

## CLINICAL DECISION-MAKING IN PATIENT-CENTRED NURSING CARE

**Margaret Omowaleola Akinwaare**

*Department of Nursing, Faculty of Clinical Sciences  
College of Medicine, University of Ibadan, Nigeria.*

*E-mail: [margaretakinwaare@gmail.com](mailto:margaretakinwaare@gmail.com)*

### INTRODUCTION

Patient-centred care is a model of care that respects the patient's experience, values, needs and preferences in the planning, co-ordination and delivery of care (Gluyas, 2015). A central component of this model is a therapeutic relationship between the patient and the team of healthcare professionals. The implementation of a patient-centred care model has been shown to contribute to improved outcomes for patients, better use of resources, decreased costs and increased satisfaction with care. Collaboration between patient and healthcare professionals is at the heart of values-based practice and shared clinical decision making (Stacey, Felton, Hui, Stickley, Houghton et al, 2015). The

service user movement and consumerist models of health care have significantly changed the perception of the role of patients in their own care. This change has culminated in a policy framework that enshrines patients' choices at the heart of health care (Department of Health 2012). Patients should be fully involved in decisions about care, support and treatment as well as the views of families, carers and others, should be fully considered when taking clinical decisions. Clinical decision making therefore involves incorporating the differing and sometimes conflicting values of people involved in planning and delivering services, including patients and healthcare professionals (Cleary 2003).

## Patient-Centred Care

There has been a concerted effort to move from a model of care where patients are passive recipients of care, to one where patients and their family members are active participants in planning their care and decision making (Bellows et al 2015, Press & Richards 2015). Governments and healthcare organisations have committed to this paradigm, since clinical outcomes and patient safety are improved when a patient-centred approach to care is used effectively (Stone 2008, Meterko et al 2010, Hansson et al 2015, Mazurenko et al 2015). There is an imperative to partner with patients and families to improve quality of care.

The term patient-centred care encompasses numerous aspects, such as:

- Sharing information, power and responsibility by engaging patients and their family and carers in the clinical decision-making and care process.

- Fostering a therapeutic relationship between the patient and nurses
- Recognising and responding to the uniqueness of the patient's experience, values, needs and preferences.
- Providing emotional support and physical comfort.
- Designing clinical-decision making and care processes to suit patient needs and ensure continuity of care.

Until recently, patient care was based on a paternalistic model, where nurses and other healthcare professionals directed healthcare decision-making on behalf of patients and their families. This was based on the generally accepted premise that nurses were well informed and had access to information that made them experts in the field (Mazurenko et al 2015). Indeed, nurses are experts in terms of their clinical knowledge compared with the general public. However, the

paternalistic model is no longer the favoured model of care (Edwards & Elwyn 2009). The general public is realising that, while clinical expertise and knowledge are important, so too are their personal circumstances and experiences in terms of making clinical care decisions. Also, patients' expectations of their healthcare encounters are evolving and include the desire to be involved in decision-making about their care and treatment (Conway et al 2006, Royal College of General Practitioners 2014).

Patient-centred care is reliant on a professional relationship with the patient that recognises and responds to the patient's needs and preferences. Gawande (2014) described three types of relationships that characterise healthcare professionals' interactions with patients. The first is the paternalistic relationship (as described previously). The second is an informative relationship, where the healthcare professional

provides all the information about the illness and treatment options, allowing the patient to make a choice. The third is an interpretive relationship, where the healthcare professional takes time to determine what is important to the patient, their values and preferences, and helps them sort through the information about the health condition and treatment options to achieve their desired outcome. The latter relationship recognises that patients want information and control, but that they also want guidance in applying the information to their circumstances (Gawande 2014). This interpretive relationship results in shared clinical decision making, which is at the core of patient-centred care.

Patient-centred care leads to increased patient and family satisfaction with care and results in improved patient outcomes (Charmel 2009). Studies have reported decreased readmission rates to hospital, decreased average length of stay, decreased

mortality, improvement in chronic disease management and decreased costs (Charmel 2009, Meterko et al 2010). Thus, it makes sense to embrace the patient-centred care model from a financial perspective, as well as from a patient and family perspective. However, professional factor is one of the pervasive barriers that may impede the successful introduction and provision of patient-centred care.

### **Professional Factors in Patient-Centred Nursing Care**

Patients and families are influenced by the structural constraints of the power imbalance between patients and nurses. Furthermore, the beliefs held by nurses about their roles can reinforce the power imbalance and act as a deterrent to developing patient-centred care. It will be difficult for a patient to overcome this barrier and become an active participant in the care planning and decision-making process if nurses are not clear about what is involved within the patient-centred care paradigm, or do not have the

skills to engage in conversations that can lead to shared decision-making.

Negative nurses' attitudes and a lack of commitment can act as significant barriers to the successful integration of patient-centred care into the care process (Edwards and Elwyn 2009, Larsson et al 2011, Mulley et al 2012, Porter et al 2013, Wyskiel et al 2015). Negative nurses' attitudes may not present as overt resistance to patient-centred care, but may take the less obvious form of discouragement of patients' involvement in the decision-making process. This can manifest as a lack of engagement with the patient during the care process, a lack of understanding and empathy of what is important to the patient or a paternalistic attitude where the patient is not presented with any options (Larsson et al 2011).

Wellard et al (2003) noted that while nurses verbalized their commitment to involving

patients in their care, observational studies of the same nurses demonstrated that this did not translate into their nursing behaviours when providing care. There was little communication or choice about the patient's personal preferences in the care provided, with nurses focused on task completion. In a study of barriers to providing patient-centred care, West et al (2005) reported that the majority of nurses identified that they did not have the time to address patients' anxieties and fears or to give patients and their families' information about their health care. According to Larsson et al (2011), patients reported that nurses' attitudes involved exerting control of nursing care without consideration of the patient's choices and excluding the patient from the nurse's conversations with relatives. Patients indicated that they felt powerless in these situations and did not attempt to participate, anticipating that there might be negative consequences.

Nurses may be committed to providing patient-centred care and feel that they understand and consider the patient's choices in decision making; however, these perceptions may not be accurate. Overcoming such discrepancies in perception between nurses and patients is vital if patient-centred care is to be realised.

### **Shared Clinical-Decision Making**

Evidence shows that patients want to be more actively involved in their care, and specifically in making clinical decisions about their care and treatment options (Coulter and Collins 2011). In the United States, the government outlined detailed proposals to increase the opportunities for patients to be more involved in decisions about their care (Department of Health, 2012). The aim is to put the needs and preferences of patients at the centre of clinical decision making by implementing shared clinical decision making.

Shared clinical decision making is defined as a framework in which clinicians and patients collaborate to select tests, treatments and management plans, based on clinical evidence and patients' informed choices (Coulter and Collins 2011). Shared clinical decision making involves the provision of evidence-based information about options and outcomes and is a system for recording and implementing the patient's preferences (Coulter and Collins 2011). This approach to care may be particularly useful in the management of those with multiple long-term conditions (such as asthma, rheumatoid arthritis, chronic obstructive pulmonary disease, diabetes mellitus, mental health disorder and heart failure) through the development of personalised care plans that reflect their individual preferences (DH 2012). It changes the role of the healthcare professional from paternalistic care to a coaching role, one responsible for the provision of evidence-based information about health problems, options for

treatment and self-management, benefits and risk, together with decision-based counselling, in terms of goal setting and action planning. This framework acknowledges the patient as responsible for their own decisions and priorities in how they manage their condition, while being supported and coached by the nurse.

Involving patients routinely in their care decisions should help to promote better health outcomes. It is expected that shared clinical decision making will save money by encouraging and supporting patients to take more responsibility for their health and wellbeing, improving understanding of long-term conditions and reducing the need for recurrent crisis management. However, while shared clinical decision making can be liberating for some patients, others may prefer the more traditional paternalistic care relationship, in which they are advised what to do by healthcare professionals.

Shared clinical decision making is an approach that moves beyond the traditional model, in which the healthcare professional is viewed as the expert, to a collaborative relationship, in which the patient is acknowledged as an expert in their condition. Traditionally, the healthcare professional was viewed as the expert in all aspects of care, however in shared clinical decision making the clinician works in partnership with, and acknowledges the expertise of, the patient in managing their health. Many nurses have described the experience of using a shared clinical decision-making framework as resonating with their core values of patient advocacy, and as a significant and more satisfying way of supporting the clinical decision-making process.

Shared clinical decision making is a framework that is easy to use, with well-developed tools to guide practice. However, it requires a fundamental shift in philosophy and culture, and

changes the role of the nurse to one that is more aligned with a coaching model. It is essential that nurses have access to evidence-based information, outcomes and risk-benefit analyses to support patients in the clinical decision-making process and to ensure all patients are actively engaged in managing their long-term conditions (Coulter et al 2013). In addition, it is important that the health and social care system as well as commissioners are responsive to the engaged and informed patient, otherwise the framework is less effective (Coulter et al 2013). This means services should be designed in a patient-centred way that supports patients to manage their conditions.

Shared clinical decision making involves valuing and responding to an individuals' values, social context, preferences and expertise to promote patient-centred care and recovery. Like established models of participation, such as Arnstein's (1969), it is based on

the premise that the people most affected by the outcomes of decisions should be most influential in making them. However, shared clinical decision making should not be accepted uncritically if it fails to account for issues of power, hierarchy and legally sanctioned coercive practice. Awareness of the complexities in implementing shared clinical decision making in nursing practice is therefore an important step towards enabling more equal power relationships.

### **Three is in Shared Clinical Decision Making**

In a study by Stacey et al (2015), nurses viewed themselves as the enforcers of the decisions made by other professional groups. They reiterated that, as the professional group that spent most time with patients, they had expertise. Nurses also discussed their lack of willingness to make decisions that they perceive to be the responsibility of other healthcare professionals, even when it was acknowledged that

they may be in the most informed position to make the decision. In light of these findings the authors devised a shared clinical decision-making model in which hierarchies and the effects of power are acknowledged to promote a radical level of transparency in the clinical decision-making process. Adopting such a model would require a shift in culture, and would have to be supported by multidisciplinary clinical supervision and an alternative structure or forum for decisions. In devising the model the authors realised that it is important for professional groups to maintain their professional identities in healthcare settings, but also to talk about these identities in multidisciplinary groups, and to acknowledge uncertainties of role and identity when the power to decide is shared among professional groups and patients.

The authors suggest that the concept of shared clinical decision making should be broken into its component parts. For this to occur all



participants must be informed, involved and influential - the three Is - in the decision-making process. These three Is are fluid in that they refer to a sliding scale of influence that moves between different positions according to context, capacity and desire to influence. Thus the model is called the Three Is Scale of Influence. The model draws on established theories of participation (Arnstein 1969) that recognise how the distribution of power results in a ladder of participation ranging from non-participation, which is viewed as manipulation, to involvement, which can encompass consultancy but can also be regarded as tokenism. Full participation is achieved, therefore, when there is a genuine power-sharing partnership (Arnstein 1969).

**Informed:** Being informed refers to the practice of ensuring that patients and healthcare professionals know what is available for consideration. This does not mean that professionals are

assumed to know all the options, but that they have valid information to bring to the clinical decision-making process. Nor does it mean that patients are simply told the outcomes of decisions. For instance, people experiencing mental health problems have insights into the distress that such problems can cause, how they affect their sense of identity and relationships, and how other people view them. They may also have insights into the stigma that is associated with their conditions and what it feels like to live with their diagnoses. Healthcare professionals rarely have such expertise unless they have had their own experiences of mental distress. However, they do have expertise in different treatment options, services and resources, and insights into the structure and organisational culture of health services that are unavailable to patients or other professionals. Being informed entails genuinely valuing the significance of all information and having an

understanding of the rationale for decisions.

**Involved:** Being involved entails being willing to adapt decisions in light of the information shared. Thus, all parties to decision-making processes should respond to the expertise of others to reach decisions. Traditionally, involvement has entailed consultation with patients and carers. Research shows, however, that consultation does not translate into power sharing, and that professionals' views tend to prevail (Schauer et al 2007). In recovery and shared decision making, the expertise of patients and carers is valued (Deegan and Drake 2006), and patients are regarded as active participants in their own care. The problem with traditional forms of involvement is that the power to decide when and how patients are involved in decisions lies with the professionals. This may be valid in situations where patients cannot make decisions, but clinical decision-making abilities are often fluid and it should

not be assumed that a person is permanently irrational or incompetent, and therefore can never be trusted (Olsen 2003). For instance, patients want to be involved in clinical decision making (Matthias et al 2012) and, if healthcare professionals question their abilities to be involved these professionals may prevent patients from communicating their views (Chong et al 2013).

An alternative conceptualisation of involvement would concern how patients involve professionals, rather than the other way around. One example of this process is direct payments. These are based on assessments of needs but with patients choosing who provides the services required to meet these needs. If this process were applied to clinical decision-making forums, patients would set the agenda and decide on which experts to consult. For professional groups, being involved means having opportunities to contribute their views and to be included in collaborative

processes. It encourages professionals with different views to be confident in offering them and people who perceive themselves to be outside clinical decision making processes to come inside, while those viewed as being in control of making clinical decisions become open to the views of others.

**Influential:** Being influential in clinical decision making entails considering and respecting other people's views, even if they are not held by the majority. For patients, having influence means genuinely holding power and accountability for decisions. This may challenge healthcare professionals to support patients' choices that are perceived as risky or 'bad'. Patients in distress may perceive compulsory care as a preferred option even though it limits their opportunities to influence clinical decision-making processes. In these circumstances, they should be confident that their opinions are respected, and that they

will remain informed and involved wherever possible, for example through the involvement of advocates. Patients involved in the authors' study said that this means that compulsory treatment is carried out in a compassionate and ethical manner.

In the Three Is model, all people who contribute to clinical decision-making process can and should be influential. This does not necessarily mean there is equality of power but that, where there is conflict, all participants would have opportunities to influence decisions. It also means that the people involved are defined by their relationships with the patients, not their positions in a hierarchy.

The informed and involved phases of the Three Is model suggest that patients who are not directly involved in such processes are best placed to decide who should speak for them. The Three Is model can ensure that the least

restrictive option is taken and that individual patient's independence is maximised by involving them in their care and treatment. The model can empower patients through improved communication and information sharing, and by giving patients involvement in, and influence over, their care and treatment. If patients are kept informed and involved, they will be treated with greater dignity and respect; if they are influential in clinical decision-making processes, they are more likely to feel empowered. Thus by ensuring patients are informed, involved and influential, a more equitable approach to clinical decision-making processes can be taken. It is important to note that implementation of the principles presented under each of the three Is is as fluid as the prominence of each of the three Is at any given time during the shared decision-making process.

Shared clinical decision making approach is vital; information giving alone may not be adequate. A research study by

Madsen & Fraser (2015) showed that nursing curricula may teach about patient motivation, but do not focus on nurses developing the skills required to explore patient priorities and ability to change, taking into consideration issues such as culture and belief systems. Current health and social care services are not producing behavioural change because patients are not self-managing long-term conditions as successfully as they could. It has been recognised for some time that long-term conditions are poorly managed in health and social care services, particularly in older people (Coulter et al 2013).

In a paper titled "Equity and Excellence: Liberating the NHS" (DH 2010b), shared clinical decision making features prominently, with bold statements such as 'we want the principle of "shared clinical decision-making" to become the norm... It can also bring significant reductions in cost... to improve the management of long-term conditions'. This paper and other policies raise

the issues of increasing costs and making savings, but none addresses the resources required for new initiatives - such as the time it takes and money it costs to implement shared clinical decision making - or the possible resistance to any cultural and behavioural change. The paper also assumes patients will make decisions that are beneficial to their health. The aim should always be supporting people to live more healthily, but the obesity crisis shows that people do not always make optimal decisions (NHS Choices 2014).

### **Importance of Clinical Shared Decision Making**

Research shows that clinicians believe shared decision making is important and is an integral part of practice (McGuire et al 2005, Fenety et al 2009). However, some evidence suggests that decision sharing is poorly defined and irregularly used in practice (Stringer et al 2008). The Health Foundation (2012) states that shared decision-making strategies can:

- Improve patients' understanding and knowledge of their condition.
- Raise patients' awareness of the care and treatment options available to them.
- Increase patients' involvement in their care.
- Improve patient satisfaction.
- Increase patients' confidence in their ability to manage their condition.
- Improve communication between patients and clinicians.

Shared clinical decision making recognises that clinicians and patients bring different but equally important forms of expertise to the decision-making process (Coulter and Collins 2011). Where expertise exists on both sides, a more collaborative approach to treatment and care planning is required. The plan should be

sustainable for the patient, as well as cost-effective and efficient in healthcare budget terms. It is also important to consider the patient's resources, for example informal support, understanding and problem-solving skills, and be aware of the possible consequences of decisions the patient is assisted to make. Ethical considerations remain important. If a patient is persuaded to adopt a plan, then they might not follow it in the long term and a bond of trust might be broken between the patient and the healthcare professional.

### **Stages and Tools for Shared Clinical Decision Making Process**

The process of shared decision making is supported by several stages and tools, including:

- Agenda setting. This involves clarifying any issues raised by the patient, as well as ascertaining their importance to the patient.
- Identifying activation levels, or the expertise of

the patient and their readiness and motivation to be involved in managing the condition. Also involves clarifying areas of uncertainty.

- Providing information about the risks and benefits of each option to enable informed consent. Discussing the options available and checking that the patient and clinician have a shared understanding of the situation.
- Supporting the patient to set SMART (specific, measurable, attainable, realistic and time-bound) goals.
- Assessing the patient's confidence in achieving their goals.
- Exploring how the patient will get support to achieve their goals.

Underpinning the philosophy and principles of shared clinical decision making is an understanding of the interdependent relationship between the biological (the long-term condition) and the

psychological (patient beliefs and behaviours). The ability to self-manage will be influenced by an individual's belief system, confidence in their abilities and their motivation to make changes. The nurse should understand and consider these factors when engaging with the patient. Training in shared decision making provides clinicians with a framework that encompasses a range of techniques and tools, all of which are based on coaching. The aim of coaching is to help people to gain the skills and confidence to manage their health; it involves listening, questioning techniques, support for deliberation and non-directive guiding (Rollnick et al 2008).

## CONCLUSION

Shared clinical decision making is a new approach to making clinical decisions that involves a collaborative partnership between patients and clinicians. The shared clinical decision-making framework could reduce healthcare costs and be a more effective way of working,

particularly with increasing numbers of people with multiple long-term conditions. More importantly, patients want to have increased control and choice in decisions regarding their care. Shared clinical decision making has the potential to enhance the nurse-patient relationship and promote patient-centred care delivery.

## REFERENCES

- Arnstein S, 1969. A ladder of citizen participation. *Journal of the American Planning Association*. 35 (4): 216-224.
- Bellows M, Kovacs B. K, Jackson K, Surgeoner B, Gallivan J, 2015. Meaningful and effective patient engagement: What matters most to stakeholders. *Patient Experience Journal*. 2 (1): 18-28.
- Charmel P, 2009. Building the business case for patient-centred care. In Frampton S, Charmel P (Eds) *Putting Patients First. Best*

- Practices in Patient-Centred Care. Second edition. Jossey-Bass, San Francisco CA, 191-210.
- Cleary M, 2003. The challenges of mental health care reform for contemporary mental health nursing practice: relationships, power and control. *International Journal of Mental Health Nursing*. 12 (2): 139-147.
- Conway J, Johnson B, Edgman-Levitan S et al, 2006. Partnering with Patients and Families To Design a Patient and Family-Centered Health Care System. A Roadmap for the Future. A Work in Progress. Institute for Family-Centred Care, Bethesda MD, and Institute for Healthcare Improvement, Cambridge MA.
- Coulter A & Collins A, 2011. Making Shared Decision-Making a Reality. No Decision About Me, Without Me. Accessed: March 18 2015.
- Coulter A, Roberts S & Dixon A, 2013. Delivering Better Services for People with Long-Term Conditions - Building the House of Care. The King's Fund, London
- Department of Health, 2010. Equity and Excellence: Liberating the NHS. The Stationery Office, London.
- Fenety A, Harman K, Hoens A, Bassett R, 2009. Informed consent practices of physiotherapists in the treatment of low back pain. *Manual Therapy*. 14 (6): 654-660.
- Department of Health, 2012. Liberating the NHS: No Decision about Me without Me. Accessed: November 23 2015.
- Edwards A, Elwyn G, 2009. Shared decision-making in health care: Achieving evidence-based patient choice. In Edwards A, Elwyn G (Eds) *Shared Decision-Making in Health Care. Achieving Evidence-Based Patient Choice*. Second edition. Oxford



- University Press, Oxford, 3-10.
- Gawande A, 2014. *Being Mortal: Illness, Medicine and What Matters in the End*. Profile Books, London.
- Gluyas, H. 2015. Patient-centred care: improving healthcare outcomes. *Nursing Standard*. 30 (4): 50-59.
- Hansson E, Ekman I, Swedberg K et al, 2015. Person-centred care for patients with chronic heart failure - a cost-utility analysis. *European Journal of Cardiovascular Nursing*. pii: 1474515114567035.
- Larsson I, Sahlsten M, Segesten K, Plos K, 2011. Patients' perceptions of barriers for participation in nursing care. *Scandinavian Journal of Caring Sciences*. 25(3): 575-582.
- Madsen C & Fraser A. 2015. Supporting patients in shared decision making in clinical practice. *Nursing Standard* 29 (31): 50 - 57
- Mazurenko O, Bock S, Prato C, Bondarenko M, 2015. Considering shared power and responsibility: Diabetic patients' experience with the PCMH care model. *Patient Experience Journal*. 2 (1): 61-67.
- McGuire A, McCullough L, Weller S, Whitney S, 2005. Missed expectations? Physicians' views of patients' participation in medical decision-making. *Medical Care*. 43 (5): 466-470.
- Meterko M, Wright S, Lin H, Lowy E, Cleary P, 2010. Mortality among patients with acute myocardial infarction: the influences of patient-centered care and evidence-based medicine. *Health Services Research*. 45 (5):1188-1204.
- Mulley A, Trimble C, Elwyn G, 2012. Stop the silent misdiagnosis: patients'

- preferences matter.  
BMJ.345, e6572.
- NHS Choices, 2014. Report Warns of a Looming UK Obesity Crisis. Accessed: March 18 2015.
- Porter J, Cooper S, Sellick K, 2013. Attitudes, implementation and practice of family presence during resuscitation (FPDR): a quantitative literature review. *International Emergency Nursing*. 21 (1): 26-34.
- Press Z, Richards D (2015) The power of patient ownership: The path from engagement to equity. *Patient Experience Journal*.2(1): 15-17.
- Rollnick S, Miller W.R, Butler C.C, 2008. *Motivational Interviewing in Health Care: Helping Patients Change Behaviour*. Guildford Press, London.
- Royal College of General Practitioners, 2014. *An Inquiry into Patient Centred Care in the 21st Century: Implications for General Practice and Primary Care*. RCGP, London.
- Schauer C, Everett A, delVecchio P et al, 2007. Promoting the value and practice of shared decision-making in mental health care. *Psychiatric Rehabilitation Journal*. 31 (1): 54-61.
- Stacey G, Felton A, Hui A, Stickley T, Houghton P et al, 2015. Informed, involved and influential: three Is of shared decision making. *Mental Health Practice* 19 (4): 31 - 35.
- Stone S, 2008. A retrospective evaluation of the impact of the Planetree patient-centered model of care on inpatient quality outcomes. *Health Environments Research and Design Journal*. 1 (4): 55-69.
- Stringer B, Van Meijel B, De Vree W, Van der Bijl J, 2008. User involvement in mental health care: the role of nurses. *A literature*

- review. *Journal of Psychiatric and Mental Health Nursing*. 15 (8): 678-683.
- The Health Foundation, 2012. *Helping People Share Decision Making - A Review of Evidence Considering Whether Shared Decision Making is Worthwhile*. The Health Foundation, London.
- Wellard S, Lillibridge J, Beanland C, Lewis M, 2003. Consumer participation in acute care settings: an Australian experience. *International Journal of Nursing Practice*. 9 (4): 255-260.
- West E, Barron D, Reeves R, 2005. Overcoming the barriers to patient-centred care: time, tools and training. *Journal of Clinical Nursing*. 14 (4): 435-443.
- Wyskiel R, Weeks K, Marsteller J, 2015. Inviting families to participate in care: a family involvement menu. *Joint Commission Journal on Quality and Patient Safety*. 41 (1): 43-46.

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