Problem-based shared decision-making in diabetes care: a secondary analysis of video-recorded encounters

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ABSTRACT

Objectives To describe the range of collaborative approaches to shared decision-making (SDM) observed in clinical encounters of patients with diabetes and their clinicians.

Design A secondary analysis of videorecordings obtained in a randomised trial comparing usual diabetes primary care with or without using a within-encounter conversation SDM tool.

Setting Using the purposeful SDM framework, we classified the forms of SDM observed in a random sample of 100 video-recorded clinical encounters of patients with type 2 diabetes in primary care.

Main outcome measures We assessed the correlation between the extent to which each form of SDM was used and patient involvement (OPTION12-scale).

Results We observed at least one instance of SDM in 86 of 100 encounters. In 31 (36%) of these 86 encounters, we found only one form of SDM, in 25 (29%) two forms, and in 30 (35%), we found ≥3 forms of SDM. In these encounters, 196 instances of SDM were identified, with weighing alternatives (n=64 of 196, 33%), negotiating conflicting desires (n=59, 30%) and problem-solving (n=70, 36%) being similarly prevalent and developing existential insight accounting for only 1% (n=3) of instances. Only the form of SDM focused on weighing alternatives was correlated with a higher OPTION12-score. More forms of SDM were used when medications were changed (2.4 SDM forms (SD 1.48) vs 1.8 (SD 1.46); p=0.050).

Conclusions After considering forms of SDM beyond weighing alternatives, SDM was present in most encounters. Clinicians and patients often used different forms of SDM within the same encounter. Recognising a range of SDM forms that clinicians and patients use to respond to problematic situations, as demonstrated in this study, opens new lines of research, education and practice that may advance patient-centred, evidence-based care.

Introduction

Biomedical and technological advances in healthcare have resulted in an increased array of treatment options available to improve healthcare outcomes. This is especially pertinent in diabetes care, where the development of e.g. novel pharmacological agents (such as GLP-1 (glucose-like peptide 1) receptor agonists 1,2 and sodium-glucose cotransporter-2 (SGLT2) inhibitors 3,4) and technological innovations (such as flash glucose monitoring,3,4 smart insulin pens6,7 and pumps 8 and the artificial pancreas 9) are rapidly changing the field. To form sensible plans of care that respond well to and advance the situation of the individual patient, that is, to make care fit, patients and clinicians must collaborate to determine what to do, work often referred to as shared decision-making (SDM).10-13 SDM is crucial for the practice of evidence-based medicine.14

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Conventionally, shared decision-making (SDM) is often defined as a stepwise, collaborative process in which the pros and cons of multiple options are weighed. However, in clinical practice, patients and clinicians need to respond in a sensible way to a broad range of situations, going beyond selecting one alternative from a set of prespecified options.

WHAT THIS STUDY ADDS

⇒ SDM is highly prevalent in primary diabetes care after considering collaborative decision-making processes other than weighing alternatives only. Most consultations contained multiple forms of SDM, with SDM focused on solving problematic situations being most prevalent.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Allowing for the range of SDM forms that occur in practice beyond weighing alternatives expands the practice relevance of SDM and changes the problem researchers and policymakers need to solve: from non-occurrence to quality improvement.
To ensure that evidence-based diabetes care is personalised, international diabetes guidelines emphasise the importance of SDM. In theory, SDM is frequently considered a process for decisions in care which are subject to patient preferences (‘preference-sensitive’) and in which a stepwise approach can be used of fostering choice awareness, discussing options, discussing preferences and making a final decision. It is often focused on ‘taking the right steps, in the correct sequence, at the right time’. Although it may seem useful to circumscribe SDM to this particular practice, SDM, defined in this way, is reported as rare in practice, even as clinicians report ‘doing SDM’ routinely. In practice, however, patients and clinicians must respond to a broad range of situations collaboratively. The problems they face may call for different manners of making decisions together other than selecting from a set of established alternatives as they form plans of care that make sense as possible ways to respond to the call for different manners of making decisions together other than selecting from a set of established alternatives as they form plans of care that make sense as possible ways to respond to the problematic situation of each patient. Hargraves et al have proposed that there may be different forms of SDM depending on the situation that needs to be resolved. This ‘purposeful SDM framework’ proposes that the situation the patient is facing determines the way in which patients and clinicians interact and collaborate in the decision-making process. Purposeful SDM identifies at least four forms of SDM appropriate for different situations: (1) weighing treatment alternatives, (2) negotiating conflicting desires, (3) solving problematic situations and (4) developing existential insight (Table 1). The framework, thus, suggests that in addition to the canonical form of SDM in which alternatives are weighed, there are at least three other SDM forms in which patients and clinicians jointly and deliberately engage in conversations to decide how to address the patient’s situation. Hargraves et al do not consider these forms to be separate entities but rather a spectrum of collaborative decision-making processes.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Forms of shared decision making, according to the Purposeful SDM framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forms of purposeful SDM</td>
<td>Type of decision sought</td>
</tr>
<tr>
<td>1. Weighing alternatives</td>
<td>A determination that pros, cons and preferences are optimally balanced in the selected option</td>
</tr>
<tr>
<td>2. Negotiating conflicting desires</td>
<td>An agreement reconciling conflicting positions or desires within or between parties to decisionmaking</td>
</tr>
<tr>
<td>3. Solving problematic situations</td>
<td>The conclusion that different potential ways of understanding and advancing the problematic situation have been sufficiently uncovered, evaluated and coordinated.</td>
</tr>
<tr>
<td>4. Developing existential insight</td>
<td>The existential insight into what ultimately matters that has developed sufficiently that what to do becomes obvious and meaning is found in the splintered elements of a person’s life.</td>
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</tbody>
</table>

Based on Hargraves et al., Hargraves et al., and Hartasanchez et al.

HbA1c, haemoglobin A1c; SDM, shared decision-making.

Methods
Data source
This is a secondary analysis of the TRICEP study (“Test Use of a Decision Aid in a Clinical Visit to Help Patients Choose a Diabetes Medication” registration #NCT01293578 ClinicalTrials.gov), a multicentre randomised trial (n=350 patients), which compared primary care as usual with and without using a within-encounter SDM conversation aid. This conversation aid presents general considerations and adverse effects of diabetes medication, organised by topics that matter to patients, such as weight change, daily routine, ‘blood sugar’ levels (haemoglobin A1c (HbA1c)), daily ‘blood sugar’ testing, hypoglycaemia and cost. The latest version of the tool is freely available at https://diabetesdecisionaid.mayoclinic.org/. The study took place between July 2010 and May 2014 across 20 rural, suburban and inner-city primary care practices from six health systems in the Midwest (Minnesota, Wisconsin), USA. The video recordings of the patient–clinician encounters were used in this secondary analysis. The Mayo Clinic Institutional Review Board approved the original study and this secondary analysis (IRB #10–006952 and #19–011553). All participating patients and clinicians provided written informed consent.

Sample size and study design
This is an observational, cross sectional retrospective study using video recordings. Using a random number generator, we selected a random convenience sample of 100 video-recorded clinical encounters, irrespective of the TRICEP trial arm. We judged that 100 encounters would be sufficient to address the descriptive primary aims (aims 1–3). We selected 20 encounters from TRICEP as a training set to practice the self-designed coding scheme
and subsequently coded the remaining 80 selected encounters. Patients and members of the public were not involved in the design, conduct, reporting or dissemination plans of this research, and decision scientist) coded all encounters in duplicate and independently. All codings were discussed in regular meetings and disagreements were resolved by discussion and consensus.

**Data extracted**

We extracted patient and clinician characteristics along with the assigned study arm from the TRICEP database. In addition, from the database we extracted scores from the 12-item Observing Patient Involvement in Decision Making (OPTION12) scale for each encounter, a validated observer-based scale used to quantify the extent to which clinicians involve patients in the decision-making process. Researchers scored the encounters with the OPTION12-scale in the original trial, prior to this secondary analysis, and, thus, blinded to our research questions. Scores are reported on a 0–100 scale, with higher scores implying more behaviours to involve patients. The reviewers of this secondary analysis were blinded to the OPTION12 scores while coding.

**Statistical analyses**

We used descriptive statistics to report on participant characteristics and numerical estimates, mean and SD for continuous variables and counts and frequencies for categorical variables. To compare study arms, we used a Kruskal-Wallis test for continuous and a χ² test for categorical variables. To assess SDM instances, an Analysis of Variance (ANOVA) was conducted, where the number of instances was categorised into groups, adjusted by whether a medication change occurred as well as the intervention arm. We used an alluvial plot to represent the instances and forms of SDM used and the order they occurred within the encounter. We used a boxplot to show the distribution of the OPTION12 score for encounters focused on weighing alternatives, either as the only form of SDM used or as part of multiple forms used or encounters that were not focused towards weighing alternatives. We collected data in REDCap (Grant ULTR002377) and conducted our analysis in SAS V.9.4 (SAS Institute, Cary, North Carolina).

**Results**

**Participants**

In total, we included and coded 100 video-recorded clinical encounters (intervention arm: n=69, control arm: n=31). Of the 100 participating patients, 59 were men. Patients had a mean age of 60 years (range: 41–85 years) and a mean Body Mass Index (BMI) of 36.7 (SD 9.14) kg/m². The average HbA1c was 8.9% (SD 1.26%) and most patients (54%) had an HbA1c >8.5%. A third of the patients had lived with diabetes for over 10 years (table 2). Patients in the intervention arm were younger compared with those in the control arm (59 vs 63, p<0.03). Otherwise, all patient characteristics were comparable between arms (online supplemental table 1).

The clinical encounters involved 89 clinicians, of which 44 (49%) were men. On average, clinicians had been working in practice for 12 years (SD 10.4) and 79% of clinicians had completed their medical training (table 2). The average length of the clinical encounter was 17.0 min (range: 4.0–43.6 min).

**Forms of SDM used**

In 86 of 100 clinical encounters, we identified at least one form of SDM. In 31 (36%) of these 86 encounters, we identified one single form of SDM, two forms in 25 (29%), and three or more instances in 30 (35%) encounters. Figure 1 depicts the instances in which patients and clinicians switched to a different form of SDM during the clinical encounter.

**Table 2** Participant demographics

<table>
<thead>
<tr>
<th>Patient demographics</th>
<th>N=100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study arm (n)</td>
<td></td>
</tr>
<tr>
<td>Primary care (control)</td>
<td>31</td>
</tr>
<tr>
<td>Primary care using a within-encounter conversation aid (intervention)</td>
<td>69</td>
</tr>
<tr>
<td>Age, years (mean, SD)</td>
<td>60.0 (9.7)</td>
</tr>
<tr>
<td>Women (n)</td>
<td>41</td>
</tr>
<tr>
<td>Body mass index, kg/m² (mean, SD)</td>
<td>36.7 (9.1)</td>
</tr>
<tr>
<td>Race (n)</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>85</td>
</tr>
<tr>
<td>Black</td>
<td>9</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
</tr>
<tr>
<td>Education* (n)</td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td>29</td>
</tr>
<tr>
<td>Vocational/4-year college degree</td>
<td>46</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>9</td>
</tr>
<tr>
<td>HbA1c, % (mean, SD)</td>
<td>8.9 (1.3)</td>
</tr>
<tr>
<td>Years with diabetes* (n)</td>
<td></td>
</tr>
<tr>
<td>&lt;5</td>
<td>27</td>
</tr>
<tr>
<td>5 to&lt;10</td>
<td>32</td>
</tr>
<tr>
<td>&gt;10</td>
<td>30</td>
</tr>
<tr>
<td>Literacy* (n)</td>
<td></td>
</tr>
<tr>
<td>Inadequate</td>
<td>9</td>
</tr>
<tr>
<td>Adequate</td>
<td>81</td>
</tr>
<tr>
<td>Clinician demographics</td>
<td></td>
</tr>
<tr>
<td>Age, years (mean, SD)</td>
<td>45.2 (11.3)</td>
</tr>
<tr>
<td>Women (n, %)</td>
<td>45 (50.6)</td>
</tr>
<tr>
<td>Years in practice, mean, SD</td>
<td>12.0 (10.4)</td>
</tr>
<tr>
<td>Number of encounters included (mean, SD)</td>
<td>3.8 (3.3)</td>
</tr>
</tbody>
</table>

*pSelf-reported by patients, missing responses are not represented in counts or percentages. HbA1c, haemoglobin A1c.
Of the observed total of 196 instances of SDM, 70 (36%) were focused on solving a problematic situation, 64 (33%) on weighing treatment alternatives and 59 (30%) on negotiating conflicting desires. Three (1%) of the instances sought to develop existential insight.

**Treatment decisions**
Patients and clinicians decided in 27 of the 100 encounters to change the medication of the patient, with no differences between study arms. A change in medication was related to more instances of SDM used during the encounter (no change: 1.8 instances of SDM (SD 1.46); change: 2.4 instances of SDM (SD 1.48), p=0.050). This effect was maintained after adjusting for the use of a conversation tool.

**Patient involvement in decision-making**
When patients and clinicians used SDM focused on weighing different treatment alternatives, either as the only form of SDM used during the encounter (no change: 1.8 instances of SDM (SD 1.46); change: 2.4 instances of SDM (SD 1.48), p=0.050). This effect was maintained after adjusting for the use of a conversation tool.

**Secondary aim: desires**
In 83 of the 100 encounters, we identified at least one voiced desire, resulting in a total of 247 voiced desires with a mean of 2.5 (95% CI 2.07 to 2.87) desires per encounter. Most encounters contained one (n=23, 28%), two (n=14, 17%), three (n=19, 23%) or four (n=12, 15%) desires (online supplemental table 2). Desires were more often stated by patients than by clinicians (N=157, 64% vs N=90, 36%, p<0.001) (online supplemental table 3). Voiced desires were directed towards a personal want or disposition (n=132/247, 53%), a type of medication or lifestyle (n=81/247, 33%), a situation (n=27/247, 11%) or about the integrity of self (n=7/247, 3%).

We found that the use of a conversation aid did not significantly affect the number of desires voiced during the clinical encounter (2.6 desires (95% CI 2.1 to 3.1) with the use of the conversation aid versus 2.2 (95% CI 1.5 to 2.9) without the conversation aid, p=0.42) or the type of desire voiced.

**The correlation between forms of SDM and voiced desires**
In the 55 encounters in which we identified multiple instances of SDM, we observed 107 switches between forms of SDM, of which half (N=53 switches) were directly preceded by a desire voiced by either the patient or the clinician. Of these 53 switches, 39 (64%) preceding desires were in line with the form of SDM used, for example, an SDM conversation focused on solving a problematic situation following a desire voiced towards a situation (online supplemental figure 2).
will underestimate the prevalence of SDM in practice. This leaves efforts of patients and clinicians unacknowledged and hampers the successful, flexible and meaningful implementation of SDM in clinical practice.

Scores on clinician’s efforts to involve patients in decision-making, measured by OPTION12, were associated with SDM focused on weighing treatment alternatives. This finding is in line with our hypothesis, based on a paper recently published by Hartasanchez, et al., that showed SDM measures to predominantly measure collaborative processes focused on decision-making when weighing multiple options, only one form of SDM used during patient–clinician collaborations.

We found that patients and clinicians often switched between different forms of SDM during their encounter. In half of the cases, a desire—voiced by a patient or clinician—preceded a switch in the SDM form used and, usually, the focus of the voiced desire was in line with the form of SDM that followed its utterance. While the exact meaning of these switches remains a topic to be investigated further, we propose that these switches reflect a change in the purpose of the collaborative deliberation, that is, patients and clinicians alter their deliberative approach to better respond to the situation as it becomes clearer during the conversation. In this way, a voiced desire may flag a change in needs and therefore may be the starting point of a different form of SDM.

There is substantial debate as to SDM’s nature and boundaries. Nearly 30 years ago, SDM stood between the paternalistic form of decision-making and so-called informed decision-making, in which the responsibility of the decision lied with the patient. Over the last decades, SDM has evolved with the identification of steps and ‘talks’, the development of conversation tools and their implementation through policy and practice. Throughout this evolution, SDM has referred narrowly to situations in which the fundamental process is to rationally match the patient’s preferences to the pros and cons of the available options. At the same time, research indicates that SDM is rare in practice, even as clinicians insist that they ‘do SDM all the time’. This may be explained in part by what actions have counted as ‘doing SDM’. Assuming that a single method should be used to address the broad range of problematic situations, patients and clinicians collaborate to advance may have hindered the study and optimal practice of SDM.

In 2019, Hargraves et al expanded the remit of SDM by proposing that the nature of the problem and the patient and clinician are trying to solve determines the form of SDM they adopt to address it. This was supported by Shoesmith et al in 2022, when trying to develop a scale to measure patient-collaboration, carer-collaboration and clinician-collaboration in clinical care. They found that shared problem-solving was an important component of collaboration, together with SDM. To acknowledge the range of forms of SDM used in response to the problem that needs to be solved, Hargraves et al proposed a framework of ‘purposeful SDM’. Purposeful SDM states that each form of SDM involves the use of form-specific and general elements, such as communication, information sharing and collaborative deliberation, with different emphases and roles depending on the situation. Adding to the knowledge about purposeful SDM, Hartasanchez et al recently showed that the current available observer-based SDM measures all describe behaviours that are pertinent to all forms of SDM but fail to distinguish between them. Our study now adds to this knowledge with evidence from real-life clinical practice on the prevalence and use of different forms of SDM in primary diabetes care, further emphasising the need to move away from an overly narrow definition of SDM (that ultimately describes only one of the forms of SDM observed in practice, and not the most common

Table 3  Use of the different forms of SDM in encounters with and without the use of a conversation aid intervention

<table>
<thead>
<tr>
<th>Form of SDM</th>
<th>Not using a within-encounter conversation aid (n=31)</th>
<th>Using a within-encounter conversation aid (n=69)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighing alternatives</td>
<td>12 (24%)</td>
<td>51 (35%)</td>
<td>63 (32%)</td>
</tr>
<tr>
<td>Negotiating conflicting desires</td>
<td>17 (34%)</td>
<td>43 (29%)</td>
<td>60 (31%)</td>
</tr>
<tr>
<td>Solving problematic situations</td>
<td>20 (40%)</td>
<td>69 (34%)</td>
<td>89 (45%)</td>
</tr>
<tr>
<td>Developing existential insight</td>
<td>1 (2%)</td>
<td>3 (2%)</td>
<td>4 (2%)</td>
</tr>
<tr>
<td>Total</td>
<td>50 (100%)</td>
<td>146 (100%)</td>
<td>196 (100%)</td>
</tr>
</tbody>
</table>

Numbers represent the amount of occurrences (counts (%)) of a particular form of SDM in a total of 100 encounters (without conversation aid: n=31, with conversation aid: n=69). P value 0.51 (Fisher’s exact test).

SDM, shared decision-making.
one) and expand its remit from the preference-sensitive selection among alternatives to a method of care that practically contributes to the work patients and clinicians do together to address problems of care. How these problem-based forms of SDM relate to the conventional steps of SDM will be discussed in a different manuscript.

There are some limitations to be considered. First, we used video-recorded clinical encounters of the TRICEP trial, a study implementing a within-encounter conversation aid in primary diabetes care. Our study was a secondary analysis making use of videos of encounters with and without the conversation aid. Our analysis did not show any statistically significant differences in the amount and type of SDM forms used, nor in the amount and types of desires voiced between the study arms. Second, with this study being conducted in primary diabetes care in the Midwest of the USA, it remains unclear whether our findings are generalisable to other healthcare settings and patient populations. Diabetes care visits may involve problems solving SDM more often than preventive care visits in which deciding whether to participate in cancer screening programmes may require weighing options SDM. SDM focused on developing existential insight is particularly appropriate in situations where the patient is troubled by issues of existential fracture or transition. Studies in oncology or the intensive care unit, particularly at the end of life, may involve this form of SDM frequently, while a rare finding in the diabetes care setting. Finally, with no validated coding scheme available regarding this subject, we self-developed a coding scheme based on the available literature on forms of purposeful SDM. This coding scheme was not externally validated, but we aimed to optimise the reliability of our data by coding all encounters independently and in duplicate, by two researchers with different backgrounds, and resolving all disagreements through consensus. Strengths of this study are the large sample size and the use of a random selection of video-recordings from the TRICEP database.

Notably, this study provides evidence of the presence of multiple forms of SDM within diabetes care encounters. It does not evaluate the quality of the SDM form used, for example, the appropriateness, effectiveness, grace or adequacy with which a form of SDM was used or moved away from. Furthermore, we did not assess the ability of SDM to form care plans that fully make sense for the patient and their situation or the effects of SDM on clinical or quality of life outcomes or treatment adherence. These gaps should be addressed to identify any needs or opportunities for further supporting, improving and promoting the use of multiple forms of SDM and to develop and evaluate interventions that will enable their optimal use in care.

Clinicians that are able to flexibly dance across the different forms of SDM with their patient to find out the one that better helps advance the patient’s situation may increase the chance that the resulting care plans will respond to the patient’s situation and fit within their life and living. In this manner, investments in purposeful SDM can contribute to improved patient-centred care and outcomes, in line with the recommendations of the American Diabetes Association and the European Association for the Study of Diabetes and will provide new insights for training and teaching healthcare professionals.

Conclusion
This study shows that SDM occurs often in diabetes care, particularly when deliberative approaches beyond weighing treatment alternatives are considered. We found SDM focused on solving problematic situations together account for over a third of the SDM forms observed in primary diabetes care. Weighing alternatives, the only form of SDM usually considered in the literature, and negotiating conflicting desires each accounted for approximately another third of the instances of SDM. Furthermore, patients and clinicians often switched from one form of SDM to another, a behaviour that was even more pronounced when a change in medication was warranted.

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Contributors MMR, VM and MK conceived and designed this study. MMR and MK coded all video-recorded clinical encounters in duplicate. MEB performed all data analyses. MMR, VM, IH, MEB, MLG, EJPdK and MK helped to interpret the study results, drafted and revised the manuscript and approved the final version. MMR and MK are the guarantors of this work and, as such, had full access to all the data in the study and take responsibility for the integrity and accuracy of the data and data analyses.

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Competing interests None declared.

Patient and public involvement Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication Consent obtained directly from patient(s).

Ethics approval The Mayo Clinic Institutional Review Board approved the original study and this secondary analysis (IRB #10-006952 and #19-011553). Participants gave informed consent to participate in the study before taking part.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data are available upon reasonable request. Deidentified data from the video recordings used in this study are available upon reasonable request at the ‘Knowledge and Evaluation Research Unit, Mayo Clinic, Rochester’.

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