Structured reflection on shared decision making

Rachel Leyland, Miranda Heath, Hilary Neve and Veronica Maynard
Plymouth University Schools of Medicine and Dentistry, Plymouth, Devon, UK

SUMMARY
Background: Shared decision making (SDM), whereby patients and clinicians work collaboratively to make healthcare decisions, brings multiple benefits. It has, however, been slow to integrate into clinical practice. There are some examples of SDM being embedded and evaluated within medical undergraduate curricula but, despite role models being important in promoting students’ patient-centred attitudes, these examples do not involve students reflecting on clinicians’ use of SDM in practice.

Methods: We undertook a qualitative evaluation of a small group educational intervention. A key element was the students’ use of a structured reflective template, drawing on the SHARE (seek, help, assess, reach, evaluate) SDM tool, to analyse examples of clinicians using SDM in practice critically. We undertook a thematic analysis of students’ completed templates and evaluated their engagement with the SHARE tool.

Findings: A total of 44 templates were analysed. Four main themes were identified, including new learning about SDM, noticing and deconstructing SDM, participants’ responses to SDM and struggles in learning. Students were positive about SHARE and used it to critique experiences and suggest specific ways that clinicians could have improved SDM.

Discussion: A structured training intervention that promotes critical reflection on clinical role models can help to shift undergraduate medical students’ understanding of, and attitudes towards, SDM. The ethical arguments for SDM, evidence for its benefits and the alignment of SDM with participants’ own core values appeared to help achieve student ‘buy in’. Students struggled with notions of power, risk and time constraints, and empathised with both patients and clinicians. They highlighted the scarcity of SDM in practice.
INTRODUCTION

'Shared decision making (SDM) is 'a process in which clinicians and patients work together to select tests, treatments, management or support packages based on patients’ informed preferences' and the best available evidence.' SDM, a key factor in enhancing patient safety and quality of care, can reduce prescribing errors and improve medicines adherence, and is increasingly being recognised as a key element of value-based health care. The integration of SDM into clinical practice has, however, been 'glacial' and difficult, and a recent systematic review was unable to confirm that interventions to increase SDM are effective. Indeed, students report that as they progress through medical school the patient centredness of their environment decreases.

A recent scoping review found just 12 examples of SDM training being embedded and evaluated in medical undergraduate curricula internationally, with most suggesting a positive impact on students’ confidence and attitudes to SDM. Alongside theoretical teaching these used role play, standardised patients and simulation, but no reflection on students’ experiences of clinical role models. Yet evidence suggests that role models are important in promoting students’ patient-centred attitudes, particularly where students are supported to critically reflect on which behaviours they would and would not want to emulate.

This article describes the evaluation of an educational intervention in 2017, which supports Year-3 students to reflect critically on their clinical experiences of shared decision making.

Study aims

- To explore how small group discussion and guided, structured reflection influenced students’ understanding and perception of SDM.
- To identify lessons for future teaching and learning.

BACKGROUND

Throughout our 5-year spiral medical undergraduate programme, students attend regular 2-hour doctor-facilitated small group sessions, where they explore a range of topics related to professionalism and patient care, reflect on their clinical experiences and consider how to apply new learning as future doctors. Each curriculum topic has specific learning objectives. Students are expected to research and prepare for sessions in line with these specific learning objectives.

We reviewed the SDM literature and designed an educational intervention that builds on students’ previous learning about SDM in clinical skills sessions and sociology and humanities workshops. We introduced SDM as a topic into the Year-3 professionalism curriculum: following a small group discussion exploring the principles and literature, students complete a structured reflective template based on observed clinical experiences of perceived ‘good’ shared decision making (Box 1). Year-3 students rotate through a range of medical, surgical and community placements, from which they draw these experiences. We undertook an informal evaluation that led to the refinement of the learning objectives (Box 2). Some students inadvertently used a different template, enabling us to identify which questions favoured deeper reflection and then re-design the template accordingly. We chose the SHARE (seek, help, assess, reach, evaluate) consultation tool (Figure 1) to guide students’ analysis because of its memorable mnemonic and guidance on useful phrases and skills. Tutors were trained to facilitate the intervention.

METHODS

All Year-3 students (n = 89) were invited to participate by giving consent for their anonymised reflective templates to be analysed. Qualitative data were obtained from students’ templates that were posted on their group e-discussion boards and downloaded by an independent administrator.

Box 1. Structured reflective template

- Briefly describe the consultation
- How did the doctor/health professional work with the patient to help them understand their health issues, and to find out what matters or concerns them the most (e.g. specific skills, language, body language used)?
- When discussing what to do next, how did the doctor/health professional discuss different options, risks and benefits with the patient, and link this to what was important to the patient (e.g. specific skills, language, body language used)?
- How did I react at the time?
- What did I think afterwards, having reflected on the consultation?
- Looking at the SHARE shared decision making (SDM) tool, what, if anything, do I think the clinician could have done differently to improve SDM?
- As a result of this reflection and the session, what have I learned about SDM that I will use in practice?
- What further issues and questions does this raise for me?
Three researchers undertook an initial analysis of a random selection of 15 templates, independently reading and re-reading each template to identify themes inductively. Themes were then negotiated and refined to create a coding framework. A fourth researcher coded the data using the framework and final framework refinements were agreed. At this stage it became apparent that student engagement with the SHARE tool varied, and a three point scale was developed to assess this (Table 1).

RESULTS

Of 89 students, 44 (49%) participated. Consultations in secondary care predominated (n = 33), followed by primary care (n = 7). Students mostly described consultations between a single doctor and a patient (n = 30); in 13 of these consultations, family or friends were also present. A few described other interactions, e.g. nurse–patient, pharmacist–patient or multidisciplinary teams (including ward rounds).

Four overlapping themes were identified, each with several subthemes. These are illustrated in Figure 2 and detailed in Table 2.

The SHARE tool

Most students’ level of engagement with the SHARE tool was assessed as high (n = 21) or medium (n = 20). Low engagement was rare (n = 3). Half of the students (22/44) reflected on the utility of the SHARE tool itself.

I have learnt that there is actually a structure to shared decision making … I never considered … evaluating the decision the patient makes with them, or assessing their beliefs, not just listening to them and trying to rationalise them. Student 28

Students were largely positive about SHARE, commenting on its simplicity and memorability. One-third of the students explicitly said that they would use it in the future. Students frequently referred to SHARE when suggesting opportunities for improvement, e.g. ‘The clinician could have: …’
This made me realise... that the healthcare professional doesn’t need to take a back-seat role and can question a patient...

Table 1. Assessment of students’ engagement with the SHARE tool

| Engagement Level       | Description                                                                 |
|------------------------|-----------------------------------------------------------------------------|
| High engagement        | Participants demonstrated an understanding of the SHARE tool (e.g. by explaining parts of the acronym), applied it to their observations and indicated its value in achieving shared decision making (SDM) or considered its benefits and limitations. |
| Medium engagement      | Participants simply showed an understanding of the SHARE tool and applied it to their observations. |
| Low engagement         | Participants did not demonstrate an understanding or application of the SHARE tool. |

DISCUSSION

This study suggests that a simple training intervention can help to shift undergraduate medical students’ understanding of, and attitudes towards, SDM. In order to develop SDM skills, clinicians need to believe in the fundamental precept. In this study the ethical arguments for SDM, evidence for improved adherence and cost benefits (e.g. patients choosing less invasive treatments), and alignment with their own core values appeared to help achieve student ‘buy in’.

Our intervention differs from those of others by encouraging reflection on students’ experiences of role models undertaking SDM in practice. Role modelling is recognised as a powerful tool for learning, particularly where students are encouraged to critically reflect on clinician behaviours. In our experience, students often find it easier to ‘deconstruct’ negative clinical encounters, breaking them down into their different elements and identifying specific aspects that they perceive as less good (e.g. ‘her tone of voice was quite aggressive’). When reflecting on positive experiences, however, they commonly discuss them in more general terms (e.g. ‘she communicated well’). In this study, the structured reflective template seemed to facilitate students to deconstruct both helpful and unhelpful SDM behaviours. The SHARE tool also appeared to support their analysis: even where students were positive about their ‘good’ SDM experience in the early sections of the template, once they had applied the SHARE tool they often noticed less positive elements and suggested ways that SDM could have been improved.

Many of the barriers and struggles identified by participants were related to power imbalances between patient and clinician. Understanding that SDM is a meeting of experts, where the clinician is an expert in medicine but the patient is an expert in their own health needs, was a significant ‘a-ha’ moment for some students. They also described strong emotions, such as frustration and awkwardness, when they observed SDM going badly. When this happened, their analysis often highlighted steps that the health care practitioner had not followed. Some students also struggled with the idea of patients making the ‘wrong’ choice, and who held the responsibility for this if, for example, the patient subsequently became unwell. Students also reflected on the scarcity of SDM in practice and how time constraints in health care practice may limit the opportunities to fully embrace SDM, mirroring the barriers to clinician engagement with SDM identified in the literature.
| Theme 1: learning about SDM | Description and subthemes | Illustrative quotes |
|---------------------------|--------------------------|---------------------|
| The philosophy of SDM, and how this aligns with their own views | A shift in understanding, perspective or an ‘a-ha’ moment. Common shifts included: | ‘On [a] human level, I can’t imagine not wanting to be involved with decisions about my health, or at least being asked if I want to be involved.’ **Student 39**  
‘This made me realise … that the health care professional doesn’t need to take a back-seat role and can question a patient on whether they believe that the decisions they are making are truly in their best interest.’ **Student 16**  
‘I have recognised … how the information that patients provide is just as important as what the doctors provide.’ **Student 41**  
‘It reminded me that I first have to get the patient to agree to be a part of shared decision making.’ **Student 29**  
‘Including patient’s preference into their treatment will make it more likely for the patient to adhere to the treatment … because the patient has an understanding of the importance of the treatment or (it) fits into the patient’s daily routine.’ **Student 41**  
‘I want to look into different methods in which shared decision-making can be done in a shorter time frame.’ **Student 24** |
| Evidence of new learning, reinforcement of existing learning or significant shifts in understanding | • that SDM is about sharing decisions, not total patient autonomy  
• recognising the relevance and importance of patient perspectives and SDM in achieving positive health outcomes  
Some students identified specific learning that they would apply in the future | ‘On [a] human level, I can’t imagine not wanting to be involved with decisions about my health, or at least being asked if I want to be involved.’ **Student 39**  
‘This made me realise … that the health care professional doesn’t need to take a back-seat role and can question a patient on whether they believe that the decisions they are making are truly in their best interest.’ **Student 16**  
‘I have recognised … how the information that patients provide is just as important as what the doctors provide.’ **Student 41**  
‘It reminded me that I first have to get the patient to agree to be a part of shared decision making.’ **Student 29**  
‘Including patient’s preference into their treatment will make it more likely for the patient to adhere to the treatment … because the patient has an understanding of the importance of the treatment or (it) fits into the patient’s daily routine.’ **Student 41**  
‘I want to look into different methods in which shared decision-making can be done in a shorter time frame.’ **Student 24** |
| Theme 2: deconstructing SDM | Evidence that participants analysed the observed interaction and the implications for SDM | ‘… if at any point she would like to change/amend the plan, she would simply have to make another appointment.’ **Student 1**  
‘It was clear in hindsight what the agenda of the nurse was … If the patient had wanted something different it could have gone downhill.’ **Student 3**  
‘Instead of standing above the patient, he knelt beside her to examine, and remained at this height throughout the rest of the consultation … I almost felt that I was invading their conversation.’ **Student 5** |
| • Overt techniques, such as explaining all the pros and cons of treatments or giving patients time to think through their options |  
• Consultation dynamics: who held power and whether there was confrontation or collaboration; rapport or discord  
• The manner adopted by the HCP (e.g. empathic, sympathetic, dismissive, authoritarian) | ‘… if at any point she would like to change/amend the plan, she would simply have to make another appointment.’ **Student 1**  
‘It was clear in hindsight what the agenda of the nurse was … If the patient had wanted something different it could have gone downhill.’ **Student 3**  
‘Instead of standing above the patient, he knelt beside her to examine, and remained at this height throughout the rest of the consultation … I almost felt that I was invading their conversation.’ **Student 5** |
| Theme 3: participants’ reflection on their own and others’ responses | Participants frequently exhibited empathy and perspective-taking towards patients. They appreciated why patients may not always choose medically-advised options and how it feels to be on the receiving end of poor SDM  
Empathy towards HCPs – understanding how challenging it can be to achieve SDM  
Students reflected on their own experiences and attitudes – often associated with shifts in understanding. They described a range of emotional responses: pride and awe at observing; frustration at ‘difficult’ patients; disappointment, even discomfort where SDM failed.  
Assumptions and stereotyping:  
e.g. that older patients prefer a paternalistic style of doctoring or career stereotyping | ‘I can imagine as a lay person it can be quite odd to formally put into words what it is that they value and want from their care.’ **Student 32**  
‘I hadn’t really thought about the recovery process … this helped me understand the patient’s perspective more.’ **Student 12**  
‘I could sense the doctor was getting a bit exasperated so it’s quite likely the patient could sense that as well. I suppose I felt a little uncomfortable.’ **Student 9**  
‘From my point of view … it was obvious that the patient should have opted for the surgical repair… My evaluation of the risks involved might differ dramatically to those of my patients, which is important for me to remember.’ **Student 14**  
‘I felt … frustrated that the occupational therapist hadn’t attempted to explore the patient’s interests. And empathy towards the patient as it seemed like he felt obliged to blindly agree.’ **Student 19**  
‘At the time, I was shocked. I had never truly seen SDM and I certainly wasn’t expecting to witness it on an orthopaedic placement.’ **Student 5** |

(Continues)
Some students also struggled with the idea of patients making the ‘wrong’ choice

Table 2. (Continued)

A strength of this study is that it captures a large number of reflections: 49% of our student cohort consented to take part. A limitation is that the reflections of non-volunteer students may have been very different. Although the reflections seem authentic, it is possible that students wrote what they thought we wanted to hear. A further limitation is that we focused on one particular SDM model. Although a few students referred to other tools, only one student seemed to indicate a preference for an alternative tool. The scarcity of SDM experiences in practice could be a barrier to delivering similar training elsewhere, but all of our participants were able to describe a ‘good’ example of SDM. Sharing the templates on the group’s e-discussion board enabled students to learn from, and comment on, each other’s reflections. Facilitators also gave formative feedback, most often in the form of further reflective questions.

The study findings, including the challenges identified by students, are now shared with facilitators to help guide continuing SDM sessions. We are exploring using a similar structured approach, based on the SHERPA model, to help later-year students reflect on SDM in patients with multimorbidity.13

CONCLUSION

Shared decision making (SDM) is increasingly recognised as an ethical imperative in health care, yet it has not been widely adopted in practice and evidence for the benefit of training activities is limited. This article describes how supporting undergraduate medical students to undertake structured reflection on role models using SDM in practice can deepen their understanding of SDM. We hope that this will guide their future practice. The intervention and its findings may also be applicable to postgraduate settings and other health professions.

REFERENCES

1. Coulter A, Collins A. Making shared decision-making a reality. London, UK: The King’s Fund; 2011.
2. Godolphin W. Shared decision-making. Healthc Q 2009;12:e186–e190.
3. Hurst L, Mahtani K, Pluddemann A, et al. Defining value-based healthcare in the NHS: CEBM report May 2019. Oxford, UK: CEBM, University of Oxford; 2019. Available at: https://www.cebm.net/2019/04/defining-value-based-healthcare-in-the-nhs/ Accessed on 30 April 2020.
4. Maskrey N. Shared decision making: why the slow progress? An essay by Neal Maskrey. BMJ 2019;367:l6762.
5. Durand MA, DiMilia PR, Song J, Yen RW, Barr PJ. Shared decision making embedded in the undergraduate medical curriculum: a scoping review. PLoS One 2018;13(11):e0207012.
6. Légaré F, Adeckpedjou R, Stacey D, et al. Interventions for increasing the use of shared decision making by healthcare professionals. Cochrane Database Syst Rev 2018;7(7):CD006732.
7. Wilcox MV, Orlando MS, Rand CS, Record J, Christmas C, Ziegelstein RC, Hanyok LA. Medical students’ perceptions of the patient-centredness of the learning environment. Perspect Med Educ 2017;6(1):44–50.
8. Benbassat J. Role modeling in medical education: the importance of a reflective imitation. Acad Med 2014;89(4):550–554.
9. Agency for Healthcare Research and Quality. The SHARE approach. 2014. Available at: https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html. Accessed on 16 May 2019.
10. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology 2006;3(2):77–101.
11. Bennett D, Barrett A, Hemlisch E. How to … analyse qualitative data in different ways. Clin Teach 2019;16(1):7–12.
12. 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.

13. Jack E, Maskrey N, Byng R. SHERPA: a new model for clinical decision making in patients with multi-morbidity. *Lancet* 2018;392(10156):1397–1399.

**Corresponding author’s contact details:** Rachel Leyland, Plymouth University Schools of Medicine and Dentistry, Plymouth, Devon, PL4 8AA, UK. E-mail: rachel.leyland@plymouth.ac.uk

**Funding:** None.

**Conflict of interest:** None.

**Acknowledgements:** None.

**Ethical approval:** The Plymouth University Faculty of Health and Human Sciences Research Ethics Committee approved the study as an evaluation project that raised no ethical concerns.

This is an open access article under the terms of the Creative Commons Attribution License, which permits use, distribution and reproduction in any medium, provided the original work is properly cited.

doi: 10.1111/tct.13233

‘My evaluation of the risks involved might differ dramatically to those of my patients, which is important for me to remember’