Review of shared decision-making for nursing students

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Abstract:

Shared decision-making has received national and international interest by providers, educators, researchers, and policy makers. The literature on shared decision-making is extensive, dealing with the individual components of shared decision-making rather than a comprehensive process. This view of shared decision-making leaves healthcare providers to wonder how to integrate shared decision-making into practice. To understand shared decision-making as a comprehensive process from the perspective of the patient and provider in all healthcare settings. Fifty-two papers we re included in this integrative review. Three categories emerged from the synthesis: (a) communication/ relationship building; (b) working towards a shared decision; and (c) action for shared decision-making. Each major theme contained sub-themes represented in the proposed visual representation for shared decision-making. A comprehensive understanding of shared decision-making between the nurse and the patient was identified. A visual representation offers a guide that depicts shared decision-making as a process taking place during a healthcare encounter with implications for the continuation of shared decisions over time offering patients an opportunity to return to the nurse for reconsiderations of past shared decisions.

Keywords:

1. Introduction:

Shared decision-making (SDM) has received national and international attention from providers, educators, researchers, and policy makers. Shared decision-making has been described as taking place in a relationship where there is a partnership between the provider and the patient characterized by a collaborative bi-directional mutual exchange of information and discussion involving negotiation leading to a shared decision. Shared decision-making, therefore, takes place in a relationship that is participatory, collaborative, open, and respectful. The relationship is one in which there are at least two participants: the nurse, as the provider, and the patient. Trust and respect between providers and patients has also been described as foundational for SDM.

The literature on SDM is extensive. These works describe the individual components of SDM, including the facilitators and barriers to the achievement of SDM. Provider SDM competencies have also been explored in the literature along with the context of the provider and patient relationship such as the need for resources, including time. Research has also been conducted to examine the effect of SDM on patient outcomes with regard to chronic and acute illnesses; treatment adherence; patient coping; knowledge attainment and empowerment; autonomy and self-determination; and, patient satisfaction. Despite this research, the overall evidence as to the effect of SDM leading to positive patient outcomes is inconclusive.

The focus on SDM has been on the dyad relationship and the individual components of SDM rather than describing and explaining the process taking place within the relationship. Gulbrandsen noted that the contemporary literature's portrayal of SDM does not do an adequate job of illustrating the processes of SDM. A comprehensive understanding of SDM as a process would be meaningful for nurses as they work with patients towards shared decisions about care management.

2. Aim:

The aim of this integrative review is to understand the comprehensive process of SDM from the perspective of the patient and provider in all healthcare settings. Understanding the process will create a common language and appreciation of SDM for meaningful nursing practice.

3. Methods:

This integrative review applied the comprehensive and systematic approach described by Whittemore and Knafl consisting of the literature search, data evaluation, and data analysis.

This method facilitated the gathering of information and research from a variety of methodologies (quantitative, qualitative, and theoretical) supporting an integrative approach allowing for a comprehensive depiction of the process of SDM.

3.1. Inclusion criteria:

Articles considered for inclusion were qualitative or quantitative research articles or theoretical literature that addressed SDM taking place within a relationship between the patient and the provider. Patients needed to be 18 years of age or older and providers could represent any healthcare field. Only articles published in English were considered. Articles were excluded if they solely addressed intervention strategies such as education to enhance SDM competencies in providers or decision aids as an intervention to assist patients in their shared decision rather than a focus on the process of SDM taking place in a relationship. Articles focusing on shared decision-making in psychiatric or mental health settings were excluded because of the unique issues within this patient population pertaining to SDM.

3.2. Search strategy:

A comprehensive literature search was applied in PubMed, CINAHL, the Cochrane Central Register of Controlled Trials (CENTRAL), and PsycINFO. Diverse literature available in English was searched from 1970 through January 2016, including quantitative designs (both experimental and non-experimental), qualitative designs, and theoretical papers. Three searches were conducted in each database in order to identify literature related to SDM inclusive of the patient, the provider, and the environment. (Table. 1) depicts these basic search strategies along with the key terms used.

Table. 1: Basic search term strategies used across all databases

Patient search:			
Shared decision making	AND	Patient or patients or client or clients	AND	Experience or experiences or perspective or perspectives or satisfaction or preference or preferences or competent or competency or competencies or demographics or diagnosis or outcome or outcomes or literacy or culture or education
Provider search:			
Shared decision making	AND	Physician or physicians or doctor or doctors or clinician or clinician or provider or providers or nurse or nurses	AND	Experience or experiences or perspective or perspectives or satisfaction or preference or preferences or competent or competency or competencies or

Patient search:				
				demographics or diagnosis or outcome or outcomes or literacy or culture or education
Environment search:				
Shared decision making	AND	Environment or "environmental culture" or organization or "organizational culture" or policy or "health service culture" or context or commitment or consistency or continuity or time or economics or "financial resources" or resources		

3.3. Data evaluation:

Articles that met the inclusion criteria were evaluated for methodological quality. The standardized critical appraisal instruments for experimental, observations, quantitative descriptive, qualitative, and expert opinion/theoretical works from the Joanna Briggs Institute System for the Unified Management, Assessment and Review of Information (JBI-SUMARI) were used for this assessment. This stage reduced the possibility of bias and errors by including only papers deemed reliable/dependable and valid/credible. Any disagreements between the reviewers were resolved through discussion until consensus was reached. Supplemental (Table. S1) contains the results of the critical appraisals for all included studies.

3.4. Data analysis:

Data analyses were carried out through the application of an inductive content analysis process that involved creating categories and abstractions. The categories were then further grouped under higher order headings. The synthesis process involved creating categories that describes all of the aspects of the SDM process leading to a new representation of facts offering a visual representation of SDM as a guide for nursing practice.

4. Results:

Upon completion of the initial searches, 4,674 potentially relevant titles were identified. Duplicates were removed, leaving 1,562 articles for review. After reviewing the titles and abstracts, 1,340 articles were excluded for not meeting the inclusion criteria. After full text review, an additional 166 articles were excluded for not meet the inclusion criteria, leaving 55

articles for critical appraisal. Three articles were excluded for methodological weaknesses in the research and limited results sections (Fig. 1).

Fifty-two articles published between 1997 and 2016 were included in this review. Supplemental Table (S2) contains an overview of the included articles. Twenty-three of the articles originated from the United States, six from the United Kingdom, five from Germany, nine from Canada, two from the Netherlands, and one each from Australia, Denmark, Norway, Italy, and France. Two articles originated from multiple countries. Sixteen of the articles were quantitative designs, 19 were qualitative, one was mixed method, and 16 were conceptual.

The analysis of this integrative review and the articles retained from data analysis generated three categories: (a) communication/relationship building; (b) working towards a shared decision; and (c) action for SDM, each containing sub-themes that depict the process of SDM. (Table. 2) outlines the three categories and sub-categories along with the corresponding articles informing each category. These categories and sub-categories were further contextualized into a visual representation of the shared decision-making process seen in Fig. 2.
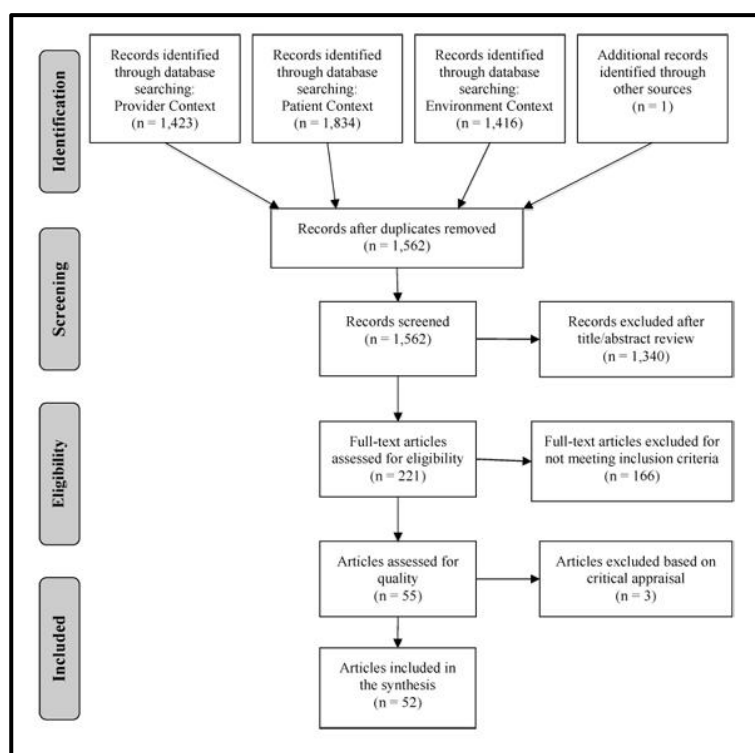

Figure. 1: PRISMA flow diagram

Table. 2: Shared decision-marking categories and subcategories

Category	Sub-category
Communication and relationship building	Individual characteristics
	Relationship building—trust and respect

Category	Sub-category
	Information exchange—communication
	Context
Work toward shared decision-making	Assessment
	Finding balance
	Teaching-learning
	The decision point
Action for shared decision-making	Taking action on the decision
	Returning to the provider to re-evaluate the decision

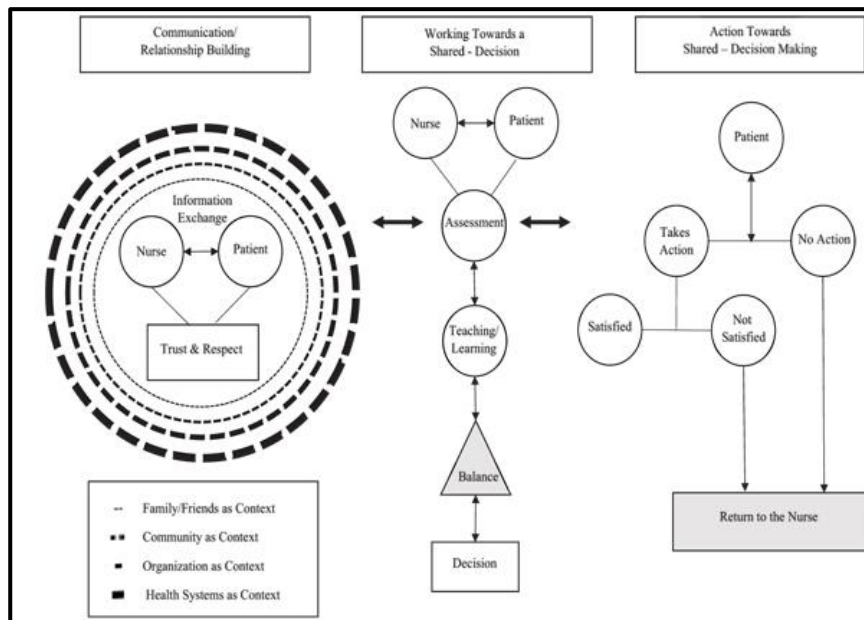*Figure. 2: A visual representation for shared decision-making in practice*

4.1. Communication and relationship:

Communication and relationship building is the first general category and is foundational for the SDM process. The three sub-themes within this theme are: relationship building—trust and respect; information exchange— communication; and context.

4.1.1. Relationship building—trust and respect:

Individuals enter into the relationship and must work towards building a trusting and respectful relationship where SDM is invited and encouraged. The work begins as the patient identifies a need or question. This need and/or question influences the patient's quest for answers. The relationship is the vehicle by which providers and patients "act in a relational way" and the

individuals are "actively seeking a personal connection with each other". The relationship is a partnership where there is collaboration and a sharing of power. With the sharing of power, there is mutual responsibility toward one another. The relationship is strengthened over time leading to bi-directional trust and respect. Patients who feel trusted and respected are more open and share information with their provider thereby facilitating communication for SDM.

4.1.2. Information exchange—communication:

Information exchange *via* interpersonal and intrapersonal communication sustains the relationship. The *interpersonal process* of communication is bi-directional between the provider and the patient when there is a mutual exchange of information. The exchange of information also involves active listening. Emotions such as fear, anger, and anxiety can

Interfere with a patient's readiness to communicate. Furthermore, a provider's readiness and receptiveness to explore a patient's feelings and preferences is important. For example, the emotional tone the provider creates facilitates an atmosphere of compassion and caring that enhances open communication. In situations where this emotional tone is not created the patient is less likely to feel compassion or care and may perceive the provider's approach as "authoritarian." This perception may prompt the patient's reluctance to communicate and establishing a "shield" –creating a barrier to SDM.

The *intrapersonal process* of communication also plays a role in the achievement of SDM taking place *within* the provider and patient through the process of reflection. The reflection process takes place at two levels. Mutual reflection takes place when the provider and the patient reflect together *via* communication, exchanging thoughts about decisions, and clarifying the patient's perspective. Individual reflection takes place autonomously within the individual provider or patient. For example, during an individual reflective moment a provider may identify "blind spots" in a patient's perception of an experience which may be limiting the patient's insight about an issue. During the corresponding mutual reflection, the provider uses communication skills to challenge the patient verbally and non-verbally while encouraging the patient to also engage intrapersonal self-reflection. The mutual reflection process, therefore, encourages patients to engage in their own independent reflections that helps them recognize "a new decision or a new position on the difficulty or challenge on which they had been reflecting". Furthermore, providers and patients continually reflect upon their relationship and communication over time known as post-decision deliberation. These deliberations offer an opportunity for reconsideration of past decisions illustrating the on-going process of decision-making.

4.1.3. Context:

The provider and the patient work within a particular healthcare context that either facilitates or creates barriers for SDM. From the patient's perspective, the context includes the patient's family, friends, and home, including community supports and networks. For example, patients who are accompanied by family members to healthcare encounters are more likely to engage in SDM. The context of the provider's work environment also influences their ability to integrate SDM into practice. Time and access to resources are facilitators for SDM. Organizational models and systems that facilitate patients' access to their provider(s) and/or healthcare team reduce fragmentation and improve collaboration, coordination, and SDM. Technology capable of tracing patients' progress through the SDM process is a valuable

Resource. Shared decision-making is prominent in the thoughts of healthcare providers within the larger healthcare system; however, so too are evidence-based practice (EBP) and clinical practice guidelines. The challenge for providers is to ensure that the realities of clinical practice are addressed along with the patient's preferences.

4.2. Work toward shared decision-making:

Communication and relationship building are foundational for the initiation of SDM. Shared decision-making, however, requires dedicated ongoing work. The second general category, work towards SDM, has four sub-categories: assessment, teaching-learning, finding balance, and decision.

4.2.1. Assessment:

The work towards SDM begins with an assessment. The assessment of the individual is foundational as the provider must "come to know one's patient" and the patient's specific preferences. Understanding the individual patient characteristics begins with an awareness of the patient's age, gender, race, spiritual and cultural beliefs, education, and life experiences. All of these characteristics influence the patient's beliefs about SDM and the value placed on SDM. For example, the assessment will reveal whether patients see themselves as sharing in decision-making, or whether they prefer the provider to be the primary decision maker? The role a patient chooses to play may change over time, depending on the situation for which the patient is seeking assistance. Furthermore, as the work towards the shared decision takes place, there will be moments when the provider's expertise will warrant that they take the lead in the encounter and other moments when the patient will take the lead. Race too may influence a patient's behavior if an individual decides not to share information for reasons of racially

inspired mistrust. Age may influence behaviors as research has shown that younger individuals choose to engage in SDM compared to older adults. This is also true of individuals with higher levels of education and literacy.

The assessment continues as the provider asks questions about the reasons the patient is seeking assistance. How SDM unfolds varies depending upon the acuity or chronicity of illness. Acute illness may foster a provider-led approach to SDM. Conversely, chronic illness fosters a patient-led approach with patients who are responsible for the self-management of their illness over time in their own home/community, often with the support of family or friends. Gathering information about social support and social networks, therefore, is a part of the assessment as these networks have been found to facilitate a patient's ability to be active and engaged in

SDM. Ultimately, the assessment offers the provider an opportunity to know the patient, the patient's family, and home/community, building a practice based on facts and evidence not assumptions.

4.2.2. Teaching-learning:

Shared decision-making warrants that patients have the necessary information that they need to know so that they can share in the decision-making process. Providers, therefore, will need to teach and provide their patients with this information. What providers teach to support learning depends on the assessment. For example, the provider needs to consider the readiness of the patient and the amount and type of information that needs to be taught and how to best teach that information for a specific patient. This is vital in today's EBP-driven healthcare environment. The EBP process involves sharing information with the patient about diagnosis and treatment, educating the patient about the disease and treatment options, and informing the patient about the strength of the evidence, as well as the risks, benefits, and possible outcomes. Information gathered during the assessment guides providers so that they are mindful of a patient's age, literacy, language, and culture in the development and delivery of educational information. Patient-centered education applies specific teaching strategies for specific patients, such as culturally appropriate decision aids, which both guide patient learning and facilitate the patient's understanding of information.

4.2.3. Finding balance:

Providers and patients come together due to identified needs/issues. A need/issue causes uncertainty and challenges providers and patients to find a resolution through SDM. Part of the work of SDM is achieving balance necessary to arrive at a shared decision. This is especially

relevant with regard to EBP. For example, in a clinical practice scenario when there is evidence that there may be alternative best practice choices, the provider's competence in the use of equipoise in the search for a balanced shared decision is sought. The concept of equipoise is exemplified by "talk" where there is the presentation of information, portrayal of options and exploitation of alternatives, as well as deliberation.

What happens, however, in situations where there is no documented evidence for best practice or there is only one best practice choice that a patient considers unacceptable because of personal ideas, values, or beliefs? These encounters invoke the ethics of practice, including the principles of autonomy and beneficence. The provider and the patient together seek to achieve balance between these principles through the application of skills such as talking, openness, and information provision. Furthermore, part of the work in finding balance requires deliberation and negotiation leading to consensus about the decision.

4.2.4. The decision:

Communication and relationship building, assessment, teaching and learning and the seeking of balance are all part of the SDM process leading to consensus about the decision. The work is individual for every patient and facilitates care that is patient-centered. Ultimately, the shared decision is not the end point but signals the need for the patient to take action and carry out the decision.

4.3. Action for shared decision-making:

This third theme, action for SDM, contains two sub-themes: Takes action or no action.

4.3.1. Takes action:

Shared decision-making does not end with the decision. Once the provider and patient come to a shared decision there needs to be action by the patient. The process of SDM, therefore, moves beyond the decision point as the patient engages in the steps necessary to take action to see the decision through. For example, patients return to their homes/communities where they attempt to carry out their decisions. During this process, the implementation of the decision may be seamless, the patient is satisfied, and the issue or question is addressed. There may be, however, times when patients find the action challenging or the actions that are required are not what was expected. In these situations, the patient may not be satisfied resulting in an unresolved issue or questions prompting the patient to return to the provider to re-evaluate the decision.

4.3.2. No action:

No action occurs when patients return to their homes/communities; however, once in their familiar environment, they chose not to initiate the steps and actions to see their decisions through. For example, patients may feel pressured by the perceived power imbalance they experienced with their provider and as a result found themselves aligning with a particular decision favored by the provider. As a result, when patients return to their homes/communities they choose not to act. This realization may trigger the need to return to the provider or in some cases a patient may choose not to return for further care.

5. Discussion:

The significance of this integrative review is noted in the presentation of the ongoing process of SDM. Box (1) below provides a case study that exemplifies this ongoing process. This process takes place in practice between a nurse and patient during a healthcare encounter where there is an identified need/issue or question. The *relationship* is one of a partnership where both parties are collaborating. The relationship that develops is one where trust and respect is fostered by the communication between the nurse and the patient. *Communication* is both interpersonal and intrapersonal. Interpersonal communication between the nurse and patient takes place during the healthcare encounter. Intrapersonal communication takes place during the encounter when the nurse and patient think about—*viareflection*—what they are saying, doing, and observing at the moment they are actively engaged. For example, a nurse may reflect on a patient's non-responsiveness to a conversation. Nurses who are knowledgeable about communication and skillful in the application of communication techniques will use strategic questioning where options are explored and listening to facilitate a patient's insight into the presiding issue. Reflection also continues after the interaction as nurses and patients reflect upon past SDM healthcare encounters. During these moments, patients may have questions and/or decide that the initial decision is no longer acceptable and wish to return to their nurse. This review highlights relationship building and communication in nursing practice that is foundational for SDM and signals that communication is complex, requiring nurses to be ever vigilant about what they are saying and doing, as well as the patient's response. Being aware of one's own reflections as well as one's skills to assist patients in their own self-reflection facilitates a practice based in SDM. In addition, this review highlights the need for a practice environment that fosters relationships and communication by establishing practice models where ongoing connections between the nurse and patient are consistent and continuous, thereby supporting and sustaining SDM.

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