Re-Thinking Shared Decision-Making: Context Matters

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Abstract

Objective: Traditional perspectives on shared decision-making (SDM) focus attention on the point in a clinical encounter where discussion of a treatment decision begins. We argue that SDM is shaped not only by initiation of a treatment decision, but by the entire clinical encounter, and, even more broadly, by the **nature** of the patient-provider relationship.

Method: The Four Habits Approach to Effective Clinical Communication, a validated and widely used framework for patient-provider communication, was used to understand how SDM is integrally tied to the entire clinical encounter, as well as to the broader patient-provider relationship.

Results: The Four Habits consists of four categories of behaviors: 1) Invest in the beginning; 2) Elicit the patient's perspective; 3) Demonstrate empathy; and 4) Invest in the end. We argue that the behaviors included in all four of these categories work together to create and maintain an environment conducive to SDM.

Conclusion: SDM cannot be understood in isolation, and future SDM research should reflect the influence that the broader communicative and relational contexts have on decisions.

Practice Implications: SDM training might be more effective if training focused on the broader context of communication and relationships, such as those specified by the Four Habits framework.

Key Words: shared decision-making, patient-provider communication, patient-centeredness

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1. Introduction

We argue in this commentary for an expanded view of shared decision-making (SDM). Using The Four Habits Approach to Effective Clinical Communication (1-6), we demonstrate that SDM is shaped by the *entire* clinical encounter—not just the point where a decision is made— and, even more broadly, by the **nature** of the patient-provider relationship **(e.g., length, degree of alliance/trust)**. Our goal is to advance thinking about SDM, while challenging researchers to find more effective and innovative ways of studying this phenomenon.

2. SDM in Health Care

SDM has been widely advocated. Policy makers promote SDM because of its potential to increase use of beneficial treatment options, decrease utilization of treatment options without clear benefits, decrease variations in health care delivery, and promote patients' involvement in their own health.(7) **Philosophically, SDM is important because patients must live with the consequences of treatment decisions, including side effects, risks, benefits, and other effects on their day-to-day lives**. Moreover, if a patient is involved in a treatment decision, they are more likely to implement—and maintain—the treatment, thereby increasing adherence and improving outcomes of care.(8;9)

SDM is also advocated for ethical reasons (10;11), with a patient's involvement in his or her health care described as a fundamental right.(12) **Part of the ethical argument concerns patients' rights to be informed about and consent to treatments, based on individual autonomy and bodily integrity (13)**. SDM moves beyond informed consent, which is primarily a legal obligation that does not necessarily seek to ensure comprehension of treatment goals

and options, risks, and benefits.(14) SDM is an interactive process that involves sharing information and opinions, discussing patient preferences and provider responsibilities, and mutual agreement on a course of action. (8;15-20)

Elwyn and colleagues (30) have argued that patients should be involved in decisions whenever options exist, noting few interventions are completely free from harm. They add that patients have perspectives providers do not have: an understanding of social and psychological consequences of decisions, in contrast to a provider's use of medical evidence, which is almost always confined to biomedical consequences.(21) **Physicians do not always understand patients' health beliefs, making patient involvement critical (22).**

Charles and colleagues describe four essential attributes of SDM. Both patient and provider 1) are involved; 2) share information; 3) express treatment preferences; and 4) agree to implement the treatment decision (23-25). Makoul and Clayman also argue for discussion of the patient's ability to achieve the treatment plan.(18)

Montori and colleagues have added that, for chronic conditions, a critical prerequisite for SDM is establishing an ongoing partnership.(8) The notion of partnership points to an essential element of SDM that has frequently been under-emphasized in the literature: **the central role of the patient-provider relationship in the process of sharing decisions. (26-33)** The importance of a productive patient-provider relationship in general has been underscored in the literature, connected to outcomes such as satisfaction, adherence, avoidance of malpractice claims, and treatment outcomes. (34-42) However, the notion of partnership is often forgotten in studies of SDM (even our own work). SDM studies tend to focus on a single clinical encounter. Even more limiting, studies typically focus only on the point where a

decision is made in a consultation—in spite of the importance of the *entire* visit to productive

SDM.(26;40;43) For example, Braddock's Informed Decision Making instrument (15) and

Elywn's OPTION scale (21) both thoroughly evaluate the nature and quality of sharing decisions,

and these scales have yielded valuable information about SDM (notably, that SDM does not

occur very often). But these scales focus only on portions of the visit where decisions are

discussed, to the exclusion of other potentially important elements in the clinical encounter.

3. SDM and the Entire Clinical Encounter

To study SDM effectively, the entire clinical encounter must be examined, not just the

point when a decision is made. Indeed, no part of an interaction can be fully understood in

isolation. What happens in the decision making process itself is inextricably linked to what

happens before and after the decision. For example, if at the beginning of the visit a clinician

uses a dominating, directive style with a patient, then later tries to involve the patient in a

decision, **the patient may be confused at best, uncomfortable and afraid to express an**

opinion at worst (44). Conversely, if the visit begins in a warm, welcoming manner and the

clinician involves the patient from the beginning, patients will likely be more comfortable

expressing preferences when decisions are made. For longitudinal relationships, these

communication patterns are established and maintained over time, so that each clinic visit may

be affected by previous visits.

Because SDM, the patient-provider relationship, and the entire clinical encounter are

inextricably connected, it is helpful to examine a model of clinical interaction that emphasizes

all elements of a consultation. The Four Habits Approach to Effective Clinical Communication

(1-6), **developed as a practical approach to teach physicians effective communication skills in**

a relatively short time, helps us to understand how SDM is connected to all parts of the encounter and to the patient-provider relationship. The model delineates four categories of behaviors critical for effective communication: 1) Invest in the beginning; 2) Elicit the patient's perspective; 3) Demonstrate empathy; and 4) Invest in the end (1). See Table 1. Communication behaviors cannot be analyzed in isolation, and the Four Habits provides a means to examine SDM in the context of the patient-provider relationship and broader context of the clinical encounter.

Habit 1: Invest in the Beginning**.** The first few minutes of a consultation can have significant effects on the outcome of the visit, including how decisions are made.(1) For instance, creating rapport, one of the skills in Habit 1, is critical to create a welcoming atmosphere where patients are comfortable sharing information and opinions, about both health concerns and treatment options later in the visit.

Habit 1 includes planning the visit (i.e., agenda setting), which is essential to create an atmosphere conducive to SDM.(26;40;43) Agenda setting allows the provider to check understanding of the patient's concerns and prioritize topics for discussion. Most importantly, the visit's agenda can be co-created with the patient, so both parties have input into what will be discussed, including negotiating priorities, which may be different. Framed another way, agenda setting is really the first SDM opportunity of the consultation.

Habit 2: Elicit the Patient's Perspective. Habit 2 continues to establish a foundation for a relationship characterized by equipoise and partnership. One skill for this habit is eliciting the patient's ideas about causes of the problem, including patient worries or fears.(45) Asking about their opinions and concerns allows the patient to be heard and feel valued, creating an

atmosphere of openness and trust, an important requirement for SDM. More fundamentally, these activities are essential partnership-building behaviors.

Another skill in Habit 2 is identifying patient expectations, which sets the stage for making treatment decisions in a cooperative, collaborative manner, particularly because SDM depends on both parties expressing their preferences and concerns openly and honestly. The final skill in this habit, exploring the impact of the illness on the patient's life, follows naturally from the prior skill. Exploring the effect(s) of an illness allows the provider to show interest and concern for the patient—further building their partnership. Thus, Habit 2 specifies important partnership-building activities that lay the groundwork for successful SDM.

Habit 3: Demonstrate Empathy. Partnership building is further enhanced by expressing empathy. By being aware of patients' emotions, a provider can respond empathically both nonverbally (e.g., pause, touch) and with brief empathic statements (e.g., "I see how difficult this is for you."(2)). Communicating caring and empathy enhances the provider's credibility and trustworthiness. Indeed, the trust fostered by seeking to understand a patient's struggle may encourage the patient to reveal important diagnostic information and participate more fully in treatment decisions.(28;46-48) And, in potentially contentious situations, empathy can defuse discord and reduce each party's need to dominate.(49;50) Empathy also helps to foster a working alliance between patient and physician, allowing the sharing of an emotional bond and instrumental goals, such as partnering to identify treatment objectives, and deciding together how to realize these objectives.(46;51) In sum, demonstrating empathy creates important therapeutic consequences, many of which produce an optimal environment for SDM.

Habit 4: Invest in the End. The final habit is where decision-making typically takes place. Other Habit 4 behaviors include delivery of diagnostic information and educating the patient. Important in these two behaviors is checking for patient understanding. "Teach backs," in which patients repeat in their own words the provider's information or instructions, are an effective way to determine patient understanding, but are rarely used.(15) Ensuring that the patient and provider have a shared understanding is an important prerequisite to SDM—and often occurs before a decision is ever deliberated.

Successful SDM is largely a function of multiple contextual elements and opportunities in the clinical encounter; it does not occur in isolation. Behaviors described in Habits 1-3 set the stage for an optimal SDM environment. Setting an agenda to ensure both parties' most important concerns are addressed, asking for patient input early in the visit (before discussing treatment decisions), and creating an atmosphere of trust and support using empathy, among other skills specified by the Four Habits, go a long way to invite active patient participation in treatment decisions, elicit patient uncertainties, and reach a decision to which both patient and provider are committed.(23)

4. Discussion and Conclusion

4.1 Discussion

The study of SDM is replete with challenges. Not all SDM interventions have been effective (7;52), and even widely used measures of SDM have had mixed support. In a recent study comparing two widely used SDM measurement tools, the OPTION scale and the Informed Decision Making instrument, there were generally low levels of agreement between the two

tools.(25) Study authors suggested these findings may be attributable in part to the inherent difficulty in capturing and measuring SDM in observable, quantifiable terms. As a result, there may be a tendency to focus on the most easily observable behaviors, which might not capture the complexity of SDM.

Our point echoes this notion: SDM is more complex than the moment an exchange about a decision begins. SDM is shaped by the context of the entire clinical encounter and the nature (e.g., alliance, trust) of the patient-provider relationship (especially long-term relationships). If the overall encounter contains suboptimal communication, the patient-provider relationship is not characterized by trust, or even if a generally positive relationship lacks equipoise, then it is unreasonable to expect that communication will suddenly improve when a decision must be made.

4.2 Conclusion

Research on SDM has made important strides: We have learned more about how decisions are made, and how this process can be improved. However, given our knowledge of communication, studying SDM in isolation is analogous to an outsider walking in on the middle of a conversation and making perfect sense of it. SDM cannot be separated from the rest of the clinical encounter, nor from the patient-provider relationship. The challenge for us as researchers is to broaden our conception of what SDM is and how it is achieved. By examining SDM as a part of a larger conversation (and relationship), we have the potential to reach a new and more complete understanding of SDM, and in turn create more effective communication approaches for patients and providers.

4.3 Practice Implications

The contextual nature of SDM has important implications for teaching SDM skills. **Current interventions have had limited effectiveness in fostering open, trusting relationships. Moreover, SDM interventions frequently ignore other potentially critical parts of the encounter (7;53). As we have argued, the simple act of setting an agenda might prove invaluable to enhance SDM (26;43). This and other behaviors specified in the Four Habits and other communication approaches can go a long way toward engaging patients in their own care. Empirical studies will be needed to determine which behaviors produce the greatest levels of patient engagement and optimal SDM.**

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Table 1: Selected Skill Areas of The Four Habits Approach

Habit	Communication Behaviors
Habit 1: Invest in the Beginning	• Creating rapport quickly • Eliciting full spectrum of patient concerns • Planning the visit with the patient
Habit 2: Elicit the Patient's Perspective	• Assessing patient attribution • Identifying patient requests • Exploring impact of symptoms on patient's life
Habit 3: Demonstrating Empathy	• Responding to patients' emotions • Discerning empathic opportunities • Expressing empathy verbally and nonverbally
Habit 4: Invest in the End	• Delivering diagnostic information • Providing education • Engaging in shared decision-making • Closing the visit (asking for additional questions, confirming next steps, ending on a personal note)

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