

# Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices

GLYN ELWYN

ADRIAN EDWARDS

PAUL KINNERSLEY

RICHARD GROL

## SUMMARY

**Background.** Involving patients in healthcare decisions makes a potentially significant and enduring difference to healthcare outcomes. One difficulty (among many) is that the 'involvement' of patients in decisions has been left undefined. It is usually conceptualised as 'patient centredness', which is a broad and variably interpreted concept that is difficult to assess using current tools. This paper attempts to gauge general practitioners' (GPs') attitudes to patient involvement in decision making and their views about the contextual factors, competences, and stages required to achieve shared decisions within consultations.

**Aim.** To explore and understand what constitutes the appropriate involvement of patients in decision making within consultations, to consider previous theory in this field, and to propose a set of competences (skills) and steps that would enable clinical practitioners (generalists) to undertake 'shared decision making' in their clinical environment.

**Method.** Qualitative study using focus group interviews of key informants.

**Results.** Experienced GPs with educational roles have positive attitudes to the involvement of patients in decisions, provided the process matches the role individuals wish to play. They perceive some clinical problems as being more suited to a cooperative approach to decision making and conceptualised the existence of professional equipoise towards the existence of legitimate treatment options as an important facilitative factor. A sequence of skills was proposed as follows: 1) implicit or explicit involvement of patients in the decision-making process; 2) explore ideas, fears, and expectations of the problem and possible treatments; 3) portrayal of equipoise and options; 4) identify preferred data format and provide tailor-made information; 5) checking process: understanding of information and reactions (e.g. ideas, fears, and expectations of possible options); 6) acceptance of process and decision making role preference; 7) make, discuss or defer decisions; 8) arrange follow-up.

**Conclusions.** These clinicians viewed involvement as an

*implicit ethos that should permeate medical practice, provided that clinicians respect and remain alert to patients' individual preferred roles in decision making. The interpersonal skills and the information requirements needed to successfully share decisions are major challenges to the clinical consultation process in medical practice. The benefits of patient involvement and the skills required to achieve this approach need to be given much higher priority at all levels: at policy, education, and within further professional development strategies.*

**Keywords:** shared decision making; patient consultations; competences.

## Introduction

THE empirical evidence that involving patients in healthcare decisions makes a significant and enduring difference to healthcare outcomes<sup>1-3</sup> is not unequivocal, although there are some studies that support this hypothesis.<sup>1</sup> One difficulty (among many) is that the 'involvement' of patients in decisions has been left undefined. It is usually conceptualised as 'patient centredness',<sup>4,5</sup> which is a broad and variably interpreted concept that is difficult to assess using current tools.<sup>6-8</sup> Nevertheless, the ethical need to respect autonomy and respond to the consumer demand for more involvement in decision making is becoming widely recognised.<sup>9-11</sup> However, apart from surveys (mostly hypothetical) of patient role preferences in decision making,<sup>12</sup> the practical problems of involving patients in decisions have not been well investigated,<sup>13</sup> although certain elements have been considered, such as the effectiveness of the risk communication stage.<sup>14</sup>

The trend to place more decision-making responsibility on the patient has led to the concern about potential 'abandonment',<sup>15</sup> where clinicians offer information about treatment choices but no guidance — a model known as 'informed choice'. Although this would seem to equate to 'unprofessional' behaviour in the eyes of some practitioners, this transfer of decisional responsibility is commonly reported by patients and is commonly described in situations where clinicians are sensitive to medicolegal risks, such as in the United States.<sup>16</sup> This can result in patient anxiety in the face of uncertainty about the best course of action. For this reason, a middle ground is being advocated where decisions are shared — an approach often known as 'shared decision making'.

The key principles of shared decision making have been conceptualised as a process that involves at least two participants — the patient and the doctor — and often many more (their respective networks of family or professional colleagues).<sup>17</sup> Both parties take steps to participate in the process of decision making. Information sharing is a prerequisite to the process, a treatment decision (which may be to do nothing) is made, and both parties agree to the decision. Towle has proposed a list of 'competencies' based on work in Canada, which we used as a starting point for the study (Box 1).<sup>18</sup> They have subsequently made minor revisions.<sup>19</sup>

This possible approach has not been tested in clinical practice, although a study with simulated patients has explored its feasibility.

G Elwyn, BA, MSc, MRCP, senior lecturer; A Edwards, MPhil, MRCP, MRCP, senior lecturer; P Kinnnersley, MRCP, senior lecturer; Department of General Practice, University of Wales College of Medicine. R Grol, PhD, professor, Centre for Quality of Care Research, University of Nijmegen. Submitted: 1 October 1999; Editor's response: 2 February 2000; final acceptance: 30 May 2000.

- Develop a partnership with the patient.
- Establish or review the patient's preference for information, e.g. amount and format.
- Establish or review the patient's preferences for role in decision-making.
- Ascertain and respond to patients' ideas, concerns, and expectations.
- Identify choices and evaluate the research evidence in relation to the individual patient.
- Present (or direct to) evidence, taking into account the above steps, and help the patient reflect upon and assess the impact of alternative decisions with regard to their values and lifestyles.
- Make or negotiate a decision in partnership, manage conflict.
- Agree upon an action plan and complete arrangements for follow-up.

**Box 1.** Suggested skills and steps for shared decision-making.<sup>18</sup>

ity and suggested important modifications.<sup>13</sup> Future pragmatic trials will need definitions of the skills (competences)<sup>20</sup> and stages in order to design measurable interventions. The question remains: what do practitioners perceive as the communications skills and stages that constitute the appropriate involvement of patients? The aim of this paper was to ask experienced general practitioners (GPs) to question these concepts, to consider the validity of existing proposals, and suggest any modifications (or additions) that would enable the process to be realistically undertaken in their own clinical environment. This was done by conducting a series of 'key informant' group interviews.

## Method

Six experienced GPs actively involved in medical education attended three focus group interviews that focused on the skills required to involve patients in decisions (two to discuss the competencies and a third interview to discuss and agree the results). They are regarded as the key informants for this study. This technique is a recognised method for obtaining the views from within specific settings and situations.<sup>21</sup> The term originates from anthropological studies<sup>22</sup> where informants are used to obtain opinions 'grounded' in specific experience and expertise.<sup>23</sup> They were chosen because they have special knowledge and skills and have access to perspectives otherwise denied to the researcher.<sup>24</sup> As they answer questions and provide explanations, they inevitably become engaged in the research process.<sup>25</sup> This straddling is important — theoretical constructs are thus tempered against field-based perceptions — and the relationship between informants and researchers contributes to a 'joint construction of reality'.<sup>26</sup> They are able to comment on the researcher's interpretations, expand, modify, and clarify views. As understanding increases, the process unfolds over time.

### Study sample

Random selection procedures are not valid as it cannot be assumed that the characteristics of key informants are distributed equally in a population.<sup>27</sup> The sampling technique used is described as purposeful — a strategy that aims to yield a small number of informants who are judged able to provide specific insights.<sup>28</sup> It was decided that the informants should be able to think critically about the skills required for involving patients in decisions and had to meet the following criteria:

- be experienced GPs who work in service settings,
- have experience in assessing consulting skills, and
- have educational involvement at undergraduate or post-graduate levels.

Informants meeting the above criteria in south Wales were identified and approached consecutively until we had achieved commitment from six practitioners (our preferred group size). One of the practitioners we approached declined the invitation; the practitioners who accepted the invitation attended each interview.

### Key informant focus group interviews

Group interviews have been shown to be an effective technique for exploring opinions as well as defining consensus; the peer safety of group homogeneity promotes the exposition of hidden attitudes, a significant advantage over one-to-one interviews.<sup>29,30</sup> By purposively selecting practitioners who had educational roles we were also emphasising the focus of the group and making the most of their role as key informants. Before the first interview, participants were asked to read an overview of studies that evaluated the decision-making roles that patients prefer<sup>31</sup> and also a paper discussing the tasks facing practitioners in the 'explanatory' phase of the consultation.<sup>31,32</sup> Before the second interview, informants were asked to read Charles'<sup>17</sup> discussion of the principles, and Towle's proposed steps, of shared decision making.<sup>18</sup> No further information was provided. A resumé of our research aims was provided and the two-hour long interviews were facilitated by one of the authors (GE). The interview questions are outlined in Box 2.

### Analysis

Transcripts of the recorded interviews were imported into NUD\*IST (qualitative analysis software).<sup>33</sup> The texts were coded into categories that corresponded with the emergent views about the skills of involving patients in decisions. Two authors (GE and AE) discussed the codes generated by this inductive approach, agreed descriptors, and compiled a logical sequence of stages for shared decision making (Box 1). Quotes were selected on the basis that they were succinct examples of consensual views. Drafts of this paper were shared with the informants, both by correspondence (three cycles) and by discussion until there was agreement that both the quotations and the text accurately summarised their views.

## Results

The focus group finally recruited consisted of two GP vocational training scheme course organisers, two GP trainers, one continuing medical education tutor (who was also an examiner for the Royal College of General Practitioners), and one medical student tutor. These doctors did not work in the same partnerships or share peer groups and their practices were based in Llanrumney and Gabalfa (different areas of Cardiff), Bridgend, Swansea, Pontyclun (Mid Glamorgan), and Abersychan (Gwent). The mean number of years in practice was 12 (range = five years to 18 years) and the mean age was 41 years (range = 36 years to 50 years). Based on the interviews, a list of competences is proposed in Box 3.

### Attitudes to involving patients in decision making

The overwhelming attitude to the concept of involving patients in decisions was 'yes, but'. The main proviso was that patient autonomy should be respected but not enforced. Involvement should be achieved only to the patient's preferred level. The informants stressed the importance of maintaining flexibility: adherence to the 'informed choice' approach was considered 'another form of paternalism'. They supported the principle of involving patients, even if practical considerations, such as the lack of time, remained a major obstacle.

**First focus group: attitudes to patient involvement in decisions**

- What are your views about the involvement of patients in clinical decisions?
- How important is it to consider the roles that patients prefer to play in decision making?
- What problems can be foreseen?
- What benefits might be anticipated?

**Second focus group: skills required for involving patients in decisions**

- What skills (if any) do clinicians need to involve patients in clinical decisions?
- What would constitute a successful shared decision between a patient and a clinician?
- What stages could be identified and observed?
- Are there any other requirements?

**Third focus group: results**

- Discussion of pre-circulated report.
- Agreement regarding amendments.

**Box 2.** Questions posed in the focus group interviews.

1. Implicit or explicit involvement of patients in decision-making process.
2. Explore ideas, fears, and expectations of the problem and possible treatments.
3. Portrayal of equipoise and options.
4. Identify preferred format and provide tailor-made information.
5. Checking process: understanding of information and reactions (e.g. ideas, fears, and expectations of possible options).
6. Checking process: acceptance of process and decision-making role preference, involving the patient to the extent they desire to be involved.
7. Make, discuss or defer decisions.
8. Arrange follow-up.

**Box 3.** Stages and competences of involving patients in healthcare decisions.

It is worth noting, however, that the informants expressed caution about the supposed wide applicability of shared decision making. The informants strongly agreed that some decisions lend themselves more naturally to the process of involvement. As one informant noted:

*'Shared decision making is a tool I keep in my back-pocket for those occasions when I really need to use it'* (second interview).

Decisions where several legitimate treatment options were available were frequently cited as examples where the 'tool' was useful — situations such as atrial fibrillation, menorrhagia, early 'prostatism', and the consideration of hormone replacement therapy. Whether all decisions in clinical practice can accommodate a shared approach deserves to be explored in more depth.<sup>34</sup> Nevertheless, even where legitimate options clearly exist and co-operation is feasible, it was felt that clinicians must remain alert to any resistance and modify the communication process accordingly.<sup>35</sup> Despite these reservations, the practitioners agreed that the potential benefits (i.e. increased satisfaction and commitment to agreed management plans) outweighed possible problems.

**Competence 1**

*Implicit or explicit involvement of patients in decision-making process.* The informants disagreed with Towle's first requirement — that clinicians should be explicit about the adoption of the shared decision-making process at the start of a physician-patient relationship.<sup>18</sup> This 'explicitness' was consid-

ered to reflect an insurance-based setting where patients take a more consumerist approach to health care. They did agree that patients should realise that they will be expected to take an active role in decisions but this need not be expressed explicitly — informants were aware that patient willingness to participate in decisions is often conveyed by non-verbal signals as much as by overt assent:

*'... it's about giving options and talking about them, not about actually saying, "Hey ... this is [shared] decision-making time ... lets do this". I think patients would think I have gone barmy if I did that ...'* (second interview).

Informants suggested the use of phrases such as:

*"There are several treatments that we could use here and I'll run through them and see which one suits you best", rather than saying, "I'm involving you in a shared decision"* (second interview).

The clinicians did, however, feel that it was important to frame the process so that patients fully understood that there was an opportunity to take part in a decision and monitor non-verbal signals to check that patients had accepted the offer. An informant noted that involving patients cannot occur unless there is a 'trust-in-context' — a sense of:

*'... an equal relationship. [Patients] have to feel they are equal. If somebody feels they are equal with you and you're treating them as an equal ... they will discuss [decisions] with you ...'* (second interview).

**Competence 2**

*Explore ideas, fears, and expectations of the problem and possible treatments.* The informants confirmed that practitioners who are inexperienced at involving patients at the management stage of the consultation report that when they use phrases such as, 'What do you think we should do?', or, 'Did you have any views about the best thing to do?', they are commonly rebutted with responses such as, 'I don't know, you're the doctor'.<sup>13</sup> Exploring the 'patient's perspective on illness' is particularly difficult at this stage of the consultation, where the 'power' differential is clearly tipped towards clinicians. The informants emphasised the need to achieve an understanding of this area by being open to the patient's contributions. They suggested that by using mitigated phrases, deploying pauses, and becoming sensitive to both verbal and non-verbal signals, it is possible to explore these issues without causing the impression that the enquiries are rhetorical.<sup>34,36</sup> Another suggested ploy to draw out patients' views about possible choices was the use of 'listing':

*'[If] you ask [patients] what they think is wrong with them, then they won't tell you. But if you give them a list of things that are in your mind then they will usually identify some of their concerns. I think that's important ... bringing [the choices] up-front ... the patient [then] sees that the treatment options are valid'* (second interview).

Or, alternatively, exposing the legitimacy of personal preferences:

*'I say, "Well actually, I might just do nothing here, but then I'm the kind of person who often does things like that. I don't like taking tablets ..." and I explain that [to patients]'* (second interview).

### Competence 3

*Portrayal of equipoise and options.* This was considered the pivotal stage of shared decision making. It consists of listing the options that are reasonably available, including, where relevant, the option of taking no action. Patients often find this a slightly surprising move, especially those who have previously encountered a paternalistic style. As one informant noted:

*'It depends how you put it to [patients], doesn't it? If you bluntly say, "Well, we could do A, B or C ... What do you think?" Then [patients] don't like it much. Whereas if you say, "Well, you know, this isn't a black and white situation, Mrs. Jones, there are a couple of options ..." they will respond ...'* (first interview).

Although informants did not use the term themselves, they conceptualised what we term 'professional equipoise';<sup>14</sup> that is, in certain clinical scenarios the doctor can have no clear preference about the treatment choice to make. This is where shared decision making is most feasible. Legitimate choices exist. The following approach was suggested:

*'Then if you discuss them [the options] briefly and say, "I'm not really sure which is the best one at the moment, do you have any view on it?" It's then very easy for them to say, "Well not really" and you can continue'* (first interview).

Equipoise was seen to be different to the uncertainty that results from a lack of knowledge and it was felt to be essential that patients were aware of this distinction. The informants readily admitted that variable levels of uncertainty clearly exist at times but expressing equipoise was perceived to be different and seen as the skill of portraying options in an open, non-directive manner that did not lead to patient confusion, anxiety or lack of confidence in a professional's ability:

*'... it's the difference between doctor uncertainty and the uncertainty about the best treatment options. They are two very different things aren't they? If you are confident telling them that you are uncertain which is the best treatment, [patients] are happy with that. That's a totally different thing to [the situation] where you are truly uncertain [due to] a lack of knowledge'* (second interview).

Choice is always limited by the availability of specified options (unspecified options are discounted) and clinicians are in an influential position by the mere fact that they are able to decide which choices are described.<sup>37</sup> This competence consists of making the correct range of options available and listing them in a logical sequence and in sufficient clarity so that patients perceive the opportunity to take part in the decision.

### Competence 4

*Identify preferred format and provide tailor-made information.* Informants agreed that providing more information about each option was an indispensable step but drew attention to the need to identify the preferred data format. Practitioners normally use verbal skills to convey information. Patients may prefer the personal note that accompanies descriptions of this type.<sup>38</sup> But the increased emphasis on biostatistical outcomes offers the potential of giving numerical data in many circumstances — probabilities expressed as percentages and risk rates (relative or absolute, e.g. number needed to treat). Practitioners need to be sensitive to these issues:

*'I suppose we have to find out from the patient how much information they want and how best to give it to them, really, and at what level'* (first interview).

Informants emphasised the need for information accuracy<sup>10</sup> and the difficulty of extrapolating from population to individual risk. As one informant noted:

*'... it's complex because the knowledge sometimes isn't there and I don't know enough about the risks of the particular options I'm presenting. [The data] also has to be patient-centred, it has to be relevant to his or her particular concerns ...'* (first interview).

It was felt impossible for generalists to recall detailed probabilistic information about a range of clinical problems and the informants noted the need to have rapid access to this type of data, preferably at the desktop.

### Competence 5

*Checking process: understanding of information and reactions (e.g. ideas, fears, and expectations of possible options).* Pausing and checking at regular intervals that an accurate understanding of both the treatment choices and associated information had been achieved was felt to be an essential skill. It was also felt that there was a need to review patient ideas, fears, misconceptions, and expectations, which may have changed after the portrayal of treatment options. It was considered important to achieve:

*'... a shared understanding of the problem and the choices and the implications of each choice but also shared understanding about what's happening in the consultation [i.e. the decision-making process]'* (first interview).

The most consistent theme in the transcripts was the emphasis given to the exploration of patient concerns and that the clinician understood the patient's perception of the relevant problem. Patients, they noted, are:

*'... afraid aren't they, they're afraid to come up with the ideas, concerns. Often they think we would see them as being silly concerns, or they're afraid that we [would regard them] as trying to dominate the consultation. We have to actively seek patients' views and often find [that] even by asking them directly they are very reluctant ... Whereas if you say, "A lot of people in your position often wonder if so and so ..." [then they admit.] "Well actually yes, I am concerned about that ..."'* (second interview).

When asked about the checking process, the informants stated that:

*'You can't just do it once and say, "I've done that, I can forget about it" because either the patient's ideas may develop during the consultation or the patient may be reticent to share their health beliefs, ideas, and expectations ... If you give them several opportunities, by checking throughout, they will come forward with their views'* (first interview).

### Competence 6

*Checking process: acceptance of process and decision-making role preference.* It has been suggested that patients' preferences for involvement in decision making should be ascertained prior to the actual process occurring.<sup>18,19</sup> Most of the published work

reports hypothetical patient preferences for participation.<sup>12</sup> The informants disagreed and noted the impossibility of having informed views about preferred levels of involvement before an actual consultation: in effect, before receiving information about the harms and benefits of the available options. The informants agreed that role preference should be ascertained after options have been described.

Informants stated that experienced practitioners are continually alert to signals that patients accept the level of involvement being required of them and adapt accordingly. The use of pauses, the technique of 'thinking out loud', and the monitoring of non-verbal cues were among the skills deployed:

*'... there's also the business about floating out cues to patients as well. They'll either pick up on them or not. If they don't, then perhaps you make the decision for them and if they do, then you might explore things a bit further. I suppose my sort of cues are that I think out loud with the patient in front of me and say, "Well there are a few options here ..." They react in different ways and often make me discuss the choices with them or just run them through myself. I might even say, "Well of the options, I think this is the best one, so perhaps that's what we'll do ..." or involve them in it. It's like sending out a series of cues and see if they take the bait as it were ...'* (first interview).

'Checking acceptance of the decision-making process' occurs without resorting to verbal utterances. Clinicians look for signs of:

*'... active listening ... you know, they [patients] nod as we are talking and they encourage us to carry on, whereas the ones who don't want to know don't do that, they have very closed body language and don't encourage you ...'* (second interview).

#### Competence 7

*Make, discuss or defer decisions involving patients to the extent they desire to be involved.* This skill was described as the ability to make the transition from 'describing and checking' to the more active phase of achieving a decision, even if the result is to postpone the process. The competence is to convey that the decision-making or decision-deferring point has arrived and make it. Time pressure was perceived as a perpetual constraint for practitioners and the reality of short consultation lengths (in general practice particularly) led to an emphasis on the ability to bring discussions to a satisfactory close.

It was agreed, however, that the process should be perceived as open-ended: it is imperative to offer patients the opportunity to reflect and to discuss their concerns with others if needed. It was important to provide a 'cooling-off period' by using phrases such as:

*'Do you want to talk further now or would you rather go away and come and see me next week, [so that you have an opportunity to involve] other people ...'* (second interview).

It was noted that patients often seek guidance at this point by asking: 'What would you do doctor?' Even in a situation of equipoise, informants did not want to leave patients bereft of guidance. In line with the description of shared decision making as the middle ground between paternalism and informed choice, the informants strongly agreed that it was acceptable to guide patients who requested assistance. The informants felt, 'It's a 60:40 situation patients want'. Practitioners should be:

*'... prepared to share [their] views about choices as well as taking into consideration patient's views about what is best for them'* (second interview).

#### Competence 8

*Arrange follow-up.* Informants also felt that it was vital to offer an opportunity to reconsider issues on another occasion, even if, on the face of things, a firm decision had been made:

*'... if you are involving the patient it is important when the patient leaves, that they realise that the decision they've made on this particular occasion is not binding forever'* (second interview).

#### Discussion

This qualitative study reveals that this group of experienced GPs had positive attitudes to the concept of involving patients in decision making, were able to remain critical, and were able to suggest a list of skills that could be useful for others. These clinicians were not naïve to consultation skill texts, so this list of competences could not develop *de novo* but was a result of a focused analysis of existing work. The competences developed here only mirror some aspects of Towle's framework.<sup>18,19</sup> New steps were proposed and fresh insights made. Checking that patients have understood the technical information provided is an important (and recurring) task. Towle's 'explicitness' stage (explaining that 'involvement in decision making was going to occur') was rejected by the informants as being 'too intrusive'. They felt that involvement was best done by using 'implicit' communication techniques, while maintaining surveillance to ensure that this was an acceptable process.

The most fundamental change to the previously proposed competencies is that the timing of 'option portrayal' has been changed with respect to two other steps. The informants in this study stressed the importance of portraying options before checking whether the patient wishes to be actively involved in the decision. This is an important new facet to the shared decision making approach. The bulk of the literature to date has involved asking patients about their preferences for involvement in decision making before an actual decision-making experience.<sup>31,39</sup> This study notes that asking patients about their preferred level of involvement before they have become aware of the possible choices they face is to prejudge the interaction. In some consultations, where the choices are difficult and the issues painful, many patients will wish to withdraw from the decision-making process. In others, they will wish to make active contributions. In many circumstances these preferences themselves depend as much on the skill of the clinician in 'sharing the decision' as on the actual problem faced, the personality type of the patient<sup>40</sup> or socio-demographic variables such as age or educational status.

The order agreed by the practitioners also confirm the value given by Katon and Kleinman<sup>41</sup> to an exploration of patient ideas (see their description of explanatory models) before professional views or options are portrayed so that the patient perspective is not contaminated by the physician's assumptions.

Two major challenges are apparent for a professional wishing to implement the shared decision-making approach. First, involving patients appropriately requires the acquisition of a range of interpersonal skills, underpinned by a positive attitude towards the concept. Secondly, and equally difficult, portraying options requires knowledge about the existence of the legitimate choices and access to technical information about the associated harms and benefits.<sup>14</sup>

This study can be criticised for basing the definition of the

skills and stages of involving patients in decision making on a small sample of informants who may be considered unrepresentative of the majority of GPs. On the other hand, collaborating with these key informants over three consecutive discussion interviews was essential in order to explore these intricate communication skills in the intended depth and intensity. Our objective was not to aim for a generalisable lowest common denominator but to tease out what is feasible in practice, as viewed by clinicians who subscribe to the highest potential standards within their discipline. The results require confirmatory work, which should be undertaken from both professional and patient perspectives, particularly where patient involvement in the management of chronic conditions is likely to lead to significant payoffs. The process, in addition, inevitably contaminated the participants. But the data reveals that they preserved their practical standpoints and remained critical of theoretical perspectives.

The principles of patient involvement are likely to be generic, although we recognise that further work needs to be done regarding their applicability in other clinical disciplines. Taken in tandem with studies that reveal that doctors in training do not regard themselves as well equipped to share decision with patients,<sup>13</sup> these results have important implications. The benefits of patient involvement and the skills required to achieve this approach need to be given much higher priority at all levels: at policy, education, and within further professional development strategies.

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## Address for correspondence

Dr Glyn Jones Elwyn, Department of Postgraduate Education for General Practice, University of Wales College of Medicine, Cardiff CF23 9PN. E-mail: elwyng@cf.ac.uk