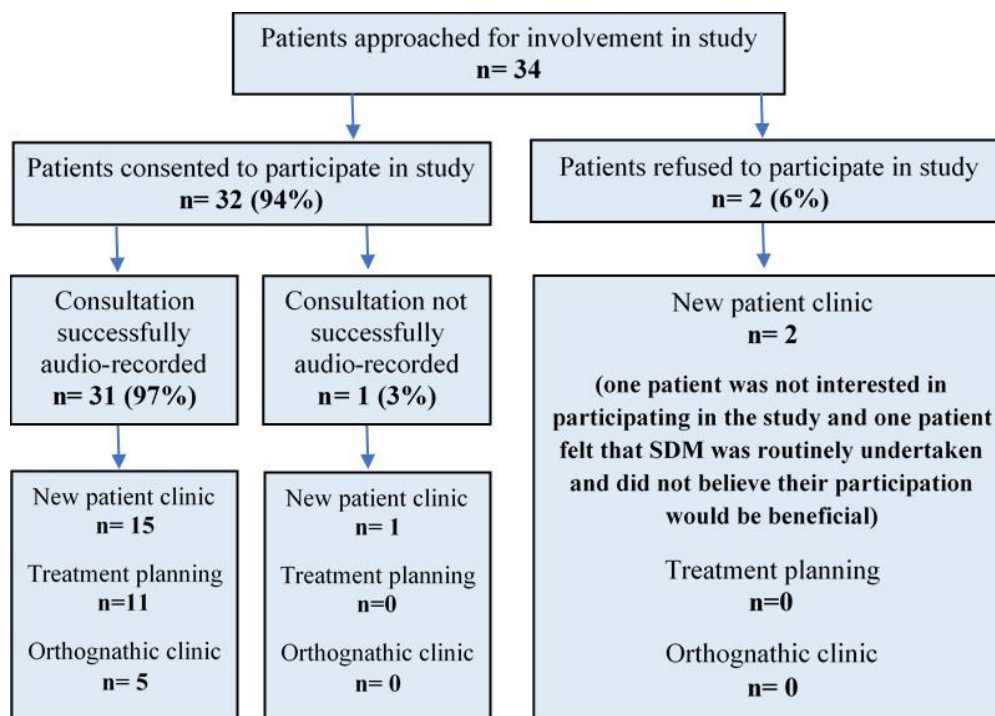


Figure 1. Flow diagram illustrating the patient recruitment process.

Patient and clinician demographics

Of the 31 patients included in the study, 23 were male and 8 were female, the age range was 16 to 40 years (mean age 19.4 years). Of note, 23% of patients presented with a Class I incisor relationship, 32% with Class II/1 and 45% with Class III.

A total of 14 clinicians (10 female and 4 male) participated in the study as some clinicians took part in more than one of the consultations. Of the 31 consultations, 25 were undertaken by a female clinician and 6 by a male. The treating clinicians were of varying grades, with 17 out of 31 consultations undertaken by consultants and 14 by specialty registrars.

OPTION scores of SDM

As recommended in the OPTION¹² training pack, raw SDM scores were converted to a score out of 100 for all three questionnaires to provide a score which is easier to interpret (Table 2) [insert Table 2.].

The mean patient dyadic score for the 31 consultations was 90.4% (SD 9.1, range 70.8% to 100%), which was greater than the mean clinician score of 76.2% (SD 8.95, range 62.5% to 95.8%). The overall mean of the combined OPTION¹² score for the two assessors was considerably lower at 42.6% (SD 17.4, range 13.5% to 68.8%). The inter-rater reliability between the two raters using OPTION¹² was deemed as ‘excellent’ with an Intraclass Correlation Coefficient (ICC) of 0.909, i.e., greater than 0.90 (Koo and Li, 2016). Whilst an ICC is suitable for analysing numeric data, it is assumed to be suitable in this study as the underlying variables were ordinal with numeric labels.

The total patient dyadic scores of SDM for each consultation were greater than the clinician dyadic and OPTION¹² scores, with the exception of four consultations where the clinician dyadic scores were equal to, or greater, than the patient dyadic scores. The OPTION¹² observer scores of SDM were consistently the lowest score in every consultation (Table 2 & Figure 2).

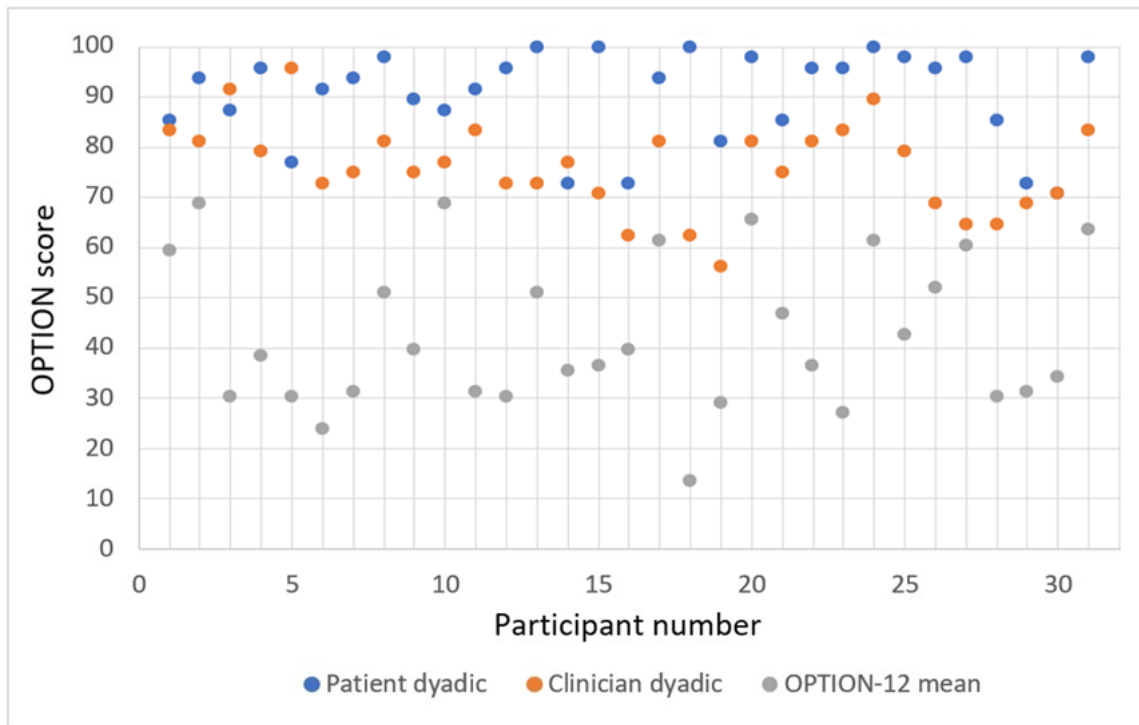


Figure 2. Scatter plot showing patient dyadic, clinician dyadic and OPTION¹² scores for the 31 consultations.

The Intraclass Correlation Coefficient for the patient dyadic, clinician dyadic and OPTION¹² scores was -0.323, a negative ICC is unusual and suggests greater intra-patient variability compared with inter-patient variability. A Spearman’s rank correlation coefficient as presented in Table 3 also showed non-significant low correlations (Chan, 2003) for all comparisons (patient and clinician dyadic: 0.119, patient dyadic and OPTION¹²: 0.279, clinician dyadic and OPTION¹²: 0.255). The positive correlations indicate that one would expect higher dyadic-OPTION scores in cases where higher OPTION¹² scores are given, however the correlation between the scores was low and non-significant [insert Table 3.].

The majority of patients who participated in the study were between 16 and 25 years old and only 3 of the 31 patients were over the age of 25 years. As most patients were in the younger age group, it is not possible to draw definitive conclusions on the relationship between the patient age and perceptions of SDM. There was no statistically significant correlation noted between age and patient dyadic-OPTION score.

Interestingly, there was no statistically significant correlation observed between SDM scores and grade of the clinician and no significant difference between the scores for the two groups [insert Table 4.].

Discussion

Shared decision making in orthodontics

To the best of our knowledge, this study is the first to investigate the extent of SDM with adult orthodontic patients from the viewpoint of patients, clinicians, and independent observers and to triangulate the results. The results showed that patients generally perceived the practice of SDM to be better than clinicians, and both consistently perceived superior SDM than the independent raters.

It is encouraging that patients largely felt that they were being involved in their treatment decisions and based on the patients' perspectives, it could be concluded that SDM is practiced to a high standard in this population. Although there are limited numbers of studies in the literature reporting SDM scores using the dyadic-OPTION scale, a simulated study conducted in general medical practice reported mean scores for SDM using patient dyadic, clinician dyadic and OPTION¹² scores as 81.8%, 70.3% and 53.1% respectively, compared with 90.4%, 76.2% and 42.6% in the current study (Melbourne et al., 2011). The scores were broadly similar to those in this study and differences which exist may have been due to the study by Melbourne and colleagues (2011) being simulated and/or the different specialties of medicine and orthodontics.

As in this study, low levels of SDM have been reported using the observer rated OPTION¹² scale in a number of other studies. Mean OPTION¹² scores ranged from 16% to 30% in other non-simulated studies across many fields of medicine, including primary care, psychiatry, prenatal screening, family medicine and immunotherapy for multiple sclerosis (Elwyn et al., 2003; Goss et al., 2007; Goss et al., 2008; Gagnon et al., 2010; McKinstry et al., 2010; Kasper et al., 2011; Pellerin et al., 2011). The low scores could be because the practice of SDM is not conducted optimally or it may be due to the lack of applicability of the OPTION¹² scale to all areas of healthcare as it was designed initially for general medical practice. For example, item 12 *'The clinician indicates the need to review the decision'* does not fit with a consultation where orthodontic treatment is not suitable for that patient, therefore the need to review the decision is not indicated, a score of zero would be given which reduces the overall SDM score for that consultation. Another potential explanation for the difference between subjective and objective SDM scores may be that clinicians and independent observers are more critical in their scoring as they are better informed of possible options, risks and

benefits of treatment compared with the patients. For example, items 4 and 5 on both the OPTION¹² instrument and dyadic-OPTION instrument relate to *'The clinician lists options, which can include the choice of no option'* and *'The clinician explains the pros and cons of options to the patient'*, patients may provide higher scores in these domains as they do not know all of the options, advantages, and disadvantages, therefore may not know if this information has been comprehensively covered. There is currently knowledge deficit in the literature as to why patients, clinicians and observers score aspects of SDM differently; there is scope for future qualitative studies to address this area of knowledge deficit.

Furthermore, whilst the researchers aimed to reduce response bias by not recruiting their own patients and assuring patients that the treating clinician would not see their responses, there may be an element of response bias, as patients generally do not like to criticise professionals unless they are highly dissatisfied (Fischer and Ereaut, 2012).

Despite the dyadic OPTION scale and OPTION¹² scale measuring opinions/perspectives and objective measures of SDM respectively, it could be argued that the patient's perception is the most important measure of SDM as it is ultimately their care which is affected by their involvement.

Study limitations

The authors acknowledge the generalisability of the results are limited to adult orthodontic patients only. Another limitation of the study is that there was a greater proportion of male patients recruited compared with female participants; this is not representative of the usual gender distribution of patients seeking orthodontic treatment, which is predominantly female (Harris and Glassell, 2011). The relevance of this is that it has been reported that male patients were significantly more likely to choose a passive role in SDM compared with females (Motamedi-Azari et al., 2020). Future research could use stratification methods and a sample frame to avoid an atypical gender imbalance. Furthermore, given the variability in scores, the sample size in this study may not be sufficient to fully understand the nature of the relationships assessed and a larger sample size would be beneficial in future studies.

The authors found some limitations using the OPTION scales for the orthodontic setting. In general medical practice, a patient may attend a consultation with a particular problem which is often addressed at that given visit, whereas in orthodontics the first appointment consists of taking a history and undertaking an assessment; treatment planning is subsequently undertaken at future visits once imaging and other diagnostics have been

assessed. It is therefore probably not representative of the complete decision making process to measure SDM from a single orthodontic appointment as many of the items covered in OPTION¹² and the dyadic-OPTION scale are undertaken over several appointments. Also, the OPTION scales do not assess all aspects of SDM, for example respondents are not asked whether the clinician gave the patient sufficient time to make an informed decision. Finally, the Hawthorne effect for clinicians may have skewed the results as clinicians knew that the consultation was being audio-recorded and their level of SDM would be scored by the patient and observers, however, this is similar to other studies using the OPTION scales, therefore may result in a systematic error across all studies allowing comparison of results.

Whilst not all of the items in the OPTION¹² and dyadic-OPTION scales are appropriate for use in orthodontics, there is no condition or treatment specific measure of SDM currently available for use in orthodontics. The development of a condition or treatment specific measure of SDM for orthodontics would be an interesting future area for research.

Conclusions

- The results showed higher levels of perceived SDM by the patients and clinicians using the dyadic-OPTION scale compared with the observer OPTION¹² scale. Patients generally gave the highest scores for SDM. Low scores were obtained using the observer OPTION¹² scale which is consistent with other studies. This may indicate that there is scope for improvement of SDM practices or alternatively, the low scores may demonstrate the limited suitability of using the OPTION¹² scale to measure SDM in orthodontics.
- There was no significant correlation between the patient, clinician, and observer scores of SDM, illustrating that the SDM scores from each of these three groups are independent of one another.

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Declaration of interest statement

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Tables

	Dyadic-OPTION	OPTION ¹²
Requires audio or video-recording consultation	✘	✓
Independently rated by...	Patient and clinician	At least one observer
Consists of a 12 item scale	✓	✓
Requires training and calibration	✘	✓

Table 1: Summary of the OPTION scales used in this study.

OPTION score converted to a percentage (score/48x100)					
Consultation number	Patient dyadic-OPTION mean score (%)	Clinician dyadic-OPTION mean score (%)	Rater 1 mean OPTION ¹² score (%)	Rater 2 mean OPTION ¹² score (%)	OPTION ¹² mean of both raters (%)
1	85.4	83.3	56.3	62.5	59.4
2	93.8	81.3	60.4	77.1	68.8
3	87.5	91.7	33.3	27.1	30.2
4	95.8	79.2	37.5	39.6	38.5
5	77.1	95.8	37.5	22.9	30.2
6	91.7	72.9	31.3	16.7	24.0
7	93.8	75.0	37.5	25.0	31.3
8	97.9	81.3	50.0	52.1	51.0
9	89.6	75.0	43.8	35.4	39.6
10	87.5	77.1	66.7	70.8	68.8
11	91.7	83.3	31.3	31.3	31.3
12	95.8	72.9	31.3	29.2	30.2
13	100.0	72.9	47.9	54.2	51.0
14	72.9	77.1	35.4	35.4	35.4
15	100.0	70.8	35.4	37.5	36.5
16	72.9	62.5	41.7	37.5	39.6
17	93.8	81.3	58.3	64.6	61.5
18	100.0	62.5	14.6	12.5	13.5
19	81.3	56.3	31.3	27.1	29.2
20	97.9	81.3	64.6	66.7	65.6
21	85.4	75.0	45.8	47.9	46.9
22	95.8	81.3	39.6	33.3	36.5
23	95.8	83.3	29.2	25.0	27.1
24	100.0	89.6	62.5	60.4	61.5
25	97.9	79.2	41.7	43.8	42.7
26	95.8	68.8	52.1	52.1	52.1
27	97.9	64.6	56.3	64.6	60.4
28	85.4	64.6	29.2	31.3	30.2
29	72.9	68.8	33.3	29.2	31.3
30	70.8	70.8	35.4	33.3	34.4
31	97.9	83.3	62.5	64.6	63.5

Table 2: SDM scores for the 31 consultations using the patient dyadic, clinician dyadic and OPTION¹² scales converted to a percentage.

	Patient dyadic	Clinician dyadic	OPTION ¹² mean
Patient dyadic	-	0.119 (p=0.523)	0.279 (p=0.128)
Clinician dyadic	-	-	0.255 (p=0.167)

Table 3: Spearman's rank correlation coefficient for the patient dyadic, clinician dyadic and OPTION¹² scores.

OPTION instrument	Specialty registrar trainees (n=14)	Consultants (n=17)
Mean Patient dyadic- OPTION score	93.6 (SD 6.0, range 81.2 to 100)	87.7 (SD 10.5, range 70.8 to 100)
Mean Clinician dyadic-OPTION score	78.3 (SD 7.9, range 56.3 to 89.6)	74.5 (SD 9.6, range 62.5 to 95.8)
Mean OPTION ¹² score	47.6 (SD 15, range 24 to 68.8)	38.5 (SD 14.1, range 13.5 to 68.8)

Table 4: Mean SDM scores based on clinician's grade.

Appendices

Dyadic OPTION questionnaire

Participant Identification Number for this study:

Most encounters about health problems lead to decisions of one sort or another. These questions ask about the idea of being or feeling involved in decisions, for example, having an opinion or deciding whether to take medication, and if so which one, or what to do next.

Answer the questions from your point of view by putting a tick in one box for each question. Please answer every question.

What was the main problem you talked about? Please describe it in a few words.

.....

	Strongly agree	Agree	Disagree	Strongly disagree
1. A health problem was identified, where it was made clear that a decision was needed.				
2. More than one way to manage the health problem was described.				
3. Different sources of information (e.g. leaflets, websites, contact with other people) to help make the decision were offered.				
4. Different options (including the possibility of doing nothing) were discussed.				
5. The advantages, disadvantages and possible outcomes of options were discussed.				
6. Ideas or expectations about managing the health problem were discussed.				
7. Concerns or worries about managing the health problem were discussed.				
8. It was made sure that information had been understood.				
9. There were opportunities to ask questions.				
10. The preference to take part in the decision (or not) was respected.				
11. During the consultation, a decision was made; or there was an agreement to postpone making the decision.				
12. The possibility of coming back to the decision was discussed.				

Appendix 1. Dyadic-OPTION scale. Modified from Melbourne et al (2010).

OPTION¹² questionnaire

1. The clinician <i>draws attention to</i> an identified problem as one that requires a decision making process.	0	1	2	3	4
2. The clinician <i>states</i> that there is more than one way to deal with the identified problem ('equipose').	0	1	2	3	4
3. The clinician <i>assesses</i> the patient's preferred approach to receiving information to assist decision making (e.g. discussion, reading printed material, assessing graphical data, using videotapes or other media).	0	1	2	3	4
4. The clinician <i>lists</i> 'options', which can include the choice of 'no action'.	0	1	2	3	4
5. The clinician <i>explains</i> the pros and cons of options to the patient (taking 'no action' is an option).	0	1	2	3	4
6. The clinician explores the patient's <i>expectations</i> (or ideas) about how the problem(s) are to be managed.	0	1	2	3	4
7. The clinician explores the patient's <i>concerns</i> (fears) about how problem(s) are to be managed.	0	1	2	3	4
8. The clinician checks that the patient has <i>understood</i> the information.	0	1	2	3	4
9. The clinician offers the patient explicit <i>opportunities</i> to ask questions during the decision making process.	0	1	2	3	4
10. The clinician elicits the patient's <i>preferred level of involvement</i> in decision-making.	0	1	2	3	4
11. The clinician indicates the need for a <i>decision making</i> (or <i>deferring</i>) stage.	0	1	2	3	4
12. The clinician indicates the need to review the decision (or <i>deferment</i>).	0	1	2	3	4

Score	Description
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.

Appendix 2. OPTION¹² scale. Modified from <http://www.glynelwyn.com/training-pack.html>