

# **Professional centred shared decision making? Patient decision aids in practice**

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## Abstract

**Background:** To explore health care practitioner's perceptions and use of patient decision aids (PDAs) in routine clinical practice as a baseline study prior to an intervention involving the introduction of a suite of PDAs.

**Methods:** Health Care Practitioners (HCPs) from five general practice surgeries in northern England participated in focus group sessions around the themes of patient decision aids, patient and HCP preferences and shared decision making (SDM). Participation included general practitioners (n=17), practice nurses (n= 5) and auxiliary staff (n=3). Transcripts were analysed using a framework approach.

**Results:** We report a) HCP's discussion of the current impetus towards sharing decisions and their perspectives on barriers to SDM, and b) the implementation of PDAs in practice and impediments such as lack of an evidence base and time available in consultations.

**Conclusion:** We demonstrate two orientations to sharing decisions: HCP-centred and patient-centred with the former predominating. We argue that it is necessary to rethink the changes required *in practice* for the implementation of SDM.

**Key words:** shared decision making; routine practice; distributed decision making; patient decision aids, qualitative research

## Background

Engaging patients in clinical decision making has become a guiding ethical principle underpinning much contemporary and routine clinical practice [1-5]. Development of Patient Decision Aids (PDAs) has been proposed as one component of clinical practice through which to enable evidence-based patient choice (EBPC) and shared decision making (SDM)[4]. PDAs are designed to assist in decision making about healthcare by providing the best available evidence of the risks and benefits of particular therapeutic options in association with the elicitation and incorporation of patient values. When used in SDM it is anticipated that patients will be involved in the decision making process to the extent that they desire, and that decisions will be made in a partnership between patient and physician that acknowledges rights and duties of all parties involved[6].

Despite broad acceptance of the use of PDAs in improving patient based outcomes and health, evidence for their successful implementation and use in extending SDM in routine practice remains scarce [7-10]. SDM is commonly contrasted with paternalistic approaches to decision making which is characterised by the expression, 'doctor knows best'. The shift towards SDM may then be seen to involve a philosophical reorientation that understands patient/health care practitioner relations differently, requiring (or perhaps producing) a new 'way of viewing the world' in which patients and HCPs share input into treatment decisions [7, 11]. Despite the wide-reaching implications of SDM to decision making in healthcare, there is little background information that addresses how and if PDAs are effectively incorporated by HCPs into their routine practice [8, 12, 13]. Others who have examined the practice of SDM however have limited their examination to general practitioners[14], specifically to those who have an existing interest in and knowledge of SDM[10]. Our approach differs in that we include a broad spectrum of HCPs, including those already skilled in SDM and those with little or no knowledge. Moreover, in our analysis we consider the patient/HCP interaction as well as the social and organisational context of decision making.

## Methods

Five general practice surgeries in northern England were invited to participate in the study. Within each of the participating practices a one hour presentation was given by RGT to introduce the study, the concept of SDM and current developments concerning PDAs. The presentation included a brief overview of different approaches to decision making and gave examples of different PDAs and modes of implementation. It also introduced the work and resources of organisations involved in the development and use of PDAs such as the Ottawa Health Research Institute (OHRI) and International Patient Decision Aids Standards Collaboration (IPDAS). Participants were asked to reflect on the presentation, to begin to consider the potential for using PDAs in their practice and to identify particular areas of clinical practice where a PDA could be of value. After a two week period for reflection participants were invited to take part in focus groups to discuss further the topic of

SDM and PDAs. Focus groups were conducted around the themes of SDM and PDAs in general practice, exploring potential for further development of SDM in the practice.

A framework approach was used (by DBW and MJM) in the analysis of focus group transcripts [15]. The framework approach has been identified as a suitable method for analysing data where the objectives of the research have been set in advance of the analysis, for example where particular themes are considered of relevance to a research topic [16]. The main objective of the focus group was to consider issues of relevance to SDM and PDAs in routine settings from the perspective of health care practitioners. A five stage process of analysis [15] was adopted involving: familiarisation with the data through reading and rereading the transcripts for recurrent themes; identification of a thematic framework based on the objectives of the research; a process of indexing in which transcripts were annotated with codes derived from the thematic framework; summarising and synthesising this data into charts that use representative quotes to demonstrate themes (Tables 1-5). Some themes overlap with others. Analysis was designed to clarify the key issues of importance to SDM in routine practice and to use these to inform the introduction of SDM tools in routine practice prior to an intervention study.

## **Results**

Our findings suggest that at both institutional and individual levels HCPs had different understandings and perceptions of their roles and relations in respect to patients that ranged from an implicit understanding and commitment towards the principles of SDM that was patient-centred to a protective paternalism that was more HCP centred.

### ***Sharing Decisions***

Different *practices* adopted approaches more or less consistent with the principles of SDM. The transcripts from FG1 demonstrated the least familiarity with principles of SDM, and FG2 the most. One HCP in FG1 demonstrated a protective paternalistic approach to HCP/patient relations in suggesting his role was to “explain what I think is best” to the patient (Table 1:1). Discussing the topic of prescription of antibiotics for sore throat, the same HCP argued that it was not appropriate, and even undesirable, to share information or decision making with patient about this topic because while there may be limited benefit for some individuals, the social consequences of using antibiotics were too great (Table 1:2). HCPs in FG1 appeared concerned that PDAs might threaten their current roles. Two GPs associated PDAs with technological change and a declining role for human HCPs, invoking dystopian images of “virtual GPs” (Table 1:3). Moreover, participants in FG1 appeared to have difficulty contrasting information giving with SDM. Asked how SDM was enabled in the practice one participant replied “I do share with patients’ information and the main source of information is my brain” (Table 1:4) thereby not only conflating information provision and SDM but also effectively dismissing the need for an evidence base for this information. Participants

appeared reluctant to devolve decision making arguing that patients may not understand, may act irrationally with information given and may not act in the interests of public health (Table 1:5).

Table 1: Representative quotes

1:1	Well I explain what I think is best ... and with a bit of luck they'll say "that's fine" and do it (FG1)
1:2	There is one area where I don't particularly want decision aids or I don't want too much information [or] discussion, that's antibiotics because very few patients consider the public health implications of resistance. (FG1)
1:3	[If an interactive PDA introduced] you might lose doctors and clinicians altogether! Virtual GPs! (FG1)
1:4	I do share with patients' information and the main source of information is my brain... Shall we do A or shall we do B? (FG1)
1:5	Some patients are able to process the information that you give them very easily and other people might even be not able to read or the information that is given to them is very difficult to interpret. (FG1)

In contrast, FG2 and FG3 appeared, most consistently, to recognise and support a role for HCPs in facilitating patients' involvement in decision making (Table 2:1). HCPs in FG2 were sympathetic and responsive to the importance of SDM in the consultation and despite one describing patient competencies negatively and suggesting that the basis of individual's decisions were "probably...irrational" (Table 2:2). Participants reflected that their shared understanding and approach to SDM could be attributed in part to the adoption of a patient-centred culture in the practice, including regular involvement in training (Table 2:3) They were able to refer to key literature/authors on SDM (Table 2:4) and demonstrated they had applied the principles in practice by recording shared decisions when they occurred (Table 2:5). In FG4 participants expressed surprise that SDM was considered as something new (Table 2.6). When asked to reflect on SDM one GP suggested that most people wish to engage at some level, and that sometimes this engagement occurred outside the consultation as patients could (and sometimes did) reject what the HCP offered as a treatment option or change their decision (Table: 2.7). Despite recognising that decisions could be modified by patients because of the values they held, there was little mention of eliciting values as part of the consultation process itself, and not in any systematic way.

Table 2: Representative quotes

2:1	At one end you've got doctors making decisions not giving patients any information or choice and at the other end you've got consumerism, essentially you just give them the choice and the price and all the other bits and pieces and they choose and shared decision
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making is some sort of negotiated pathway that involves both the doctors and the patients knowledge, opinions, experience. (FG2)

2:2 Information implies that decision making is relatively rationale where as of course most people make decisions probably on relatively irrational basis so it's actually acknowledging that, understanding that. (FG3)

2:3 We have communication skills regularly training with an outside trainer and its [SDM] one of the areas we've looked at. (FG3)

2:4 I went to a presentation by Glyn Elwyn who has done a lot on shared decision making and he went through some of the more sophisticated computer based tools. (FG3)

2:5 I've recorded it on the screen, you know. We came to a shared decision that it was appropriate not to have the medication. (FG3)

2:6 It seems an odd idea that we weren't doing it before, like somehow it's a new thing that wasn't going on before. (FG4)

2:7 ...you took the decision for them last time [but] they go away, they take a decision, you know, a separate one and you then move forwards from where you are at that point, it's not as simple as they want to or they don't want to. (FG4)

Even those practices and participant HCPs sympathetic to SDM found the idea of sharing responsibility for decision making difficult 'in practice' (Table 3:1). First, some patients try to devolve responsibility for decisions to HCPs or expect the HCP to take the decision (Table 3:2). Second, HCPs recognised that shared decision making often involved areas of uncertainty where neither the HCP nor patient had sufficient information upon which to base a decision (Table 3:3). Third, some patients were reported to be more indecisive than others (Table 3:4) and HCPs found their role difficult because it involved assessing patients decision making desires and abilities. Fourth, HCPs reported it was difficult to remove themselves from the role of decision maker (Table 3:5). One GP suggested it was hard not to "push the decision", referring to the example of the older man who had shared a decision not to take preventive medication and who had subsequently had a stroke. She suggested that "a little bit of me thinks I should have been more forceful" [in making him take the medication] (Table 3:6). In such a situation the patient made a choice, but its legitimacy for the HCP came into question with the perception of a 'wrong' outcome. Therefore, despite a recognition that "this generation don't like telling people what to do" (Table 3:7), there are powerful rhetorics at play in which responsibility is still seen to ultimately rest with the HCP. While participants in FG2 considered it desirable to empower patients, "real shared decision making" involved a sometimes uncomfortable and difficult transition in HCP roles. HCPs across all focus groups suggested patients also failed to enact shared roles in decision-making. One respondent in FG2 suggested SDM felt more like "collusion" (Table 3:9)– a simulacrum of choice in which the role

of the HCP is to authorise the patients decision through the rhetoric of shared decision making; and most often when it suited the HCP: “I often find it easier to be involved in real shared decision making where I don’t feel strongly either way” (Table 3:9).

Table 3: Representative quotes

3:1	It’s difficult to achieve equality but real genuine shared decision making is trying to do it from a position of equal basis, not necessarily equal knowledge but equal weight from both sides into making the decision and I think it’s a bit of a challenge but very important. (FG3)
3:2	...sometimes it is quite clear ... they want you to make the decision on their behalf... it’s a very complicated part about decision making. (FG3)
3:3	You may be motivated to share the decision and either you don’t have access to the information which would populate the decision boxes or there is no information about relative risk, benefit and all the rest...[it’s] shared guess work. (FG2)
3:4	Well, its very tricky with indecisive people. (FG3)
3:5	Its actually very difficult for us to move back from the role of being the person who's really got the agenda, knows what should, or we feel should be done and not actually to sort of push the decision. (FG3)
3:6	I just heard yesterday he's had a stroke...a little bit of me thinks I should have been more forceful...you know we came to a shared decision that it was appropriate not to have the medication. (FG3)
3:7	I think our relationship has changed you know this generation we don't like to tell people what to do.(FG3)
3:8	I think we do, can collude with patients quite a lot. (FG2)
3:9	I often find it easier to be involved in real shared decision making where I don’t feel strongly either way. (FG2)

Thus participants and practices varied in their awareness of the changed relationships inherent in the move towards patient-centeredness and SDM. HCPs roles and relationships with patients were both institutionally driven and individually mediated. Where practices demonstrated commitment to principles of SDM and patient-centred practice, HCPs were more comfortable with the use of SDM language and principles and were able to recognise that SDM involved the shift of power implicit in the term. Despite facilitating SDM in practice, it was not clear that any HCPs in our focus groups felt completely comfortable with SDM or absolved from adopting more paternalistic roles with patients.

### Risk Communication

The diversity of skills, methods and resources for sharing information with patients appeared to reflect *individual* as well as *practice based* differences. In FG2 sharing information about risk was viewed by some HCPs as “spurious” (Table 4:1) and unhelpful, whilst for others risks were useful

“to grapple with” (Table 4:2). Participants in FG2 had also been involved in ongoing communication skills training and the expression of different opinions within the focus group and inclusion of all participants in the discussion demonstrated inclusiveness and openness to the views of others. In contrast, communication skills were not emphasised in FG1 or FG4 but rather expectations about communication were based on common assumptions that participants would adhere to guidelines (Table 4:3). Different communication practices in the focus group may not reflect what happens in consultation. However it is an indicator of preference for particular communication styles and suggests differences in how skills in communication are viewed as either commonsense or learned. Different practices had invested more or less time and resources towards communication and in pursuit of the particular goal of SDM as a “theory and an ideal” (Table 4:4).

Table 4: Representative quotes

4:1	I very rarely get into detailed figures about risk and I think that to some extent they are, I mean part of that is philosophical, they are slightly spurious in the sense that they give this objectivity to it which just isn't there. (FG3)
4:2	I much prefer to have a figure to grapple with. (FG2)
4:3	We never discussed it [SDM] I don't think particularly. I would expect that everybody would be following the GMC guidelines: you know communication with patients. (FG1)
4:4	I think the culture here has been around patient centredness, as you know, a theory and an ideal (FG3)

### **Using PDAs**

What is apparent across all focus groups was that HCPs had limited experience of PDAs *in practice* or in *hypothetical situations* to draw upon to describe how PDAs might be incorporated successfully. What is equally clear is that participants in those practices predisposed to a patient-centred approach and SDM were more likely to talk positively about using PDAs even when acknowledging the difficulties whereas participants from more HCP centred practices were more likely to use the difficulties rhetorically to explain and justify their lack of use of PDAs and other SDM practices. When asked to reflect on the availability and use of PDAs in their practice, none had routinely used PDAs. In FG3 two PDAs identified as used “regularly” were a risk/benefit table for using HRT (Hormone Replacement Therapy) and a Framingham derived computerised risk assessment for cardiovascular risk (by practice nurses and GPs). In both situations HCPs recognised that family history and values were not incorporated in the use of the tools. Moreover, the presentation of risk was used to “reinforce what you are saying” (Table 5:1). PDAs, in HCP centred approaches were useful if they produced decisions the HCP was happy with (Table 5:2)

The advantage of using a PDA was viewed in terms of surveillance of the patient's health beyond the consultation. One GP suggested a blood pressure monitoring machine for home use "really helps me to make a decision" (Table 5:3) about whether or not to increase medication.

Table 5: Representative quotes

5:1	I use the coronary risk calculator and manipulated it by putting in a lower cholesterol value and showing people how their risk would come back... to reinforce what you are saying. (FG3)
5:2	I think that when you're using a decision making aid I think you can only do it if you're completely happy with the decision the patient will make from that. And I think that's the critical thing because if you think one thing is right then there is no point going down that line [using a decision aid] really. You can inform them a bit about it but if you're actually using an aid and asking them their opinion I think you have to choose topics where whatever their decision is you're comfortable with that. (FG1)
5:3	They come with a big list of all their blood pressures at different times and that really helps me to make a decision. (FG4)

### PDA's in practice

Some participants who had taken part in our earlier clinical trials of a computerised PDA for atrial fibrillation[17-20] suggested the tools were "useful" (Table 6:1). In FG3 one participant suggested an Hormone Replacement Therapy decision tool had been particularly useful for improving HCP knowledge (rather than facilitating SDM with the patient) (Table 6:2). Despite this, there was a perception across the practices that PDAs were not designed with 'real life' consultation pressures in mind. As one participant suggested of a computerised PDA, it had been unfathomable to imagine how it could be incorporated into a 10 minute consultation (Table 6:3). Accessibility and lack of "faff" (fuss) appeared to be foremost in the minds of participants (Table 6:4). Nonetheless a number of difficulties in assessing how and when to use PDAs were identified: people have different conceptions of risk, risk may be a confusing way of presenting data for either/or patients and HCPs (Table 6:5), some patients are viewed as more needy of decisions than others (and this is difficult to assess) (cf. Table 1:5), and some patients may require different kinds of aids and support to use them (Table 6:6). In other words, HCPs found it difficult to envisage using PDAs given the complexity of decision making, constraints of the consultation(s), the "faff", and the restrictions imposed by external priority setting (at both practice and policy levels). At the same time there appeared to be different motivations underlying the generally positive support and desire to develop SDM and use PDAs where possible. For one GP, PDAs were equated with simplified systems for information giving such that an "NHS bank of information and decision aids" that would reduce the current deficiencies of information retrieval and hand-outs (Table 6:7). Other participant HCPs were more reflexive of their desire to work towards "real shared decision making" and

equality in the decision making process, but recognised they had limited skills or resources to do so (cf. Table 3:1). Whether in favour of using PDAs or viewing them as too much of a “faff”, HCP’s concerns predominantly centred around their own practice.

Table 6: Representative quotes

6:1	We've actually got charts of smiley faces and I haven't used them, but when it was on IT [computer based] in the DARTS [Decision aids in Routine Treatment Study] I did find it useful. (FG3)
6:2	HRT risk erm, you know like how many people get breast cancer...that sort of thing and I use that regularly because it's quite easy to understand err, it helps me understand the figures! (FG4)
6:3	[They] went through some of the more sophisticated computer based tools but [it] seemed unfathomable to get them into a 10 minute consultation and actually he was in an internet site and using it in the consultation setting. (FG3)
6:4	It needs the decision aids to be there, it needs them to be readily accessible without faff and it needs experiential training of us. (FG3)
6:5	I get jumbled you know per 100,000 or 10,000 ...Your language is so subjective isn't it because it's how you interpret the risks (FG2)
6:6	[if it is a person] who can cope with the anxiety of not making a decision [in the consultation] it might be better to give him[sic] a decision making aid he could take away and work with. (FG3)
6:7	An NHS bank of internet information and decision aids would be absolutely a good aid because the downside of leaflets on your desk is a) keep an eye on the fact and that there still in date and b) if you want to get a bit of information from leaflets on different topics you would have no desk space left. (FG1)

## Time

Time was identified as a key constraint identified across all practices (Table 2) and is recognised in other studies [10, 14, 21]. Of all the potential barriers this best represents the HCP-centredness of HCP thinking about PDAs and sharing decisions with patients. Relations between HCPs and patients were considered to be constrained by the brevity of the consultation and pressures associated with practice based targets. While it was observed that SDM may well have long term benefits in health outcomes, participants in FG4 shared the view that “selling” SDM to their practice would need to include some benefit that would at the very least, not increase time spent with patients. The perception of SDM as time-consuming was used as a rhetorical device by a HCP in FG1 to explain the lack of patient decision aids in that practice (Table 7:1). Time was treated as a fixed constant of the patient/HCP interaction such that SDM could be cast, problematically, as an

*additional element of the consultation* (Table 7:2 & 7:3). Yet time, however much a hindrance, was not necessarily viewed as an immutable barrier. While one HCP suggested “the big limiting factor is time”; he later observed that SDM might be thought of as “going on between consultations” (Table 7:4). The process of decision making was understood as on-going and not necessarily a ‘one off’ event limited to a one-off consultation: PDAs could have some utility as between-consultation tools. Other HCPs suggested PDAs could help make durable decisions that “save time in the future” (Table 7:3 & 7:5). Other participants reported that receptionists could play a screening role identifying patients with particular health concerns, directing them to HCPs (including the practice nurse) with particular areas of clinical expertise – thus reducing the possibility that two consultations would be necessary; but also potentially creating a new space for SDM and PDAs outside the consultation.

Table 7: Representative quotes

7:1	You have to cut corners in everything and the amount of information you give and use of decision aids is one of the corners that you cut. (FG1)
7:2	I think it can be more time consuming as well to have a consultation [employing SDM] (FG2)
7:3	I think probably long term it would save time but within your day to day practice you’re very much working under a lot of pressure so it could be difficult to try and fit things in. (FG5)
7:4	Perhaps we should see SDM as a lot of that going on between consultations rather than during a consultation. (FG3)
7:5	More time making the correct decision ... would save time in the future. (FG5)

## 4.0 Discussion and conclusion

### *Discussion*

We identify two broad orientations towards SDM: patient-centred and HCP-centred. In the first, practitioners recognise a changed relationship between HCPs and patients in *how* decisions get made. In the second, SDM exists along a continuum of more and less paternalistic models: a philosophical reorientation of patient/HCP roles is not evident in even the least paternalistic on this continuum. Rather, the SDM is adopted in relation to issues where there is either uncertainty about the risks and benefits of particular treatment options, or in particular relation to prevention focused interventions. For HCPs historically charged with responsibility for a patient’s welfare, the ability to devolve power is more difficult than might be suggested by the descriptions of SDM.

Rather than assuming that the traditional forms of evidence for PDAs and SDM are a sufficient base upon which to introduce them, in this study we considered a variety of practitioners' views about SDM and PDAs prior to an intervention. In establishing a baseline of how practitioners themselves understand and see a role for SDM and PDAs we are thus able to reflect on the different understandings of SDM, different approaches to it, and different needs across practices and individuals. From our findings we propose that: SDM involves more than a change in practice and requires a new way of seeing the world; some HCPs are more successful than others in recognising such a shift but still find practice difficult; HCPs views about their own and patient roles in decision making varied considerably across practices and individuals; HCPs/practices shared different understandings of where and when decision making gets done; HCPs were not equally skilled or knowledgeable about SDM; information needs and SDM are conflated; SDM language can be used to describe paternalistic relations of care; PDAs were used as a means of surveillance of patients; SDM is sometimes perceived by HCPs as not 'real'; and HCPs have few examples on which to draw that demonstrate how PDAs can work in practice.

For some, SDM involves a philosophical reorientation away from earlier paternalistic models and a new forms of thinking about patient HCP relations [7, 22]. O'Flynn and Britten (2006) view such a reorientation in terms of the biomedical model, suggesting that the ability of HCPs to share decisions and devolve power to patients is, in reality, circumscribed because it is fundamentally in opposition to the practices through which they gain their professional identity. From this perspective it is not surprising that there are "low levels of SDM observed in practice" [see also 8] because practitioners are 'socialised' to a particular way of viewing HCP/patient relations. O'Flynn and Britten (2006) surmise that practitioners need to do 'identity work', a reflexive re-examination of their role, if they are to achieve the goals of SDM. Elwyn (2004) also describes a shift in HCP/patient relations. In his view however, the process of renegotiating patient/HCPs roles is a challenge but is also inevitable given the growing recognition of uncertainties associated with decision making. The focus group findings we present here support the proposition that such a transition is underway, but one that is recognised and advanced by some HCPs more than others. Reconfiguring HCP roles *in general* suggests far broader changes in practice than introducing SDM for particular clinical conditions where there is uncertainty around treatment options or for prevention focused interventions. What is less apparent to us is how much support HCPs and patients have in recognising and appreciating the difference, and what support is required to facilitate a more general shift towards patient-centred care.

Several recent studies have sought to address the apparent lacuna in understanding HCPs views on PDAs in clinical practice [9, 13, 14, 23]. Findings of these studies tend to be conceptualised around ideas of 'barriers' and 'facilitators' to operationalising SDM [14, 21]. In these views issues of time and lack of applicability for particular consultations are routinely represented as roadblocks to the successful implementation of SDM. We do not dispute the importance of these observations in

helping to explain many of the difficulties HCPs associate with introducing PDAs into practice, or in helping develop solutions to some of the practical barriers and the identification of training needs of HCPs. However, the expectation that SDM occurs only within the consultation setting and between GPs and patients limits opportunities for introducing SDM in practice based settings. Moreover, such accounts do not take into consideration variations between institutions and individuals in how SDM is experienced or that SDM language does not in itself guarantee that SDM is being adopted.

### *Conclusion*

Rethinking the changes required *in practice* for the implementation of SDM is necessary. Current recommendations largely do not take account of the temporal, practical and other pressures in clinical practice. We support Elwyn's argument that viewing the consultation as an 'episodic didactic encounter rather than a longitudinal complex relationship' imposes limitations on how HCPs and patients can engage [7]. Across the focus groups different understandings of the consultation, and the role of SDM within that, produced different responses to the potential of SDM and PDAs. Where consultations were viewed as one off events requiring a decision, the potential for PDAs was viewed as limited and their design as requiring a time-saving element; however where the view of care was longer-term, involving more than one consultation and/or decision making as 'a dynamic process' (FG2-GP1F – Table 2), the realm of possible uses for PDAs was greatly expanded. There is here scope for a greater attention to the concept of 'distributed decision making'; that is, understanding how 'decisions are distributed across time, courses of actions, people, situations and technologies' [20]. At the same time, the limitations of practice based targets and particular institutional organisations of referral that resulted in different levels of opportunity for the introduction of PDAs across practices need to be acknowledged.

### *Practice implications*

Our findings suggest that the implementation of PDAs in clinical practice must involve a more explicit recognition of the challenge of this approach and the implicit reordering of power that it may involve. First, evaluative frameworks and modes of delivering SDM tools into practice need to address how different institutional settings and cultures modify the introduction of PDAs. Second, PDAs could be incorporated into routine practice beyond the confines of the consultation. Third, HCPs may need more supportive frameworks to enable them to do 'real shared decision making'. Support that involves more than training in the methods of implementation and addresses the implications for HCPs that make devolving responsibility to patients immensely difficult.

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I confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.