COMMUNICATING WITH PATIENTS FROM ALL BACKGROUNDS

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INTRODUCTION

The doctor-patient relationship is at the heart of every GP consultation and the nature of that relationship has evolved over the years. In the past, patients were seen to be passive recipients of healthcare services with doctors making the key medical decisions. More recently, this relationship has evolved to one of doctors working in partnership with their patients to make the best decisions for them. Yet, in 2018, 17% of hospital inpatients did not feel they were involved in decisions about their care - a figure that has not improved in 10 years (1).

Shared decision-making and collaborative co-production recognise that while the doctor may be the 'medical expert', the patient is the expert in their own values, preferences, circumstances and illness experience and both are needed to support the best health outcomes for that individual patient.

NEED TO KNOW

ASPECTS OF SHARED DECISION MAKING AND COLLABORATIVE CO-PRODUCTION

Shared decision making (SDM) is defined as ‘a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and patient’s informed preferences’ (2). It appreciates that doctors and patients bring equally important expertise to the clinical encounter (see Table 1) and acknowledges that there is an increasing expectation that people have the right to make decisions about their own healthcare (3,4).
In SDM, doctors and patients work together to:

- Clarify goals
- Share information about options and preferred outcomes
- Reach mutual agreement on the best course of action (5).

SDM links with the concept of collaborative coproduction which views the outcomes of healthcare as coproduced by the patient and their healthcare team (6). For example, a patient’s diabetic control can be influenced as much by the patient’s actions as it is by medication and other medical interventions.

Viewing healthcare this way acknowledges that the doctor’s role includes enabling the patient i.e. extending the scope of what they can do, rather than seeing the patient as a mere consumer of healthcare. Put simply, healthcare is something doctors do with patients and not just for them (2). Batalden et al (6) devised a conceptual model aiming to illustrate the concept of co-production (see Figure 1).

![Figure 1 - Conceptual model of healthcare service coproduction – from ‘Coproduction of Healthcare Service’ (6).]
In this model, the most basic level of interaction between a patient and a professional is *civil discourse*. Building on this, they can move to *co-planning* which involves establishing a deeper understanding of the expertise each brings to the interaction. NHS initiatives such as ‘What matters to you?’ [https://www.whatmatterstoyou.scot/](https://www.whatmatterstoyou.scot/) aim to encourage such meaningful conversations between patients and those who support and are involved in their care.

At the highest level, *co-execution* emphasises the need for mutual trust as well as both parties appreciating their responsibility for the desired outcome. This relationship is then situated within the contexts of both the healthcare system and society.

**THE IMPORTANCE OF SHARED DECISION MAKING AND COLLABORATIVE COPRODUCTION**

Aside from the ethical imperative of patient autonomy (i.e. that patients have a right to be involved in decisions about their own care), there is evidence that taking a SDM approach can have benefits for both patients and the health service. The benefits of SDM include (7):

- Improved patient knowledge of their condition and treatment options
- Increased patient confidence to self-manage aspects of their own care
- Increased likelihood of adherence to a chosen course of treatment and participation in monitoring and prevention programmes
- Improved satisfaction with care and chosen treatment
- More accurate risk perceptions by patients
- Reduced length of hospital stays and readmission rates.

Shared decision-making is particularly beneficial for *chronic health issues* where self-management can make a significant difference to health outcomes (8).

**FACILITATING SHARED DECISION MAKING AND COPRODUCTION**

Various models and tools exist which can inform healthcare professionals’ approaches to shared decision making (SDM). The three-talk model (see Figure 2) identifies the key stages in the SDM process and was developed in conjunction with patients. Medical decisions vary in their complexity – some decisions are easy to make (e.g. only one obvious treatment option) while others are more complex (e.g. less chance of success, range of options available). Therefore, it is recognised that not all stages of this process will always occur in a single clinical encounter. For more complex decisions, the strength of general practice is the rapport and trust built in an ongoing relationship between a GP and their patient as well as the ability to see patients back following their consideration of the available options.
A variety of decision aids have been developed to help patients think about the different options available to them and what each might mean. There is no set format for a decision aid - it might be a leaflet, an online resource for them to work through. The key feature is that the decision aid allows the patient to access the information they want in a way that is understandable to them.

It is impossible to discuss SDM without considering the concept of health literacy. Health literacy (HL) is defined as the degree to which an individual has the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions (10). A doctor must not assume that all patients have the same level of health literacy - in fact, one study estimated that just under half of adults have inadequate health literacy (11).

Inadequate HL can affect an individual's ability to navigate healthcare, share their history, engage in self-care and understand key treatment and health concepts such as probability and risk. An individual's level of HL is shaped by several factors including the communication skills of both the doctor and the patient, culture, lay and professional knowledge of health topics and the demands of the situation.
For example, for years it was incorrectly believed that exercise was bad for back pain. Now, we know that in, most cases, exercise can be beneficial for back pain. A skilful doctor could engage with and challenge a patient's flawed existing belief about their pain to enable them to self-manage more effectively. Communication skills teaching enabling doctors to explore patients' ideas, concerns and expectations (often referred to as ICE) is one way to starting to develop a shared understanding with patients. Despite policy advocating SDM for many years, it is still not universal. Some doctors perceive that they are 'already doing it' while others remain to be convinced of the value, especially for those with low health literacy (2). SDM must not just be an approach for the well-educated middle class. Many patients can be encouraged and empowered to be active partners in their own care with resultant better health outcomes.

**ACTIVE LEARNING**

- Watch Dr Kieran Sweeney talk about his experience as a cancer patient - highlighting the transactional and relational aspects of good medical care from a patient's point of view.
  

- During a surgery, focus on how your GP tutor is working in partnership with patients to make key decisions:
  - How applicable did you find the 3-stage model to what you are seeing in practice?
  - What techniques are they using to involve patients in decision making?
  - How are they empowering patients to be partners in their own healthcare?

- Try putting yourself in a patient's shoes - identify some key patient decisions being made during a surgery and think what decision you might make in the same situation. What informed your decision?

- Have a look at some of the decision aid resources that area available online to help doctors and patients with SDM. How useful do you think these might be? Why do you say that? What information would you want to consider? E.g.
  - AF medicines to reduce risk: [https://www.nice.org.uk/guidance/cg180/resources/patient-decision-aid-243734797](https://www.nice.org.uk/guidance/cg180/resources/patient-decision-aid-243734797)
  - Statin to prevent CV disease: [https://www.nice.org.uk/guidance/cg181/resources/patient-decision-aid-243780159](https://www.nice.org.uk/guidance/cg181/resources/patient-decision-aid-243780159)
FURTHER LEARNING

RESOURCES

- NHS England Shared Decision-Making Guide
- Realistic Medicine
- Making Shared Decision Making a Reality: No decision about me, without me
- Read up about the House of Care model in 'Delivering better services for people with long-term conditions. Building the House of Care' (12).

REFERENCES

2. Coulter A, Collins A. MAKING SHARED DECISION-MAKING A REALITY No decision about me, without me [Internet]. [cited 2019 Jul 8]. Available from: www.kingsfund.org.uk
3. REALISTIC MEDICINE Chief Medical Officer’s Annual Report 2014-15 Chief Medical Officer's Annual Report 2014-15 REALISTIC MEDICINE Letter to doctors from the Chief Medical Officer for Scotland [Internet]. [cited 2019 Jul 8]. Available from: www.surveymonkey.co.uk/r/LMDCMWM

The following resources have been developed in conjunction with SAPC Heads of GP Teaching. If you have any queries or questions regarding the resources on offer, please contact Prof. Joe Rosenthal or Prof. Alex Harding, Co-Chairs of SAPC's Heads of GP Teaching Group.