

Editorial

Health-related decision making: the use of information giving models in different care settings

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There are a number of ways health professionals can approach health-related decision making with patients. In this article, we discuss two studies which have explored health professionals' approaches to information provision and consider ways in which practice might move towards supporting patients' health-related decisions.

Medical practice has traditionally delivered information using a paternalistic model where responsibility for health-related decision making is professionally led¹ and where patients are expected to be acquiescent. This model assumes that patients have limited knowledge of their condition and the treatment options available to them and that health professionals are the 'experts' in their field. This approach may be justified in situations where patients are unable to participate in health-related decisions, such as during emergencies or where cognitive difficulties render the individual unable to take an active role. However, this model is no longer seen as appropriate since some patients want to actively participate in decisions about their own health care.

Consumerists support the view that patients should have an active role in their health-related decisions² and suggest that this can be implemented using a shared decision-making model. In 1997 Charles *et al*¹ suggested that shared decision making comprised four components: 1) two participants are involved (health professionals and patient); 2) both parties share information; 3) both parties take steps to build a consensus about the preferred treatment and 4) an agreement is reached on the treatment to implement. However, true shared decision making can be difficult for both health professionals and patients because of the imbalance of power between the parties concerned.

There is evidence that the majority of patients prefer the shared decision-making model, though many would still choose to take a passive role, allowing decisions to

be made by health professionals.^{3,4} In a study of patients with wide ranging medical diagnoses, Deber and colleagues found that of 2704 patients questioned, the majority wanted to engage in shared decision making, only 1% wanted to make decisions autonomously, but that 20% preferred to take a passive role, allowing health professionals to make decisions on their behalf.⁴

In their study of decision making and information needs in patients on dialysis with end-stage renal disease, Orsino *et al* found very similar preferences, with 80% of patients preferring a shared decision-making approach.³ Both studies found that older people were more likely to choose to take a passive role, but the authors were keen to note that by no means all older people chose this method. The findings of these papers suggest that health professionals need to determine people's health-related decision-making preferences and to individualise consultation behaviour to adapt to patients' needs.

A third model of decision making exists, namely the information giving model.^{1,5} This model incorporates the idea of information sharing (from health professional to patient) but for the health professional the responsibility ends there. The informed patient is left to make their own decision and the health professional has no further input into the process. Criticisms of the information giving model are that it assumes that information is understood by everyone in the same manner. Furthermore, the information giving model is based on a view that people make conscious, rational choices about health behaviours and that factual information alone will influence choices. This assumption of rationality is problematic as it does not take into account the complexity of the decision-making process and the multitude of factors that influence health behaviours.⁶

Buck⁶ undertook 34 semi-structured interviews with physicians ($n=5$) and nurses ($n=4$) about their

roles and responsibilities in relation to supporting patients' ($n=20$) decisions about dialysis. The study showed that within a limited chronic care environment decision making usually takes one of two forms – either the paternalistic model or the information giving model. Where the information giving model was used, medical and nursing staff viewed their roles to be providers of information, but felt that their responsibilities ended there. Patients were then expected to reach decisions with no further input. This proved insufficient for many patients, to the extent that clinical care suffered as a result of lack of decision making. Truly shared decision making rarely took place. However, one of the main findings from the study was that different patients have different preferences for decision making and that decision-making preferences can change over time and at different stages of illness.

Redsell *et al*⁷ undertook a qualitative study with health visitors ($n=22$), exploring their perception of their role in the immunisation programme, with an emphasis on communication strategies. The majority of health visitors believed that, unlike themselves, general practitioners used a paternalistic model when delivering immunisation information to parents. Health visitors suggested that they worked in partnership with parents but went on to describe how they provided parents with information about immunisation and then withdrew from the decision-making process altogether. They phrased this as treating parents as the decision makers with the right to choose whether or not to have their child immunised. However, health visitors also appeared to fear imposing their will on parents (presumably in fear of litigation) and therefore this aspect of their practice comprised of little more than an information giving model.

In both these studies the majority of health professionals were keen to move away from a paternalistic model of information provision. In the case of the health visitors, they clearly wanted to set themselves apart from what they perceived to be medical paternalism.⁷ In the study by Buck,⁶ health professionals were similarly keen to ensure that they did not unduly influence decisions and keen to be seen as treating patients as intelligent individuals capable of making their own decisions, which in itself is a noble sentiment and one arising from respect for patients. However, the information giving approach used by health professionals in both studies does not allow the recipient the opportunity to engage in a debate about their health-related decisions. The health visitors were aware that other approaches to information provision exist but most did not apply them to routine immunisation information provision.⁷ This is despite evidence that health professionals' current approach to providing information is unsatisfactory for some parents.⁸ A systematic review exploring decision making in relation to child health decisions including immunisation

found that parents would prefer a less professionally led approach to discussions.⁹

It is not surprising that health professionals have moved towards an information giving model. The NHS patient choice agenda is underpinned by a strategy to increase information in order that patients can make informed choices.¹⁰ A great deal of emphasis is placed system wide on developing information for patients, with for example NHS trusts introducing patient information panels to review information before it is released. This may be appropriate where the need is simply to inform patients about a choice of clinic or consultant. However, this is only one aspect of the information that patients need and a wider range of skills and expertise is required where the information is to be used to inform health-related or clinical treatment decisions.

There are studies in the medical literature that have looked at how shared decision making might be implemented. Elwyn *et al*¹¹ explored GP registrars' ($n=39$) views on involving patients in decisions and the skills required. The authors found there were barriers to sharing decisions with patients, which included lack of information and a reluctance to share data, and ensuring appropriate 'timing' for shared decisions. They concluded that changes in health professionals' attitudes were needed, as well as training in the skills needed for involving patients in decision making. In a further paper, Elwyn *et al*¹² developed a series of competencies required to enable shared decision making. Among them were providing tailor-made information, checking that the patient understands the information, exploring their reactions and, crucially, finding out the patient's preferred role in the decision-making process. Underlying all of these is the need to engage with patients as individuals and to develop systems that are adaptable to different styles of participation.

Conclusion

The health visitors and health professionals recruited to our different studies commonly used paternalistic and information giving models in their discussions with parents and patients about health-related or clinical treatment decisions. Grol² suggests that 'shared decision-making and informed choice illustrate the emancipation of the patient' (2001), yet we know that shared decision making is relatively rare. Health professionals seem to be ill-equipped to practise shared decision making as it represents a vast change from the traditionally paternalistic style, yet equally requires different skills from those required by the increasingly dominant information giving model. The skills required

include a need to find out a patient's preferred role in the decision-making process, and possibly greater evidence-based knowledge about the treatment options available, to enable a dialogue about the risks and benefits. It requires a shift in attitude that acknowledges that patient treatment decisions are often influenced by a myriad of cultural and psychosocial factors which may lead to conflict within the patient–healthcare provider relationship when decisions are difficult to reach. Understanding the context of the decisions within the patient's life is a vital aspect of shared decision making.

Practising shared decision making may not be easy. Not least because decision-making preferences can change over time and can vary throughout an illness based perhaps on the stage of acceptance, complexity of the decisions to be reached or time available to choose. The findings of our two studies^{6,7} highlight the need to develop tools to assist health professionals to recognise patients' preferred decision-making style and to assess this regularly.

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PEER REVIEW

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CONFLICTS OF INTEREST

None.

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