

Patient Partnership and Shared Decision Making: Involving Patients in Management Decisions

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Research shows that involving patients in decisions about their health care and treatment improves outcomes and patient satisfaction. This article explores the meaning of patient partnership and shared decision making, and discusses the contrast between these two concepts and consumerism.

Fifty years ago the doctor-patient relationship was characterised by an unequal sharing of power between doctor and patient. Patients were often nervous when consulting their general practitioner and certainly in awe of hospital specialists. Doctors usually worked within a framework of paternalism (the practice of treating people in a fatherly manner), providing for their needs without giving them rights or responsibilities. Older patients may remember being prescribed medication that was dispensed in a bottle bearing only the inscription: "Tablets to be taken two to three times a day". Doctors expected that once they had diagnosed the patient's condition, the patient would obey their orders without question. Patients did not need an explanation of their problem, why they had become ill, what the treatment was and how it worked. They simply needed to take the medicine as prescribed and not ask questions.

Now, in the 21st century, patients are being treated more as partners with their medical clinicians. Patients want more information and indeed many wish to be involved in making decisions about the management of their health care. While some health professionals may dismiss patient empowerment as the rise of consumerism in medicine, many doctors and other allied health workers realise that patient partnership is the way forward. The benefits of such a partnership are being researched and the results are encouraging for those who wish to practise health care in this climate of choice and information giving.

The Patient-centred Approach

During a consultation with a general practitioner, the first part of the process is usually concerned with the doctor eliciting information from the patient in order to decide on a diagnosis of the patient's problem. This information gathering has traditionally been called 'taking a history'. However, such 'taking' can be a one-sided affair — an interrogation of the patient with a series of closed questions from the doctor and minimal input from the patient. The more modern way of gathering information is to adopt a 'patient-centred approach' that recognises that a patient's problem may be defined in terms of its physical, psychological and social components — the biopsychosocial model as first described by Engel (1960). The doctor helps the patient to tell the story of his or her illness or condition and how it affects the patient's (and the family's) life.

A diagnosis may therefore encompass more than a medical problem. The doctor needs to be aware of the nature and cause of the problem, the reason for the patient seeking medical advice at the time, and should try to discover the patient's ideas, concerns and expectations. This approach has been called the 'patient-centred clinical method' (Levenstein et al. 1986).

In the patient-centred clinical method/approach the clinician explores:

- the patient's Ideas about what is wrong;
- the patient's feelings (Concerns) about the illness(es);
- the impact (Effect) of the patient's problems on function/daily living; and
- the patient's Expectations about what should be done.

It has been known for many years that if a doctor explores the patient's understanding of the problem, discusses concerns and expectations, and enquires about the impact of the problem on daily life, there is better resolution of anxiety and symptoms (Haezen-Klemens & Lapinska 1984). More recent research has shown that what patients want from consultations include:

- exploration of main reason for consultation;
- integrated understanding of patient's world (whole person, emotional needs, life issues);
- common ground as to the nature of problems;
- mutual agreement on management;
- enhancement of health promotion and disease prevention; and
- enhancement of doctor-patient relationship (Stewart 2001).

However, many patients are unused to interacting with doctors in a patient-centred way. Even when asked to share ideas and concerns, patients may find it difficult to express their feelings, especially if they are not used to articulating their thoughts. Patient and doctor factors interact when considering the success or otherwise of a consultation. Skilled doctors are more able to put patients at their ease and facilitate two-way communication, explaining why they are asking certain questions and probing into certain areas. This skill does not come naturally to all doctors, and learning communication skills is therefore an important part of health professionals' and doctors' training.

Sharing Information

Once a diagnosis is made, doctors are still in the position of deciding how much information to give patients about their condition and the possible management of it. The quantity and quality of this information affects how patients make decisions relating to their own health care and may limit their choice of treatment depending on the number of options they are given. The paternalistic doctor expects patients to obey instructions regarding treatment without question. If patients do not obey, they may be labelled as non-compliant.

In contrast to this the doctor may adopt a completely neutral stance and give the patient a range of options without expressing any preference—the 'informed model'. This model has been seen as a move towards increased patient autonomy. The rationale is that patients should be free to decide on an option without being influenced by the doctor's experience or recommendation. However, the informed model has been criticised as sacrificing competence for consumerism. "Too often autonomous patients and families are asked to make critical medical decisions on the basis of neutrally presented statistics, as free as possible from the contaminating influences of physicians" (Quill & Brody 1996).

Quill and Brody (1996) suggest that enhancing patient autonomy requires doctors to engage in open dialogue with patients, fully informing them of the options for treatment, with all their attendant advantages and disadvantages; but doctors should also offer recommendations that consider both the doctors' and the patients' sets of values, health beliefs and experiences. Not surprisingly, they call this the 'enhanced autonomy' model. Doctors should have genuine concern about their patients' best interests. They should support and guide patients' decision making without surrendering the medical power on which patients depend (Quill & Brody 1996).

However, even if a doctor suggests different options and discusses these alternatives, the information is often based within a conventional biomedical framework. This framework tends to exclude psychological, social and spiritual factors as contributing to illness, and

concentrates mainly on biological factors in the causation of such illness. Thus choices involving alternative or complementary treatments are often ignored (Canter 2001).

Shared Decision Making

While the enhanced autonomy model is a useful concept in considering doctor-patient interaction, the model more usually referred to in the medical literature is the shared decision making model. Shared decision making acknowledges the patient as a partner within the medical consultation. The model has four main characteristics:

- both the patient and the doctor are involved;
- both parties share information;
- both parties take steps to build a consensus about the preferred treatment; and
- doctor and patient reach an agreement on the treatment to implement (Charles et al. 1997).

For such shared decision making to be carried out in practice the commitment of both doctor and patient to engage in the process is crucial although the extent of involvement may vary.

Shared decision making involves a full and frank discussion of options, risks and benefits. Patient and doctor come to a mutual agreement about the management plan. This may not be the optimum plan in the doctor's opinion but is the plan that the patient is more likely to follow. For example, the doctor may recommend that a person with mild to moderate depression begins a course of antidepressants. However, the person may prefer to see a counsellor or simply talk things over with his family and see if issues may be resolved by changing lifestyle. If the doctor issued a prescription for tablets, the patient would probably not take them and may be put off returning to the doctor because his/her needs had not been addressed.

While medical students and doctors do now receive training in communication and consultation skills, Towle and colleagues from the Informed Shared Decision Making project of the University of British Columbia believe that patients also need certain attributes in order to participate fully in decisions. They have defined a set of knowledge, skills and attitudes for patients (see Box), but have suggested that patients may learn these in schools, support groups and/or through publications (Towle et al 1997).

Competencies Patients Require to be Involved in Shared Decision Making

1. Ability to define the preferred doctor-patient relationship for oneself.
2. Finding a doctor and establishing, developing and adapting a partnership relationship.
3. Articulating health problems, feelings, beliefs and expectations in an objective and systematic manner.
4. Communicating with the doctor in order to understand and share relevant information clearly and at the appropriate time in the medical interview.
5. Accessing information.
6. Evaluating information.
7. Negotiating decisions, giving feedback, resolving conflict and agreeing an action plan.

Patient Wants versus Needs

The obverse of this situation is when the patient wishes for something that the doctor does not consider entirely clinically justified. This may be medication or investigations. While doctors may feel pressurised by such demands, the assumption that patients with unexplained symptoms want interventions such as prescriptions or tests has recently been challenged. A qualitative study from the United Kingdom suggested that the reason doctors intervene in this way is either because they mistake the patients' insistence on conveying the reality of their symptoms as a desire for investigation or treatment, or because doctors lack an alternative way to respond to the patients' suffering (Ring et al 2004). If, and when, the doctor decides that the symptoms are self-limiting and/or that nothing is seriously wrong, effective management with information sharing, a full explanation and reassurance usually avoids investigation and prescribed medication. Reassuring patients is a complex task that involves the shared decision making skills of negotiation and consensus building. It is not always enough for the doctor to state that serious disease has been excluded. Patients want an explanation for their symptoms. A successful outcome is that the patient and doctor agree nothing needs to be done at this time — there is a shared decision to do nothing.

Patient Partnership versus Consumerism

If consumerism in health care is thought of as health professionals giving patients what they want rather than what they need then patient partnership is not a form of consumerism. Doctor and patient share decisions but may disagree on treatment and management options. Certain patients may also wish to pursue types of treatment that are not yet available in a particular location, are considered too expensive to be offered in comparison with a cheaper option, or are still in the testing stage. While it can be expressed that patients have an ethical and legal right to refuse a certain treatment, this is very different from offering patients the consumerist right to have the specific treatment they demand (Downie & Macnaughton 2001). There is only a finite amount of money within a health service to provide medical expertise and care, and both doctor and patient need to acknowledge this.

The clinical freedom of doctors and the requests of patients are affected by the law and the availability of resources. For example, euthanasia is illegal in most countries, abortion is allowed under certain circumstances (but not for choosing the sex of a child) and plastic surgery for aesthetic reasons is expensive and not available as a right. Thus patient partnership does not mean that patients have the right to choose according to their wants. Management is based on clinical need for health promotion, disease prevention or alleviation of problems. But who decides between a want and a need? There is a potential conflict between patient autonomy, professional autonomy and the state's financial and ethical limits.

With the rise of information technology, knowledge dissemination and the demise of the hierarchical society in the developed countries, health professionals need to come to terms with the development of patient partnership and the principles of shared decision making. Communication and consultation skills are important, as well as a move from a paternalistic attitude to one of mutual respect between health professional and patient.

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References

- Canter, R. 2001, 'Patients and medical power', *British Medical Journal*, Vol. 323, p. 414.
- Charles, C., Gafni, A., Whelan, T. 1997, 'Shared decision making in the medical encounter: what does it mean? (or it takes two to tango)', *Social Science and Medicine*, Vol. 44, pp. 681-692.
- Downie, R. S. & Macnaughton, J. 2000, *Clinical Judgement: Evidence in Practice*, Oxford University Press, Oxford.
- Engel, G. L. 1960, 'A unified concept of health and disease', *Perspectives in Biology and Medicine*, Vol. 3, pp. 459-485.
- Haezen-Klemens, I. & Lapinska, E. 1984, 'Doctor-patient interaction, patients' health behaviour and effects of treatment', *Social Science and Medicine*, Vol. 19, pp. 9-18.
- Levenstein, J. H., McCracken, E. C., McWhinney, I. R. et al. 1986, 'The patient-centred clinical method: A model for the doctor-patient interaction in family medicine', *Family Practice*, Vol. 3, pp. 24-30.
- Quill, T. E. & Brody, H. 1996, 'Physician recommendations and patient autonomy: Finding a balance between physician power and patient choice', *Annals of Internal Medicine*, Vol. 125, pp. 763-769.
- Ring, A., Dowrick, C., Humphris, G. & Salmon, P. 2004, 'Do patients with unexplained physical symptoms pressurise general practitioners for somatic treatment? A qualitative study', *British Medical Journal*, Vol. 328, p. 1057.
- Stewart, M. 2001, 'Towards a global definition of patient centred care', *British Medical Journal*, Vol. 322, pp. 444-445.
- Towle, A., Godolphin, W. & Richardson, A. 1997, *Competencies for Informed Shared Decision-Making (ISDM): Report on Interviews with Physicians, Patients and Patient Educators and Focus Group Meetings with Patients*, University of British Columbia, Vancouver.