TAKE-HOME NOTES:

How patient-centred are you? Shared decision-making in psychiatric practice

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How patient-centred is your care? Do you involve your patients in decision-making in an open and non-directive way?

In this module we have outlined the theory of patient-centred care and defined what qualifies as shared decision-making. We have examined the various ways in which decisions regarding medication can be made, with a particular emphasis on patients diagnosed with psychosis. We have also looked at research into what patients want from psychiatrists, and highlighted the fact that psychiatrists' perceptions of their patient care often differ from patient perceptions.

Why not ask another team member to sit in on future consultations for their views on your style, or observe a colleague to see how patient-centred their style is?

Shared decision-making in medical and psychiatric practice

- The term 'patient-centred practice' can be defined as *'Respecting and responding to patients' wants, needs and preferences, so that patients can make choices in their care that fit best with their individual circumstances.'* (Institute of Medicine, 2001)

- The key characteristics of shared decision-making are: it involves at least two participants – the doctor and patient; both parties share information; both parties take steps to build a consensus about the preferred treatment; and an explicit agreement is reached on the treatment to be implemented.

- When discussing treatment options with a newly diagnosed patient, it could be helpful to provide the patient with an information leaflet. Alternatively, a checklist could be presented to patients with schizophrenia before an appointment, and discussed at the appointment (i.e. the 2-COM communication checklist or the DIALOG computer-based checklist).

- Shared decision-making also applies to people detained under the 'Participation Principle' of the Mental Health Act 1983. However, where it is not possible to reach a treatment agreement for a detained patient, the patient should be informed of their right to discuss their options or seek a second opinion.

Keeping patients informed

- Qualitative research has shown that there are differences in how psychiatrists and patients perceive their meetings with one another and in the extent to which shared decision-making occurs.

- Research has shown that in-patients with schizophrenia express a slightly greater desire for shared decision-making than patients in primary care. However, these patients **do not** want to take over decision-making completely and wish to participate on equal terms with their doctors.

- When making or changing a diagnosis, it is important to discuss the meaning and impact of the diagnosis with the patient in a sensitive manner, set aside enough time to have this discussion and be open to hearing and responding to the patient's views about the diagnosis.

- Qualitative research has shown that psychiatrists are well informed about the risks of treatment but don't always pass on all of this information to patients, and are more likely to focus on the benefits of medication.

Engaging with patients' concerns

- Qualitative research has shown that psychiatrists are much better at engaging with reports of non-adherence than side effects of drowsiness.

- It is important to engage with disclosures of side effects, and to enquire further into how the medication has affected the patient. Engagement can lead to easily achievable actions being agreed, for example minor dose reductions or timing changes.

- In order to successfully engage with patients, it is important for the clinician to repeat, clarify and empathise with the patient's concerns and experiences.

Making shared decisions

- A conversation analytic study by Quirk et al (2012) found that some shared decisions are considerably more pressured than others. Shared decisions were then split into three categories: **open**, **directed** and **pressured**.

- Open shared decisions can be defined as the doctor exerting no pressure on the patient's choice either way.

- Directed shared decisions can be defined as the doctor exerting pressure to steer the patient, while the patient shows no signs of resistance.

- Pressured shared decisions can be defined as the doctor exerting pressure on the patient and continuing to do so, even when the patient is evidently resistant to what the doctor wants. (This is not the same as coercion as the patient does agree to the treatment, albeit reluctantly, and there is no threat of adverse action being taken.)

- A patient who is pressurised into agreeing to something they evidently do not want is unlikely to view the decision as having been shared, even though they were involved and ultimately agreed to it. Hence this will reflect less patient-centred practice.

Further reading

Edwards A, Elwyn G (2009) Shared Decision-Making in Health Care: Achieving Evidence-Based Patient Choice (2nd Edn). Oxford University Press.

Quirk A, Chaplin R, Lelliott P, et al (2009) The negotiation of anti-psychotic prescribing decisions: some good practice issues. In Medicines Management in Mental Health Care. (eds N Harris, J Baker, R Gray): 133–144. Wiley Blackwell.