What’s the Role of Time in Shared Decision Making?
Alexander T. Yahanda, MS and Jessica Mozersky, PhD

Abstract
Shared decision making (SDM) is a desirable process and outcome of patient-clinician relationships. Ideally, patients and clinicians have sufficient time to engage in SDM. In reality, time is often insufficient. This article explores time as a barrier to SDM, alternative ways clinicians can think about time, and steps they can take to have fulfilling SDM interactions despite time constraints. Although discussions of time typically focus on time quantity, redirecting attention to the ethical significance of time in establishing patient-clinician relationships suggests the importance of also considering time quality.

Time as a Barrier
Shared decision making (SDM)—the process by which clinicians and patients work together to make health care decisions that align with patients’ goals, preferences, and values—is an ideal outcome of patient-clinician relationships. Yet multiple potential barriers obstruct SDM in real-life clinical practice. Chief among these is time, particularly the amount and quality of face-to-face time clinicians and patients spend together. Studies have shown that both patients and clinicians view time constraints as a frequent and substantial barrier to SDM. Prevailing sentiment among clinicians and patients is that there is an inherent tension between time and SDM.

Clinicians face substantial time pressure to efficiently accomplish clinic visits or other patient-related duties, making their time a valuable and scarce resource. They routinely deem the quantity of time they have with patients inadequate, and this perceived time shortage is compounded by mounting burdens of documentation and other administrative duties. In fact, physicians’ satisfaction with the perceived amount of time they have with each patient has decreased over the past few decades. Clinicians perceive that truly fulfilling requirements for SDM necessarily adds time to encounters with patients. Moreover, differing opinions exist among clinicians regarding the value of engaging patients in SDM, even though facilitating SDM has been associated with improved patient outcomes and quality of life.

Patients, too, are aware of clinicians’ busy schedules, which can affect the extent to which they actively participate in decision making. If patients view SDM as requiring more time, they might consider it less important than other parts of a clinic visit, and the
importance they give SDM can diminish further when faced with a clinician who seems pressed for time. Patients might elect not to elaborate on their goals and preferences for any number of reasons, including a desire to take up less time, a feeling of being rushed or pressured to speak succinctly, and not wanting to ask too many questions.23,24 Conversing with clinicians under time pressures can also alienate some patients who feel that they are not being treated as individuals.23

Does SDM Add Significant Time?
Both patients and clinicians desire more time during visits, and longer encounters have been shown to increase patient satisfaction.25 That said, a number of studies indicate that SDM does not have to add prohibitive length to patient encounters.26,27,28,29,30 A study of SDM discussions with surgical patients showed that reaching appropriate levels of SDM could be achieved in a median time of 17.8 minutes vs 15.4 minutes for meetings that failed to reach what the authors deemed a “reasonable minimum” amount of SDM.31

Efficient SDM might be achieved when appropriately tailored questions or decision aids are used to aid SDM. Decision aids are standardized, validated tools that can be used to better facilitate SDM by augmenting—rather than replacing—interpersonal exchanges.32 Decision aids can come in several different forms—for instance, printed text, audio recordings, or videos—and assist patients in personalizing uncertainties and the risks and benefits of interventions.32

Furthermore, asking the same questions of every patient has been shown to increase patient understanding and enhance SDM without increasing the duration of encounters.33 Two Cochrane review articles examining uses of decision aids to facilitate SDM found that they can improve communication, information sharing, and risk assessment, thereby helping patients feel more satisfied with their choices, knowledge base, and decisions.34,35 Importantly, across all studies, decision aids’ use added a median of 2.6 minutes to clinical encounters.34,35

Quality vs Quantity of Time
Notably, discussions of SDM and time tend to consider time in terms of objectively calculated quantities.26,28,31,35 By quantitative measures, SDM requires more time than might be available. Theoretically, by substantially increasing the amount of time per day devoted to patient care (for instance, by scheduling longer clinics or by compelling physicians to increase the number of daily rounds), clinicians would almost always have adequate time for SDM. This solution, however, is not practical given the myriad obligations that clinicians and patients have. Additionally, attempting to make patients’ time with clinicians more efficient through methods such as revamping schedules and scheduling systems, creating algorithms to provide optimal time for encounters with different patients, or giving patients “homework” between interactions is logistically challenging.

An alternative is to focus on ways clinicians can enhance the quality of time they spend with patients. This approach could help clinicians meet ethical obligations to patients without adding significant time to encounters. For example, thoroughly structuring communication to be patient centered, such that clinicians actively listen to patients; solicit questions, fears, and goals; and focus on emotional dimensions of patients’ illness experiences could help emphasize quality and mitigate perceptions of how time is limited in quantity. SDM, as we describe below, can be accomplished by adding a few
minutes. Although clinicians may feel as though they do not have sufficient time for each patient, increasing the quality of their time with patients can augment the SDM process by allowing for stronger relevant discussions within the same time limits.

**How to Increase Quality**

Clinicians can draw on decision aids, among other methods, to improve the quality of time they spend with patients and improve patient understanding of complex clinical information, which improves both SDM during a clinical encounter and patients’ adherence to treatment plans. Nevertheless, clinicians should not become overly dependent on decision aids, as patients still prefer organic interpersonal discussions over those driven by decision tools. Clinicians can also streamline conversations by asking a standard set of questions of each patient or by directly asking the patient to clarify the main reason for their visit. One study found that a patient’s purpose for visiting a physician was discussed in only 36% of encounters. Since eliciting goals is part of SDM, this finding suggests that SDM was taking place in fewer than 36% of visits.

The need to quickly learn about patients’ goals or preferences should be balanced with the need to address each patient as an individual. Improving how clinicians listen to patients is another critical step in including patients in decision making, and this skill should be emphasized in education and training. In one study, clinicians interrupted patients after a median time of 11 seconds, which was partially due to their feeling rushed. Since most patients prefer to play active roles (variously defined) in making health decisions, it is crucial that clinicians learn streamlined approaches to managing the quality and quantity of time devoted to SDM.

Clinicians should cultivate awareness of how their subtle forms of communication and body language, as well as their words, might be perceived by patients. For example, clinicians should verbally convey their recognition of the value of a patient’s time, apologize for tardiness, make eye contact, and shake hands to begin a visit on good terms. Along these lines, clinicians should then avoid sitting behind a computer screen for most of the encounter. Managing time to allow adequate time for patients to voice concerns, sitting at the patient’s level, and trying to make patients feel comfortable in exam rooms can be important expressions of a clinician’s commitment to being present with the patient and setting a positive tone during encounters. Crucially, these small actions need not add substantial quantities of time to the encounter, but they enhance quality.

**Ethics and Time**

A number of articles have focused on the tension that might exist between SDM and limited clinician time. As we have suggested, focusing on ways to improve the quality of time clinicians spend with patients can help resolve this tension. Emphasizing quality becomes easier after acknowledging the ethical components of time, a subject that has received little attention in the literature. When time is narrowly conceived in terms of quantity, it diminishes potential solutions to what appears to be an intractable problem. Being attuned to the ethical significance of time, however, directs attention to one’s duty to enhance the quality of time. Time is not just a barrier to obtaining histories and physicals, health record charting, or educational opportunities; it is a common obstruction to fulfilling basic ethical obligations to facilitate SDM.
Both time quantity and quality are necessary to build therapeutic capacity in patient-clinician relationships and to maintain focus on the virtues of compassion, trustworthiness, integrity, discernment, and conscientiousness. Time is crucial to clinicians’ establishing proper rapport with patients, fostering trust, being a patient advocate, and getting to know a patient. Cultivating strong patient-clinician relationships improves outcomes, patient satisfaction, and expresses a clinician’s moral character. It is in this type of relationship that SDM can be accomplished.

Conclusion
Clinicians need to value SDM and should strive to practice it even when time is limited—a goal we believe is achievable if they become more aware of how they perceive and use time. When the debate over time is framed solely as a quantitative issue, clinicians lose sight of time’s ethical significance and their obligation to maximize time quality to address time shortages. They should focus on restructuring how they navigate visits instead of defaulting to trimming minutes from encounters. Understandably, this approach may not always be feasible, but clinicians simply becoming more cognizant of how they spend their time may pay dividends for patients and clinicians alike.

References
1. Epstein RM, Street RL Jr. Patient-Centered Communication in Cancer Care: Promoting Healing and Reducing Suffering. Bethesda, MD: National Cancer Institute; 2007. NIH publication 07-6225. https://cancercontrol.cancer.gov/brp/docs/pcc_monograph.pdf. Accessed March 12, 2020.
2. Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. JAMA. 1992;267(16):2221-2226.
3. Elwyn G, Frosch D, Thomson R, et al. Shared decision making: a model for clinical practice. J Gen Intern Med. 2012;27(10):1361-1367.
4. Elwyn G, Frosch DL, Kobrin S. Implementing shared decision-making: consider all the consequences. Implement Sci. 2015;11:114.
5. Frerichs W, Hahlweg P, Müller E, Adis C, Scholl I. Shared decision-making in oncology—a qualitative analysis of healthcare providers’ views on current practice. PLoS One. 2016;11(3):e0149789.
6. Bastiaens H, Van Royen P, Pavlic DR, Raposo V, Baker R. Older people’s preferences for involvement in their own care: a qualitative study in primary health care in 11 European countries. Patient Educ Couns. 2007;68(1):33-42.
7. Légaré F, Ratté S, Gravel K, Graham ID. Barriers and facilitators to implementing shared decision-making in clinical practice: update of a systematic review of health professionals’ perceptions. Patient Educ Couns. 2008;73(3):526-535.
8. Chung MC, Juang WC, Li YC. Perceptions of shared decision making among health care professionals. J Eval Clin Pract. 2019;25(6):1080-1087.
9. Fraenkel L, McGraw S. What are the essential elements to enable patient participation in medical decision making? J Gen Intern Med. 2007;22(5):614-619.
10. Joseph-Williams N, Elwyn G, Edwards A. Knowledge is not power for patients: a systematic review and thematic synthesis of patient-reported barriers and facilitators to shared decision making. Patient Educ Couns. 2014;94(3):291-309.
11. Belcher VN, Fried TR, Agostini J V, Tinetti ME. Views of older adults on patient participation in medication-related decision making. J Gen Intern Med. 2006;21(4):298-303.
12. Linzer M, Bitton A, Tu SP, Plews-Ogan M, Horowitz KR, Schwartz MD. The end of the 15-20 minute primary care visit. *J Gen Intern Med*. 2015;30(11):1584-1586.

13. Konrad TR, Link CL, Shackelton RJ, et al. It's about time: physicians’ perceptions of time constraints in primary care medical practice in three national healthcare systems. *Med Care*. 2010;48(2):95-100.

14. Linzer M, Konrad TR, Douglas J, et al. Managed care, time pressure, and physician job satisfaction: results from the physician worklife study. *J Gen Intern Med*. 2000;15(7):441-450.

15. Mawardi BH. Satisfactions, dissatisfactions, and causes of stress in medical practice. *JAMA*. 1979;241(14):1483-1486.

16. Grol R, Mokkink H, Smits A, et al. Work satisfaction of general practitioners and the quality of patient care. *Fam Pract*. 1985;2(3):128-135.

17. Dugdale DC, Epstein R, Pantilat SZ. Time and the patient-physician relationship. *J Gen Intern Med*. 1999;14(suppl 1):S34-S40.

18. Hack TF, Degner LF, Watson P, Sinha L. Do patients benefit from participating in medical decision making? Longitudinal follow-up of women with breast cancer. *Psychooncology*. 2006;15(1):9-19.

19. Lloyd A, Joseph-Williams N, Edwards A, Rix A, Elwyn G. Patchy “coherence”: using normalization process theory to evaluate a multi-faceted shared decision making implementation program (MAGIC). *Implement Sci*. 2013;8:102.

20. Guerrier M, Légaré F, Turcotte S, Labrecque M, Rivest LP. Shared decision making does not influence clinicians against clinical practice guidelines. *PLoS One*. 2013;8(4):e2537.

21. Hibbard JH, Greene J. What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. *Health Aff (Millwood)*. 2013;32(2):207-214.

22. Couët N, Desroches S, Robitaille H, et al. Assessments of the extent to which health-care providers involve patients in decision making: a systematic review of studies using the OPTION instrument. *Health Expect*. 2015;18(4):542-561.

23. Rocque R, Leanza Y. A systematic review of patients' experiences in communicating with primary care physicians: intercultural encounters and a balance between vulnerability and integrity. *PLoS One*. 2015;10(10):e0139577.

24. Pollock K, Grime J. Patients’ perceptions of entitlement to time in general practice consultations for depression: qualitative study. *BMJ*. 2002;325(7366):687.

25. Lin CT, Albertson GA, Schilling LM, et al. Is patients’ perception of time spent with the physician a determinant of ambulatory patient satisfaction? *Arch Intern Med*. 2001;161(11):1437-1442.

26. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient’s agenda: have we improved? *JAMA*. 1999;281(3):283-287.

27. Stiggelbout AM, Van der Weijden T, De Wit MP, et al. Shared decision making: really putting patients at the centre of healthcare. *BMJ*. 2012;344:e256.

28. Loh A, Simon D, Wills CE, Kriston L, Niebling W, Härter M. The effects of a shared decision-making intervention in primary care of depression: a cluster-randomized controlled trial. *Patient Educ Couns*. 2007;67(3):324-332.

29. Hoffmann TC, Légaré F, Simmons MB, et al. Shared decision making: what do clinicians need to know and why should they bother? *Med J Aust*. 2014;201(1):35-39.

30. Légaré F, Thompson-Leduc P. Twelve myths about shared decision making. *Patient Educ Couns*. 2014;96(3):281-286.
31. Braddock C III, Hudak PL, Feldman JJ, Bereknyei S, Frankel RM, Levinson W. “Surgery is certainly one good option”: quality and time-efficiency of informed decision-making in surgery. J Bone Joint Surg Am. 2008;90(9):1830-1838.
32. O’Connor AM, Llewellyn-Thomas HA, Flood AB. Modifying unwarranted variations in health care: shared decision making using patient decision aids. Health Aff (Millwood). 2004;(suppl 2):VAR63-VAR72.
33. Shepherd HL, Barratt A, Trevena LJ, et al. Three questions that patients can ask to improve the quality of information clinicians give about treatment options: a cross-over trial. Patient Educ Couns. 2011;84(3):379-385.
34. Stacey D, Légaré F, Lewis K, et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev. 2017;4:CD001431.
35. Stacey D, Légaré F, Col NF, et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database Syst Rev. 2014;1:CD001431.
36. Montori VM, Shah ND, Pencille LJ, et al. Use of a decision aid to improve treatment decisions in osteoporosis: the osteoporosis choice randomized trial. Am J Med. 2011;124(6):549-556.
37. Bhavnani V, Fisher B. Patient factors in the implementation of decision aids in general practice: a qualitative study. Heal Expect. 2010;13(1):45-54.
38. Singh Ospina N, Phillips KA, Rodriguez-Gutierrez R, et al. Eliciting the patient’s agenda—secondary analysis of recorded clinical encounters. J Gen Intern Med. 2019;34(1):36-40.
39. Sturgess J, Clapp JT, Fleisher LA. Shared decision-making in peri-operative medicine: a narrative review. Anaesthesia. 2019;74(suppl 1):13-19.
40. Lussier MT, Richard C. Docter-patient communication: taking time to save time. Can Fam Physician. 2004;50:1087-1089.
41. Beers E, Lee Nilsen M, Johnson JT. The role of patients: shared decision-making. Otolaryngol Clin North Am. 2017;50(4):689-708.
42. Kiesler DJ, Auerbach SM. Optimal matches of patient preferences for information, decision-making and interpersonal behavior: evidence, models and interventions. Patient Educ Couns. 2006;61(3):319-341.
43. Tamirisa NP, Goodwin JS, Kandalam A, et al. Patient and physician views of shared decision making in cancer. Heal Expect. 2017;20(6):1248-1253.
44. Schulman-Green DJ, Naik AD, Bradley EH, McCorkle R, Bogardus ST. Goal setting as a shared decision making strategy among clinicians and their older patients. Patient Educ Couns. 2006;63(1-2):145-151.
45. Thorne S, Oliffe JL, Stajduhar KI. Communicating shared decision-making: cancer patient perspectives. Patient Educ Couns. 2013;90(3):291-296.
46. Hashim MJ. Patient-centered communication: basic skills. Am Fam Physician. 2017;95(1):29-34.
47. Braddock CH III, Snyder L. The doctor will see you shortly. The ethical significance of time for the patient-physician relationship. J Gen Intern Med. 2005;20(11):1057-1062.
48. Braddock CH III, Snyder L; American College of Physicians Ethics and Human Rights Committee. Ethics and time, time perception, and the patient-physician relationship. Philadelphia, PA: American College of Physicians; 2005. https://www.acponline.org/system/files/documents/running_practice/ethics/issues/policy/ethics-and-time-position-paper-2003.pdf. Accessed March 12, 2020.
49. Paton A. About time: how time influences and facilitates patient autonomy in the clinical encounter. *Monash Bioeth Rev*. 2018;36(1-4):68-85.

50. Beauchamp TL, Childress JF. *Principles of Biomedical Ethics*. 7th ed. New York, NY: Oxford University Press; 2013.

51. Hughes TM, Merath K, Chen Q, et al. Association of shared decision-making on patient-reported health outcomes and healthcare utilization. *Am J Surg*. 2018;216(1):7-12.

Alexander T. Yahanda, MS is a dual-degree MD and master of population health sciences candidate at Washington University School of Medicine in St Louis, Missouri. He obtained bachelor’s degrees in biology and economics from the University of Virginia and a master’s degree from Johns Hopkins University. He plans to pursue residency training in neurosurgery.

Jessica Mozersky, PhD is an assistant professor of medicine in the Bioethics Research Center at Washington University School of Medicine in St Louis, Missouri, and is currently an investigator or a principal investigator on numerous National Institutes of Health-funded projects. She holds a PhD in anthropology and a master’s degree in bioethics, and her work explores the ethical and social implications of new biomedical technologies, including cancer genetic testing, prenatal genetics, whole genome sequencing, and neuroimaging.

Citation

*AMA J Ethics*. 2020;22(5):E416-422.

DOI

10.1001/amajethics.2020.416.

Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

*The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.*