
Featured article

Saba GW, Wong ST, Schillinger D, Fernandez A, Somkin CP, Wilson CC, Grumbach K. **Shared Decision Making and the Experience of Partnership in Primary Care.** Ann Fam Med. 2006 Jan-Feb;4(1):54-62.

Research shows that shared decision-making is associated with better chronic disease outcomes, improved patient adherence, and lower costs. Shared decision making is usually studied by analyzing audio or videotaped visits. But there is more to shared decision making than meets the ear or eye reviewing those tapes.

In reviewing the literature on health communication, we discovered that communication has been researched historically as either a **set of behaviors** that can be observed, delineated, and taught or as a **facet of the patient-physician relationship**. These two perspectives have been primarily studied independently which has often led to conflicting results. We decided to examine both aspects of communication simultaneously by focusing on externally observed shared decision making behaviors and the perception of partnership as experienced by both physicians and patients. From a convenience sample of experienced primary care physicians, we recruited a stratified sample of 18 English- or Spanish-speaking patients who had hypertension and/or diabetes. We videotaped a regularly scheduled medical visit and, through *direct observation*, coded the moments of decision making between patients and physicians. Through this coding we determined the presence or absence of shared decision making. Within two weeks of that medical visit, we invited the physician and the patient to return and independently view the videotape of that encounter. In this *stimulated recall session*, they reflected on their thoughts, feelings and behaviors during those moments of decision (n=84) during the encounter. We videotaped those debriefing session and coded them for the presence or absence of a perceived sense of partnership. We combined the data from both of these methods to give us a dual perspective on health communication.

This combination yielded **4 archetypes of engagement in decision making**:

- 1) **“Looks good, Feels good”** or full engagement (22% of the decision moments.) Both the physician and the patient engaged in shared decision making and felt they had a partnership together.
- 2) **“Looks good, Feels bad”** or simulated engagement (38%.) In these decision moments, the physician and the patient engaged in shared decision making, but one or both of them did not experience a sense of partnership.
- 3) **“Looks bad, Feels good”** or assumed engagement (21%.) Despite the fact that there was no shared decision making, both the physician and patient perceived the partnership as positive.
- 4) **“Looks bad, Feels bad”** or non-engagement (19%.) In these decision moments, there was no shared decision making, and one or both of the participants experienced the partnership as negative.

What do these findings tell us about communication in primary care? For the majority of the decision moments (59%), there was not agreement between the researchers' ratings of shared decision-making and the subjective experience. While shared decision making was common (60%), it was just as likely perceived by the participants as negative as positive. When communication "looks good," it may not "feel good," and in those instances, information may be withheld. Patients in this archetypal group often talked about fear of punishment or being discounted if they revealed the truth about their beliefs, feelings or behavior to the physician (e.g., "I haven't told him I am eating pastries...I don't want to disappoint him...I can't afford to lose him... I'm not being honest.") As our sample included both racially and ethnically diverse group of patients and physicians, these feelings of mistrust and disrespect ARE important to consider and warrant further research. Physicians in this group also acknowledged that they felt mistrustful, hopeless, frustrated, or angry with the patients but did not reveal these feeling to their patients ("I'm frustrated...I don't know if we are on the same wavelength.")

These findings have implications for medical education and clinical care. A purely behavioral model for teaching communication skills appears inadequate unless we also attend to affective aspects of the relationships. Physicians and patients may find themselves "going through the motions" without achieving satisfactory clinical outcomes. Also, purely relational models of communication may fail to capture important information about beliefs and options. When working with patients who are clinically doing poorly, physicians already engaging in shared-decision making should consider asking about relational issues (e.g., asking patients how they feel about the decision-making process, giving patients permission to reveal any concerns or disagreements). Conversely, if the relationship does not feel collaborative, physicians could consider engaging in more shared decision making (e.g., eliciting and offering more information, feelings, and beliefs; reaching explicit closure).

We suggest that by looking at health communication from these two perspectives, we may gain a unique look into physician-patient interactions in primary care.

Primary Care e-letter Abstracts

Chronic Diseases Leading Cause of Death in Los Angeles County

California Healthline February 15, 2006

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Chronic diseases -- including heart disease, stroke, cancer and diabetes -- in 2002 accounted for 80% of deaths and \$48 billion in health care costs in Los Angeles County, according to a report the Los Angeles County Department of Health Services released Monday, the Los Angeles *Daily News* reports. The report found that heart disease and stroke accounted for 40% of premature deaths and were the leading causes of premature death and disability.

In addition, the report found that a lower percentage of people in affluent communities in Los Angeles County die prematurely from heart disease or stroke than in lower-income communities.

Dr. Jonathan Fielding, director of county DHS, said that high rates of premature death from heart disease and stroke are found in "communities that have problems of overcrowding, poor housing stock, poverty, high levels of unemployment, poor educational attainment, high levels of dependency on government programs and low incomes."

The report stated that the differences likely could be attributed to different levels of smoking and physical inactivity, as well as socioeconomic disparities in access to health care and the quality of living and working conditions (Anderson, Los Angeles *Daily News*, 2/14).

Monitoring diabetes treatment in New York City.

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Mandatory reporting of glycosylated haemoglobin (HbA1c) results has been introduced in New York City in an effort to monitor the effectiveness of treatment for diabetes mellitus. From this week, medical laboratories in the city that can transmit data electronically are required to provide results of the HbA1c test to the New York City Department of Health and Mental Hygiene. The health department will create a registry with dates and results of HbA1c tests, and patients' addresses and dates of birth. Treating physicians will receive feedback on all their patients' results and when repeat tests are due.

A pilot scheme will also be introduced in the South Bronx area of New York City. Patients who do not opt out will receive their HbA1c results, together with information on lifestyle measures needed to reduce their levels. Treating physicians will receive a quarterly summary of their patients stratified by glycaemic control, alerts if HbA1c is particularly high, and reminders of best practice recommendations. The registry information will be available only to the patient tested and the treating clinician. This pilot scheme is based on the Vermont Diabetes Information System, a registry-based decision support and reminder system for patients and their primary care physicians. The feasibility of implementing the system has been demonstrated, but whether there is any difference in clinical outcome in the Vermont study is as yet unknown. Promising US and Swedish research suggests that registry-based monitoring is associated with mean decreases in HbA1c and blood pressure, and increases in prescription of lipid-lowering drugs.

By introducing mandatory reporting of HbA1c levels, the authorities of New York City have become the first in the USA to require data on routine testing for a major chronic non-infectious disease in order to study the quality and effectiveness of treatment. This focus on improving glucose control is welcome in a city where one in eight adults is thought to have diabetes but only 10% of diabetic patients know their HbA1c level. HbA1c control is associated with improved clinical outcomes but overall, in the USA, only 7% of patients with diabetes have controlled their HbA1c, blood pressure, and cholesterol to target levels.

Papadakis MA, Teherani A, Banach MA, Knettler TR, Rattner SL, Stern DT, Veloski JJ, Hodgson CS. **Disciplinary action by medical boards and prior behavior in medical school.** N Engl J Med. 2005 Dec 22;353(25):2673-82.

Background: Evidence supporting professionalism as a critical measure of competence in medical education is limited. In this case-control study, we investigated the association of disciplinary action against practicing physicians with prior unprofessional behavior in medical school. We also examined the specific types of behavior that are most predictive of disciplinary action against practicing physicians with unprofessional behavior in medical school.

Methods: The study included 235 graduates of three medical schools who were disciplined by one of 40 state medical boards between 1990 and 2003 (case physicians). The 469 control physicians were matched with the case physicians according to medical school and graduation year. Predictor variables from medical school included the presence or absence of narratives describing unprofessional behavior, grades, standardized-test scores, and demographic characteristics. Narratives were assigned an overall rating for unprofessional behavior. Those that met the threshold for unprofessional behavior were further classified among eight types of behavior and assigned a severity rating (moderate to severe).

Results: Disciplinary action by a medical board was strongly associated with prior unprofessional behavior in medical school (odds ratio, 3.0; 95 percent confidence interval, 1.9 to 4.8), for a population attributable risk of disciplinary action of 26 percent. The types of unprofessional behavior most strongly linked with disciplinary action were severe irresponsibility (odds ratio, 8.5; 95 percent confidence interval, 1.8 to 40.1) and severely diminished capacity for self-improvement (odds ratio, 3.1; 95 percent confidence interval, 1.2 to 8.2). Disciplinary action by a medical board was also associated with low scores on the Medical College Admission Test and poor grades in the first two years of medical school (1 percent and 7 percent population attributable risk, respectively), but the association with these variables was less strong than that with unprofessional behavior.

Conclusions: In this case-control study, disciplinary action among practicing physicians by medical boards was strongly associated with unprofessional behavior in medical school. Students with the strongest association were those who were described as irresponsible or as having diminished ability to improve their behavior. Professionalism should have a central role in medical academics and throughout one's medical career. Copyright 2005 Massachusetts Medical Society.

Rosenblatt RA, Holly C, Andrilla A, Curtin T, Hart G.

Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion JAMA. 2006;295:1042-1049.

Context: The US government is expanding the capacity of community health centers (CHCs) to provide care to underserved populations.

Objective: To examine the status of workforce shortages that may limit CHC expansion. Design and Setting Survey questionnaire of all 846 federally funded US CHCs that directly provide clinical services and are within the 50 states and the District of Columbia, conducted between May and September 2004. Questionnaires were completed by the chief executive officer of each grantee. Information was supplemented by data from the 2003 Bureau of Primary Health Care Uniform Data System and weighted to be nationally representative.

Main Outcome Measures: Staffing patterns and vacancies for major clinical disciplines by rural and urban location, use of federal and state recruitment programs, and perceived barriers to recruitment.

Results: Overall response rate was 79.3%. Primary care physicians made up 89.4% of physicians working in the CHCs, the majority of whom are family physicians. In rural CHCs, 46% of the direct clinical providers of care were nonphysician clinicians compared with 38.9% in urban CHCs. There were 428 vacant funded full-time equivalents (FTEs) for family physicians and 376 vacant FTEs for registered nurses. There were vacancies for 13.3% of family physician positions, 20.8% of obstetrician/gynecologist positions, and 22.6% of psychiatrist positions. Rural CHCs had a higher proportion of vacancies and longer-term vacancies and reported greater difficulty filling positions compared with urban CHCs. Physician recruitment in CHCs was heavily dependent on National Health Service Corps scholarships, loan repayment programs, and international medical graduates with J-1 visa waivers. Major perceived barriers to recruitment included low salaries and, in rural CHCs, cultural isolation, poor-quality schools and housing, and lack of spousal job opportunities.

Conclusions CHCs face substantial challenges in recruitment of clinical staff, particularly in rural areas. The largest numbers of unfilled positions were for family physicians at a time of declining interest in family medicine among graduating US medical students. The success of the current US national policy to expand CHCs may be challenged by these workforce issues.

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