

THE BROADER SOCIAL CONTEXT OF DECISIONS: HEALTH CARE PROFESSIONALS' PERSPECTIVES ON SHARED DECISION-MAKING IN THE MULTIDISCIPLINARY LOW CLEARANCE CLINIC

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INTRODUCTION: National guidelines recommend shared decision-making and patient involvement in decisions about renal replacement therapy (RRT). However, there has been very little research analysing the way decisions about RRT are currently made or examining the views of clinicians about how best to involve patients in decision-making.

AIMS: To explore the views of members of the multi-disciplinary renal team about how decisions are made in low clearance clinic and how patients are and should be involved in decision-making; to challenge commonly held ideals of shared decision-making with empirical data.

METHODS: 23 health care professionals - 8 nurses, 8 doctors (5 consultants, 3 specialist registrars), 4 social workers, 3 other members of the multidisciplinary team - were recruited from three London renal units and interviewed. Semi-structured interviews were recorded and transcribed. The transcripts were read in detail and relevant sections of text were labelled. The labelled sections of text were further examined to identify themes. Emerging themes were repeatedly compared across all 23 interviews to test their validity and to identify divergent cases.

RESULTS:

Decision-making in a broader social context - The role of family

Most models of decision-making see the autonomous individual as just that – an individual. In practice, health care professionals see family members as fundamental to decision-making. None of the professionals interviewed routinely sought explicit consent from patients to involve family members in decisions. Family support was expected and positively encouraged. The benefits of such support were seen as

- a) practical - 'extra pair of ears'; necessary involvement of potential care givers;
- b) emotional – 'share the responsibility of this decision'.

On the other hand, the commonest reported cause of difficulty in decision-making was tension within families, where the patient's wishes appeared to conflict with those of other family members. This difficulty was exacerbated if there were communication issues with the patient.

How decision-making is shared

Everyone strove to involve patients in decisions about their care. There were contrasting views – which crossed professional roles – about whether an adequately informed, competent patient could make a 'wrong' decision, that is, whether anyone other than the patient (in conjunction with their family) could know their best interests. Many of the doctors and nurses prioritised information provision in the form of 'education', suggesting shared decision-making very much on the medical team's terms. An alternative view, expressed by social workers amongst others, stressed the importance of understanding the extended social context of the decision: 'decision-making about treatment is just a part of everything else that's going on in their life'.

CONCLUSION: Every health care professional placed the patient in a wider social context than just the individual. However, different ideals of shared decision-making exist within the multidisciplinary team. Explicit understanding by all team members of these different ideals may enhance multidisciplinary working, offer a broader range of options to the patient, and allow for a consistent approach to consent and confidentiality where family members are involved.