

# A Questionnaire-Based Study to Investigate the Extent of Shared Decision-making During Consultations in Out-of-hours Primary Care



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## INTRODUCTION

Out-of-hours (OOH) primary care physicians (PCPs) provide urgent primary care when in-hours practices are closed. During consultations, several decisions may be made about treatments, investigations or referral. In modern healthcare systems, there is growing emphasis on involving patients in decisions about their care. It is generally agreed that this should be achieved through the process of ‘shared decision-making’ (SDM). It is also understood that patients vary in their preferences for involvement in decision-making.<sup>1</sup>

In OOH care, the patient and clinician are not known to one another, there are little or no medical records and patients tend to present with acute problems. These factors mean there is no pre-existing relationship or implicit knowledge in the encounter which increases the necessity for eliciting and incorporating values and preferences into the consultation through a SDM approach. It is not known currently whether decisions being made in an OOH setting are being shared with patients or not. In other healthcare settings, studies suggest that the degree of patient involvement is generally low, especially in the absence of tools to promote SDM.<sup>2</sup>

This research will, for the first time in the urgent primary care setting, establish the degree to which patients want to be involved in decision-making and how much they feel involved in the decisions made about their health during consultations with OOH clinicians.

## METHODS

This was a questionnaire-based study which established patient preferences for decision-making and the degree of shared

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decision-making experienced by the patient using validated tools (Control Preference Scale (CPS)<sup>3</sup> and CollaborATE<sup>4</sup> respectively). The questionnaire was administered to competent adult patients attending three OOH treatment centres across Birmingham (England), after their consultation with a PCP or Advanced Nurse Practitioner. Control Preference Scale ratings were described and summary statistics of CollaborATE scores were calculated (0–4 in three domains; maximum score of 12) along with the proportion of responses that recorded a maximum CollaborATE score (as this ‘top score’ reporting method is used in comparable studies<sup>5,6</sup>). The Kruskal-Wallis test was applied to identify if there was a significant difference between CollaborATE scores for CPS categories.

## RESULTS

There were 120 questionnaires completed from 147 patients approached (response rate 81.6%). Respondent characteristics and CPS responses are shown in Table 1. The median CollaborATE score was 9.5 (IQR 7.5–12). Maximum scores were returned by 46 (38.3%, 30.1–47.3%) of respondents. Figure 1 shows the association between CPS and CollaborATE. As patient preferences shift towards more control of the decision-making process, they are less satisfied with the degree of decision sharing in the consultation. The difference between categories is significant ( $p = 0.018$ ).

**Table 1 Respondent Characteristic and Decision Control Preference**

		N (%)
Gender	Male	38 (31.7)
	Female	82 (68.3)
Age group	18–27	36 (30.0)
	28–37	27 (22.5)
	38–47	21 (17.5)
	48–57	20 (16.7)
	58–67	11 (9.2)
	68–77	3 (3.3)
	78–87	1 (0.8)
Decision control preference	Active	4 (3.3)
	Active shared	23 (19.2)
	Collaborative	48 (40.0)
	Passive shared	21 (17.5)
	Passive shared	24 (20.0)
Total		120 (100)

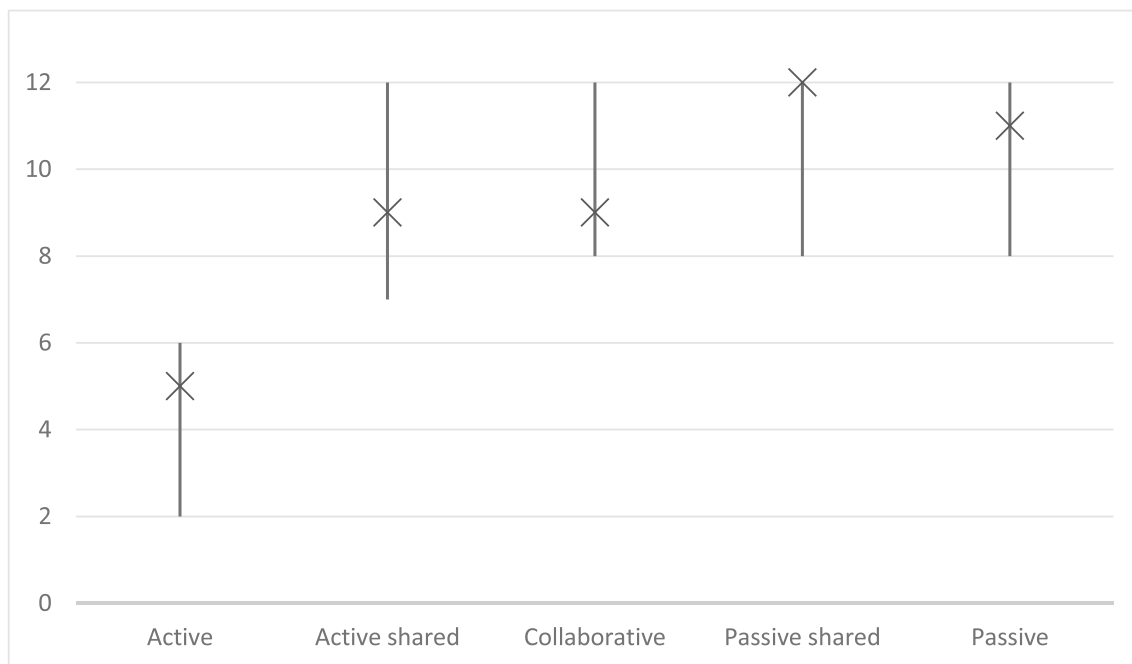


Figure 1 Median CollaboRATE scores by decision preference.

## DISCUSSION

This study shows that patients are experiencing shared decision-making in OOH primary care. However, when compared with similar tools in other settings, the results suggest that decision sharing could be improved.<sup>5,6</sup> Most patients expressed a preference for a collaborative approach to decision-making, and, although some preferred a more active role, a larger minority preferred a passive approach. Patients who prefer an active decision-making role reported a lower perception of decision sharing. As the patients did not get to choose the clinicians they saw, this suggests that the same consulting approach is perceived differently depending on decision-making preference. Those patients who wanted to participate more in the decisions may not have felt they got this opportunity. However, patients who were more passive in their approach were more satisfied with the degree of decision-making, which is understandable if the degree of sharing is the same but the appetite from the patient to get involved in decisions is reduced.

This study highlights the difficulty in measuring SDM in practice. Without understanding how patients prefer to make decisions, it is difficult to interpret metrics that are framed in one approach to decision-making, an approach that may not be congruent with individual patients' preferences. As health systems around the world focus on improving SDM, there is a need to better understand SDM measures and how to incorporate individual control preferences so we can accurately assess the impact of interventions on patient care. This will ensure that investment in SDM results in tangible and positive changes for patients.

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**Author Contributions** SF DL and JP were involved in the design of the study. SF undertook data collection and analysis and all authors contributed and approved the final manuscript.

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### Compliance with Ethical Standards:

Ethical approval was received from the Proportionate Review Subcommittee of the London Queen Square Research Ethics Committee (REC ref 18/LO/1425).

**Conflict of Interest:** SF receives income from freelance writing, lecturing and reviewing from a variety of sources including EBSCO Information Services who produce Option Grid™ decision aids.

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