Shared decision making and risk communication in practice
A qualitative study of GPs' experiences

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ABSTRACT

Background
Important barriers to the wider implementation of shared decision making remain. The experiences of professionals who are skilled in this approach may identify how to overcome these barriers.

Aims
To identify the experiences and views of professionals skilled in shared decision making and risk communication, exploring the opportunities and challenges for implementation.

Design of study
Qualitative study.

Setting
Gwent Health Authority.

Method
Exit interviews using focus group methodology with 20 GPs who had been in practice between 1 and 10 years, and participated in an explanatory trial lasting 6 months. The trial interventions comprised training in shared decision-making skills and the use of risk communication materials. The doctors consulted with up to 48 patients each (mean = 40, half of them audiotaped) for the study.

Results
The GPs indicated positive attitudes towards involving patients and described positive effects on their consultations. However, the frequency of applying the new skills and tools was limited outside the trial. Doctors were selective about when they felt greater patient involvement was appropriate and feasible, rather than seeking to apply the approaches to the majority of consultations. They felt they often responded to consumer preferences for low levels of involvement in decision making. Time limitations were important in not implementing the approach more widely.

Conclusion
The promotion of 'patient involvement' appears likely to continue. Professionals appear receptive to this, and willing to acquire the relevant skills. Strategies for wider implementation of patient involvement could address how consultations are scheduled in primary care, and raise consumers' expectations or desires for involvement.

Keywords
risk communication; shared decision making; training.

INTRODUCTION

Patient involvement and informed choice in health care are promoted from philosophical and ethical perspectives.[1-3] There is also evidence from some settings that patient involvement improves both health and 'patient-based' outcomes (for example, satisfaction, confidence),[4] although this may stem more from the 'technical' interventions such as decision aids.[5] Skills-based interventions to enhance patient-centred care or patient involvement in decision making are more equivocal in terms of achieving benefits for patients.[6-8]

Furthermore, little is described regarding how to achieve a culture and practice of greater patient involvement in decisions about their treatment or care.[9] Professionals do not readily apply the developments in practice, perhaps partly due to structural barriers, such as lack of time, but their attitudes and experiences may also be important determinants.[10,11]

We conducted a randomised controlled trial of shared decision making and risk communication training for GPs. The results of the trial are reported elsewhere.[12,13] In short, the training interventions for participating doctors achieved large changes in processes of consultations (the doctors acquired the skills and applied them with real patients) but no change in patient-based outcomes.[12,13] In this paper we report on the evaluations provided by GPs in the

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trial. Their participation in the trial was extensive and the experience gained from using the approaches with real patients attending in general practice substantial — exceeding anything else in the literature that we are aware of. We focus on data that may inform the acquisition and wider implementation of skills in shared decision making and risk communication.

METHOD

Sample

Participation in the trial of shared decision making and risk communication was based on the following criteria:

- principal in practice for 1–10 years (for familiarity with recent communication skills training methods),
- one doctor per practice, and
- completed an audiotape of a surgery session.

The sample was representative of all those invited in the Gwent Health Authority area.[12] On completing the trial all 20 GPs were invited to attend one focus group interview each (Figure 1). Each doctor had consulted with up to 48 patients (mean of 40 patients). These patients had one of four established chronic conditions — prostatism, atrial fibrillation, menorrhagia, or menopausal symptoms — and were attending for review of their condition or its treatment.

The trial evaluated the training interventions separately and combined, and the effect of varying the training sequence.[12] The training consisted of four workshops of 3 hours each (two for shared decision making and two for risk communication).[14,15] Half the study consultations occurred in routine surgery time; the other half were audiotaped in time-protected 'research clinics' for analysis, and each doctor was interviewed in detail about one consultation from each research clinic (to complement an identical interview with the patient involved).[16] GPs completed questionnaire evaluations after every study consultation. The skill acquisition and study participation 'package' were, therefore, prolonged and of high intensity.

Exit interviews

The interviews took place 2 months after the trial. Focus group methods were chosen to identify group norms or a range of views, and to capitalise on interactions within the group to elicit experiential data and to explore diversity of views.[17,18] One author, not previously known to the participants, moderated the groups. Eighteen of the 20 participating GPs attended the interviews (nine to each). Each interview lasted approximately 1.5 hours.

The interviews were analytic (testing hypotheses arising from the researchers' experience), although

How this fits in

Greater involvement of patients in decisions about their treatment or care is advocated from ethical standpoints and with evidence of benefit on patient-based and some health outcomes. The reasons for lack of widespread implementation of such approaches include time pressures, but are not fully elucidated, particularly outside academic environments. Participating GPs in this study found the experiential training process acceptable and described valuable effects on their patients' understanding of treatments. GPs were keen to implement shared decision-making skills and risk communication tools, but the frequency of situations where it was found appropriate and feasible was limited. Possible strategies to achieve wider implementation of patient involvement could address the ways consultations are scheduled in primary care, and ways of raising consumers' expectations or desires for involvement.

they also retained a descriptive scope (exploring issues raised *de novo* by the responders, in keeping with this rich data source).[19] The interview addressed the following topics: the training process, including simulated consultations, the content and sequence of the interventions, and the implementation of shared decision-making or risk communication approaches in practice. These were addressed by exploring participants' experiences in the trial and, afterwards, identifying and reflecting on consultations that appeared to have worked well or created difficulties. Practical issues were explored, as well as the participants' reflections and attitudes to the process of skill development and the use of risk communication tools in practice. The schedule is shown in Box 1.

Analysis

The interviews were audiotaped, transcribed, and anonymised. Data analysis involved examining the responders' views in relation to the key interview areas. Data were categorised accordingly, examining for evidence of agreement or disagreement within or between the interview groups, and whether there were areas of uncertainty, with discussion and agreement of the categorisations where required. Data interpretation was validated by engaging the responders in discussion of the published report from this work, attending to clarifications or modifications as indicated.

RESULTS

Data will be presented under the following interview areas:

- views on the training process,
- perceived effects of the trial interventions on patients,
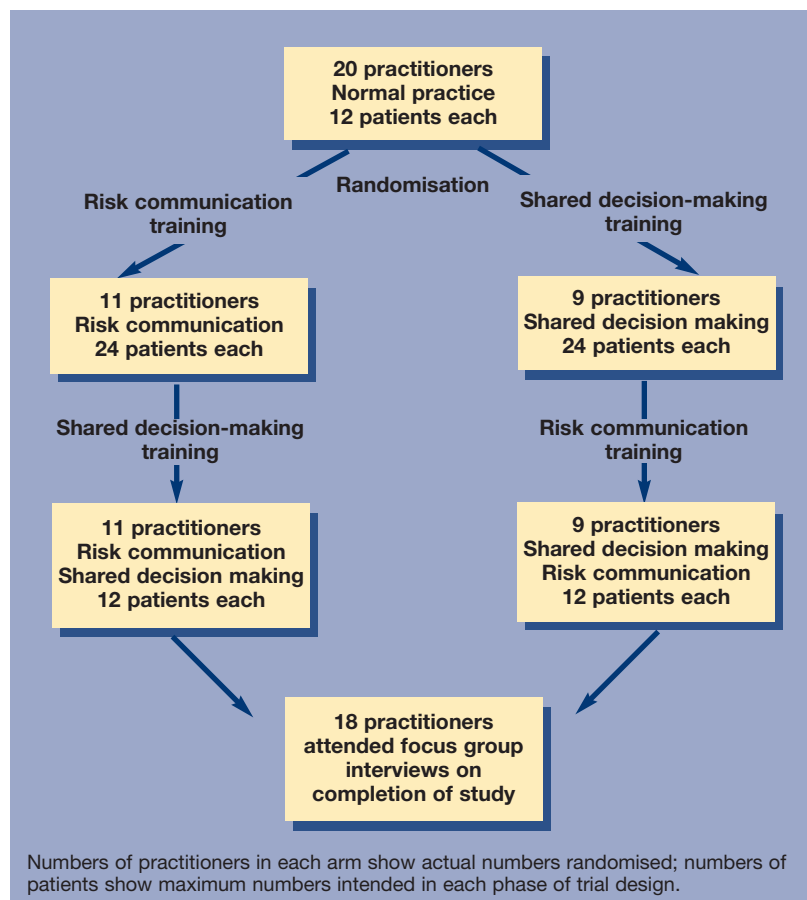- communication skill issues,
- data issues, and

Numbers of practitioners in each arm show actual numbers randomised; numbers of patients show maximum numbers intended in each phase of trial design.

Figure 1.
Trial design with exit focus group for evaluation.

- use of the approaches in practice (time considerations, selection of patients, selection of conditions, and intent to use it in the future).

Each is described and illustrated below, incorporating a number of examples of the data in each theme. Although usual focus group data presentation would illustrate interactions between participants, individual quotations are usually presented here for economy of space. They are annotated by group reference; that is, first or second interview.

Views on the training process

The great value of working through consultations with simulated patients was noted, and most responders felt there had been sufficient training to apply the new skills and tools in practice. However, some individuals suggested that, although the training was adequate for research purposes, more comprehensive training might be needed to alter practice in the longer term:

'I think we have to distinguish between training for the study and training for life. I wouldn't have considered that that was adequate

training if you were genuinely trying to alter doctors' behaviour. I mean we were prepared to try and learn this stuff for the purpose of this study. And I think if you were training doctors to change their behaviour you would have to hammer the message home a little more.'* (Group 1.)

Most participants felt they became more comfortable with the training as it progressed and also became more confident in applying the new approaches with their own patients. A minority felt that the training had been a 'useful update' but had not taught them any new skills:

'I didn't feel I acquired any new skills really. I just felt I had more information to give patients on these four subjects.' (Group 2.)

Alternatively, other doctors viewed the shared decision-making skills training as valuable and applicable across a range of conditions beyond those in the trial:

'I think they remain in the folder for very occasional use for me. Whereas much more interesting was how the shared decision making can influence what you do every day in, well perhaps not in every consultation, but the training like that remains in the back of your mind.' (Group 1.)

'This technique works best for the condition that wasn't in this study, which is the mild dysthymia where the choice is Prozac or supportive therapies. And that is the really time-consuming patient, that is the 20-minute consultation, which slows your morning surgery down. I know that is outside of the realms of this study. But that is where the techniques to me are most appropriate.' (Group 2.)

The main difficulty in training concerned the separation of shared decision making from risk communication. Risk communication training before shared decision making appeared a more 'natural' sequence, and easier to assimilate, although generally each without the other was problematic:

'Doing our arm of the study made perfect sense because you did the risks and looked at it in terms of risk management and then you did the shared decision making and the way it rolled would be the way that it would naturally be rolled out.' (Group 2.)

'I thought that was difficult until we had the risk part of it. Because I was talking about choices, and people were asking me questions and I didn't have the knowledge to back up what the choices were.' (Group 2, commenting on receiving shared decision making first.)

Perceived effects of the trial interventions on patients

These data relate to the perceptions the doctors had about how patients had reacted to the change in consultation content (risk communication) or process (shared decision making).

Positive effects on the doctor–patient relationship and levels of interaction were noted. In general, the responders felt that patients were satisfied with the process of shared decision making, appreciated the information offered, and understood more clearly the pros and cons of treatments, even if no actual treatment changes ensued. They felt that subsequent patient adherence to decisions was more likely:

'A lot of them I found you weren't changing their treatment but a lot of them said "I never knew why I was put on this and it's really nice to understand why I've been given this treatment".' (Group 1.)

'It improves your relationship with the patient if you share information, give them as much information as possible.' (Group 1.)

However, the responders felt the new approaches had confused a minority of patients. Seemingly conflicting medical advice might arise. When faced with important health decisions, the responders felt some patients still wish to defer responsibility to their GP:

'Introducing information that is contrary to what they have had before is quite difficult ... quite difficult.' (Group 1.)

'Sometimes it meets with a really flat response because it's something that they have never really encountered before. Sometimes you will be surprised and they turn around and say "well yeah, of course I want to be involved". But sometimes people turn around and say "tell me what to do doc".' (Group 2.)

Communication skill issues

The responders noted that both they and patients were learning to share decisions as a novel process. Responders felt more aware of what they were doing in consultations and skilled in judging patient desires for responsibility:

'If you are thinking about your practice in just the trial [consultation]*, then maybe for this condition they won't participate in shared decision making but somewhere down the line they will, because they are learning it at the same time as we are.'* (Group 1.)

Despite this, it remained hard to ascertain patients' desires for involvement in decision making ('role preferences'), to achieve the appropriate level of patient involvement, and particularly to remain flexible in the format of risk information presentation:

Interviewer: *'How do you identify ... the right patient to do it with?'*

Responder: *'I think we overestimate our abilities to do that. And, er, I think trying to use the shared decision-making model, there is a point in the model which I find most alien to natural practice, is where you are actually meant to ask the patient how they wish to proceed. You might say "do you want to decide, do you want me to decide, or should we decide together?" And I find this impossible to get across to patients ... and through chance the first two that were on my tape, if you had asked me beforehand, before I got to that stage in the consultation, I would have predicted that the first patient would have said "you decide" and the second one would have wanted to decide from the way they took the information and what I knew about them already, and the way I looked at them and decided what sort of person they were. And I would have been completely the wrong way round.'* (Group 1.)

Box 1. Exit interview schedule.

Aims

To explore and get feedback about training and implementation issues for the shared decision-making and risk communication interventions.

(A) Training process

Comments on process with simulated patients, comments on the sequence of training.

(B) Implementing shared decision-making/risk communication interventions

▶ Using shared decision making and risk communication in practice, their use in isolation or together.

▶ Feedback on using the risk communication and shared decision-making approaches with patients outside of the trial.

▶ Perceived patient's views.

▶ Probe for specific examples of how the process has worked well or badly.

▶ Intentions for using the materials in the future.

▶ Any other practical issues.

Responders were aware of the influence of their own preferences and experience on treatment decisions. Some reported that they had used the risk communication packages to legitimise and justify decisions already made, rather than for sharing decision making:

'That is what we all practice. You take the evidence selectively. Selected according to our prejudices as a professional, but also what we perceive our patients' prejudices are. And our patients' predilections and capabilities. And we might be mistaken in those perceptions but we would certainly adapt the evidence that we present according to the person in front of us and according to our own characters and beliefs.' (Group 2.)

In others, the risk communication tools allowed doctors to focus on decisions more efficiently, with shared decision-making principles still being employed:

'It improved your knowledge base ... and .... because your knowledge base was better, I think the consultation was honed in. You got to the nitty gritty quicker and perhaps sorted out the problem quicker, rather than going round the houses.' (Group 2.)

Data issues
Responders broadly supported having more information and being able to choose the presentation format to aid a discussion. Pictorial presentations (not numerical) were often thought the most helpful, and could reduce the length of discussions:

'That's why it was so nice to get the file [of risk information]*. To get the white file was really nice to then be able to explain the risks.'* (Group 1.)

'So I found this extremely useful. We talked about the pros and cons of HRT [hormone replacement therapy]*. She had read some of it but most of it was complete news to her.'* (Group 2.)

'They really like it don't they? Patients think it's great.' (Group 1.)

Doctors reflected concerns about understanding the range of available data and reported difficulties in applying data to individual patient situations. Other concerns included occasional difficulty in 'believing' the data made available to them in the risk tools

(derived from systematic reviews), and the practicalities of maintaining an up-to-date and sufficient database for use in clinical practice:

'I disagreed with some of the information that was in the leaflet as well. There was some of it that was incomplete, ... so that I found difficult.' (Group 1.)

'And that particular figure I didn't believe so I didn't use it.' (Group 2.)

'It would be nice to have that amount of information for a wider range of conditions, but who would be responsible for updating it and how could it be continuously updated to a high enough level to be meaningful?' (Group 1.)

Use of the approaches in practice
As patients appeared to have reacted favourably, responders noted that consultations were often easier for the doctor, allowing the opportunity for deferred decisions and achieving a better balance and sense of working with patients:

'It takes the pressure off that you have to be right first time.' (Group 1.)

'I think we have got to teach people how to take more responsibility for their own health. And I think this would be a step towards it.' (Group 1.)

One of the main limitations was lack of time. The process of involving patients was perceived usually to take longer than normal, but the process had become increasingly fluent as the study progressed:

'If you have this information which you are going to share, I think that in its own way it generates more questions with the patient. And the patient asks questions that you don't know the answer to. And of course then they are going to come back again. And I think it can do that. I think the more information you give them, it actually generates more questions.' (Group 2.)

'Seven-and-a-half minutes to do something like this is impossible.' (Group 2.)

'You need a bit more time because you are giving extra information which you wouldn't normally, because sometimes you want to discuss a couple of things and usually patients come really with three or four things which they've got on their agenda as well.' (Group 2.)

Special scheduling of some consultations might be needed, perhaps outside or after normal surgery time, if opportunities for greater patient involvement in decision making were to be created. As such, responders noted that 'shared decision making' — and risk communication as part of it — might become a commodity that could end up being prioritised (also known as rationing):

'The fear is that if I introduce this concept now, or if I introduce it with everybody, in 3 years' time I will be wading through extremely long consultations discussing all the ins and outs. And so I would suspect we would end up rationing that as well the way we do other things.' (Group 1.)

In the meantime, the doctors reported being selective as to who they felt able to involve in decision making and with whom to discuss risks in more detail. Patient characteristics, such as age, educational level, and the clinical problem influenced this. However, it was noted that sociodemographic characteristics frequently did not predict the individuals for which it would be appropriate. The nature of the patient's condition influenced the expected feasibility or apparent appropriateness of involving patients in decision making: doctors would rarely use these new approaches in situations of acute or self-limiting illnesses. The management of menopausal symptoms and mild depression were felt closest to 'equipoise' and suited to shared decision making. The doctors reported a strong desire and intention to apply the skills acquired in this study more widely in their usual consulting:

'I think also your communication skills get better or I hope they do as you get more experienced as a GP. And I think with SDM [shared decision making] *you get better at dressing it up and then gauging if they are in a position to make a decision ... do they want a decision made for them or not. So you get better at watching people's faces.'* (Group 1.)

A: *'You decide which patients you don't tell the risks to.'*
B: *'Some of it must be pressure of time, some of it may come from either your innate bias, or ...'*
C: *'knowledge of the patient'*
B: *'Yes, knowledge of the patient, feeling of what they want.'* (Group 1 interchange.)

'Even if you think you have picked your right patients you can get it wrong.' (Group 2.)

'[It depends] what kind of morning you are having [laughter]*.'* (Group 1.)

'The patients in the study weren't being selected, you were either going to use the figures or not as the case may be. That was part of the study. It's when you go back to general practice that the selection of the patient comes in and also the selection of statistics. And I think that is really part of the art of medicine. Selecting which patients you tell what to do and [with] *which patients you discuss the possibilities ... and also selecting which particular studies you feel are relevant to the particular patient. That is the art of medicine as opposed to the science bit which is doing the studies.'* (Group 2.)

Validation/consistency with other data
The responders were provided with a report and summary of the data interpretation. They agreed that it represented the content of the interviews as far as they could gauge this — each participant had only attended one interview. They offered some suggestions for clarification or regarding presentation.

DISCUSSION
Principal findings
The responders found the training acceptable, were positive about involving patients, and described positive effects on consultations when doing so. However, these doctors reported being selective about when greater patient involvement was thought appropriate and feasible. This selection is often based on fixed characteristics such as the nature of the condition (acute versus chronic, whether there is clinical equipoise), the stage or maturity of the doctor–patient relationship, and the availability of time.

Strengths and limitations of the study
Active participation for these doctors was intense, with deep learning methods and substantial experience of applying the approaches in practice. Participation lasted for 6 months, making the participants 'key informants'. We believe there is no equal sample of practising UK GPs with similar exposure to skill acquisition and the application of shared decision making and risk communication in service contexts.

The sample was representative of the area, although to be eligible the GPs had to be more recently trained than average and able to commit to a prolonged trial involving scrutiny of communication skills. The experiences and insights gathered are constrained by the analytic methods used. Different themes could emerge from more descriptive methodologies. Doctors may have given apparently favourable

responses simply because of study participation, though genuine feedback was encouraged.

Comparison with existing literature

Systematic reviews of decision aids show benefits across cognitive, affective, and behavioural domains.[20,21] Such benefits might be expected to encourage professionals to continue with these approaches. Benefits are less evident in more skills-based communication interventions.[8] In this trial neither technical interventions (risk communication, equivalent to decision aids), nor skills-based intervention (shared decision-making training) improved patient-based outcomes, but doctors were still positive about using the approaches in practice. These responses relate to feelings that patients adopted more responsibility for their health and health care, and that this rewarded both patients and doctors.

Given these perceived benefits, doctors might implement the approaches more than is usual elsewhere if other barriers are reduced. There may be separate barriers and opportunities for the skills (shared decision making) versus technical interventions (risk communication aids).[10] This study offers relevant data for each. As Holmes-Rovner also noted, some of the barriers to the use of risk communication aids reflect physical locations — their being away from consulting rooms or not being immediately available when needed.[10] Shared decision-making skills require time for training and time to use them in consultations. Resources are needed for greater professional time to be made available if shared decision making is to become more commonplace.

Competences and competencies, and skill development

Responders sometimes reported detrimental effects of the approaches on consultations, perhaps indicating that higher skill and confidence levels were needed, possibly to a threshold level, to implement the approaches successfully.[9,22] The responders identified remaining learning needs even after this extensive learning. These needs apply to the specific competences of shared decision making and the competencies (attitudes and approaches) for communication.[22]

Regarding the competences of shared decision making, there were challenges in ascertaining patients' preferences for involvement and information formats, remaining flexible for different patients, and in maintaining familiarity and confidence with the data.[15] Overall, the responders described how personal or professional prejudices can influence decision making but were unsure how to overcome these. 'More training' is easily concluded, but it is likely to be difficult to replicate even this level of training and learning for

all GPs in practice. There may be scope to integrate shared decision-making and risk communication training, as advocated in these interviews and, further, to integrate these into wider continuing professional development programmes addressing communication skills. Such learning and training should be a process that occurs over time, not just a 'one-off' intervention, in order to assimilate both competences and, in time, the competencies. The responders' apparent willingness to undertake this continuing professional development to acquire these skills 'for life, not just the study' was encouraging in this regard.

Levers for change

Accreditation and financial influences may be levers for change. Greater rewards, such as in appraisal systems, may encourage doctors to implement these approaches. For example, the UK RCGP 'Fellowship by Assessment' award has incorporated 'informed choice' into some criteria, such as with immunisations:

'Candidates who are unable to demonstrate the (required) standards must exceed the average level of vaccination in the PCO [primary care organisation] *and show how patients/parents/carers are enabled to make an informed choice about vaccination.'*[23]

Patient expectations, preferences for involvement, and feedback from positive experiences may also be helpful levers and drivers here to overcome the selectivity of applying shared decision making.[24]

Implications for future research

As the responders found difficulties identifying patients' role preferences and information format preferences, conversation or discourse analytic methods could examine the skills for these important stages of shared decision making and risk communication. All the study findings require corroboration with a wider sample of practising professionals.

CONCLUSION

These doctors responded positively to shared decision making and using risk communication tools. In-depth work-based experiential learning was acceptable, based on 'reflection-on-action'.[25,26] The participants noted continuing learning needs and a willingness to undertake this learning. Training opportunities can be developed and should be more continuous than single training interventions. More research on the skills of involving patients in decision making and risk communication is required to enhance this training. As doctors become more skilled, they may perceive greater benefits, thus encouraging greater implementation in practice. Other

levers for change include resources for more time, greater expectations from patients for involvement in decisions about their treatment or care, and financial or accreditation incentives. With such initiatives shared decision making may become less selectively implemented than at present.

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