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Viewpoint

The role of physician–patient communication in promoting patient–participatory decision making

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Abstract

Context Involving patients in decision making (DM) is being advocated in clinical practice. For it to be operational, some behavioural models have been put forward. Yet, their suitability and implementation in primary care are controversial.

Objective To illustrate: (i) some of the strategies general practitioners use to involve patients in DM and (ii) a type of patient involvement in the context of primary care based on the appropriate use of general communication skills along the physician–patient interaction to promote participation without an extensive exhibition of options.

Strategy Analysis of two real situations of family medicine practice.

Conclusion The quality of the process of involving patients in DM depends mainly on the professional's communicative effort to achieve understanding and rapport rather than on an extensive discussion of possibilities or their prioritization.

Introduction

Efforts to reform primary care increasingly emphasize active partnerships between patients and physicians, including involving patients in decision making.[1–4] However, what 'active partnership' means and how and when participation in decisions should be encouraged remains unclear and controversial.[5–7,8]

As proposed by Charles *et al.*[9,10] 'shared decision making' requires three tasks: sharing bidirectional information, deliberating upon a menu of relevant options and making a decision. Originally, this SDM model was developed to address single event high-risk problems and uncertainty faced by patients and physicians who do not know each other very well. However, these assumptions do not apply to many of the patient–physician discussions about options in primary care. In this setting, decisions are often reversible, the consequences of a 'wrong' decision might not be great, and patients and doctors often have long-term continuous healing relationships across multiple encounters. These relationships enable the judicious use of communication skills tailored to the patient's situation.

Theoreticians, clinical professionals and patients may have different perspectives on the meaning of SDM. For example, there may not

be agreement on what is mean by 'involvement' in decision making. Professionals aspiring to 'involve patients in decision making' may not actually use participatory language in clinical encounters, such as inviting patients to participate by outlining the treatment options and allowing them to make their choice.[11–13] For many patients, 'participation' can mean efforts that result in physicians knowing them as a person rather than the presentation of options in the face of equipoise.[14,15,16] Patients may value, first and foremost, building a relationship of trust and mutual respect, and open exchange of information.[14,17] For these and other reasons, Charles's model – the mutual discussion of treatment options – is uncommon in primary health care.[7,16,18,19]

This article will explore the possibility that patient 'involvement' should be viewed more broadly and flexibly, identifying the unique needs and preferences of each patient. This approach requires that the physician demonstrate respectful consideration of the patient's values and rely not only on presentation of information – the physician also should use intuitive abilities, self-awareness, curiosity and flexibility.[4,20–23] Through analysing two real situations of clinical practice in family medicine, this article describes and supports a type of patient participation in DM where the communicative qualities of the interaction are the fundamental determinants. Using this approach, the professional gains knowledge of the patient's ideas, fears, expectations, preferences, values and needs; and general communication strategies may be more important than the identification and discussion of a series of options.

Examples of clinical practice in general medicine

I present two real scenarios within the clinical context of family medicine. Situations like these are common in family medicine where family physicians act as gatekeepers to the health-care system and the average consultation time is short.[24,25]

Scenario A

The first one is an interaction between a family doctor and a female patient. The patient has had episodic acute mechanical lumbar bend pain. After some short formal greetings, the patient tells the physician the reason for her consultation (an 'acute' sudden pain that 'almost prevents' her from moving around). Next, the physician inquires about the nature and symptoms associated with the pain as well as its possible relationship with overexertion the day before. The patient seems to agree with the physician's assessment as she has no additional concerns. The doctor invites her to have a physical examination. Here is the transcript of the exchange after her examination.

A01 D: Indeed, it looks like you've hurt your back, the muscles in the lumbar area to be precise, probably due to the strenuous activity you did some days ago.
A02 …(3 s) I can't see anything else apart from this simple lumbago, that's how it's called.
A03 (The doctor is silent while looking at the patient)
A04 P: So, it's not sciatica?
A05 D: Sciatica? Why are you asking?
A06 P: Well, it's a very similar pain to the one I've got in my back and I know you get it when you do strenuous work (silence).
A07 D: Uhmmm (more silence -3 s- as the doctor nods).
A08 P: My sister had one…(2 s)
A09 D: … and?
A10 P: She had a terrible time.
A11 D: Tell me what happened, P.
A12 P: Well … I mean, that exactly, she was in terrible pain, she couldn't move or go to work for several days … (The patient stutters).
A13 (Silence) (4 s)
A14 P: … In the end, she had to see a specialist, took lots of pills and even was prescribed some shots and a resonance test …, As I said, she had an awful time, poor thing.
A15 D: I see, and you are worried you could have sciatica too, aren't you?

A16 P: Sure, to be honest, I wouldn't like that …but since it started in the same way … the pain in the back … she had already had it when she was pregnant and it came back.
A17 D: she was all pestered, right?
A18 P: You bet!
A19 D: Admittedly, sciatica may be very painful and disabling.
A20 P: Well, I mean, I don't think I am like she was but … I don't know.
A21 D: I know what you mean, after the experience you've had it's normal to be afraid this can get worse, no?
A22 P: That's right! … Now I have a new job, I mustn't be off work.
A23 D: Of course!
A23 D: Actually, this should not get any worse. Your nerve isn't affected, that happens when you have sciatica. Then, when the nerve is affected there usually are other symptoms like sharper pain, and it usually runs down your leg …
A24 P: (Interrupting) Yeah, my sister, the pain went all the way down to her heel and she couldn't move at all.
A25 D: …even you can feel a tingling sensation or loss of strength … and in your physical examination other things would have come up, like pain when raising your leg for example, … that's why I think that what you have is exactly that, a type of lumbago or muscular contraction.
A26 P: Uff! Thank goodness for that!!
A27 D: You have to keep on working you said?
A28 P: Sure I can't afford quitting my job now.
A29 D: So I guess you want something to make you get well soon, no?
A30 P: Of course.
A31 D: Have you thought of something?
A32 P: No, no, well … those shots were good for my sister, she did not get any better until she started having those injections, but from what you explained, if this isn't the same, I don't have a clue, so it's up to you.
A33 (Silence) (3 s)
A34 P: … but I wouldn't like any medication that makes me feel all weak.
A35 D: And why do you say so?
A36 P: They gave my sister some pills and she could not move, as weak as that she was.
A37 D: Of course, and if you want to keep on going to work …
A38 P: Exactly.
A39 D: Well, given what you have, you won't benefit from the injections they probably gave your sister. I guess they were some kind of strong anti-inflammatory, maybe corticoids … in your condition, there's no proof yet they can cause any improvement …(2 s)
A40 P: No, no, I was just mentioning it.
A41 D: Yes, of course … Well then, if you agree, we can try some medication that isn't too strong, like for example a combination of anti-inflammatory such as ibuprofen and a painkiller like paracetamol. These drugs are quite safe and have few after effects. Stomach problems or upsets may be most likely, but I could prescribe a stomach protector too. Do you have any stomach problem?
A42 P: No, I haven't. My stomach is fine and I've taken this sometimes before.
A43 D: Well, I could advise you also not to make any sudden movements, and whenever you have time, place an electric blanket or a hot water bottle on the area of your back, and then we'll see how it goes.
A44 … With this, you should be getting better within 5 or 6 days.
A45 (Looking at the patient and leaning towards her) What do you reckon? Is it OK with you?
A46 (There is a pause, the patient nods slowly).
A47 P: Good, good, looks very fine to me.
A48 D: All right then.
(s: seconds)

Scenario B

This second scenario is an interaction between a family physician and a male diabetic patient of his. They have known each other for almost

20 years. This is a follow-up consultation, yet both doctor and patient talk about other issues, too. At the beginning, the visit focuses on reconsidering the patient's condition after a set of blood tests. Soon, the physician expresses the need to add medications to the current patient's treatment based on diet and physical exercise. The patient seems to be aware of some available therapeutic possibilities. Here is the transcript of the parts of the DM process.

B01 P: I come to see the results of my tests.

B02 D: And how're you doing, are you OK?

B03 P: As usual, very well.

B04 D: They are over here … (5 s)

The doctor looks and watches them for a while.

B05 D: Were you nervous or what? … (1 s) I mean, I can see on the electrocardiogram that you heartbeat was a bit fast

The doctor reaches out to the patient's hand and takes his pulse.

B06 P: Nervous? ... Now I'm nervous.

B07 D: Why so?

B08 P: I don't know, well, you know about my children already, everything comes together. … (3 s)

B09 D: The little one, fine, no? The middle one was the one you were having more problems, right?

B10 P: Yes, the middle one … He should have come to see you now … it's because of work stress you know. ... Anyway, what can you tell me about the analyses?

The physician explains the results. They discuss the differences between fasting glycaemia and glycosylated haemoglobin.

B11 D: Your sugar has now reached a level where you should take pills.

B12 (Silence, 3 s)

B13 Well, if I were you I'd certainly take them!

B14 (the doctor looks at the patient, another silence, 4 s).

B15 P: (The patient looks down at the table and says slowly) Pills for sugar levels?

B16 D: We've already talked about it. You know by now the problems having such high levels can give you,

B17 or do you have any doubt left? (Silence, 3 s) If you do, tell me … (2 s)

B18 (The patient shakes his head) … pills will help to reduce them … there are various. I suggest these ones that have very few side-effects, only an increase in flatulence and maybe in the smell of stool …

B19 although there are others, but because of your other problems I don't think we should try them for the moment.

B20 (Silence, 3 s) (the patient re-establishes eye contact).

B21 D: Or should we? … (2 s) (The doctor leans towards the patient).

B22 As I've known you for so many years, asking you to lose 20 kilos isn't very realistic,

B23 is it Pedro?

B24 (Silence, 3 s) (eye contact interruption again).

B25 D: Would you be able or not?

B26 (Silence, 4 s).

B27 P: (at the same time as he scratches the back of his head with his right hand) I could try before starting on the pills…

B28 because insulin comes after the pills, doesn't it?

B29 D: Insulin comes after… that's why I'm telling you it's time to start on the pills; I have to tell you how it is.

B30 … Silence (4 s).

B31 P: … Well, let's give it a try… with the diet and exercise…

B32 what do you think, for a month?

B33 D: Yes, a month … and we'll see if the levels go down.

B34 P: Let's try it for a couple of months.

B35 D: Yes, but I'm not asking you to lose 20 kilos in one month, more like a couple of kilos or three…

B36 in a couple of months' time and if you can achieve that you won't have to take the pills.

B37 P: Right! Let's give it a try.

(The doctor tells him to see the nurse to update his diet and exercise plan)

B38 D: …As for the rest, I see your blood pressure is fine… I'm going to examine you.

(They both walk to the examination couch).

B39 D: (The doctor is examining the patient) I know slimming down to 70 kilos is impossible for you… but losing a few would do you very good … and as you said, it would spare you from having to take the pills, no?
B40 P: You know … I know myself and if I take the pills, I go on eating.
B41 D: Yes, sure.
B42 P: That's how it is, this way I hold back more…
B43 D: I understand.
B44 P: … furthermore, it's as if I am not burning off one other stage yet.
B45 (The physician looks at him with a puzzled expression).
B46 P: I mean I still have more options left rather than just insulin… and the later I begin with the shots, the better.
B47 D: We've already talked some time about the insulin and shots …
B48 P: Yes, yes … but you see…
B49 D: What I see is that we'll have to pick up the subject again.
B50 P: Yes, we'll see if I can make it this time.
B51 D: Right, let's do that, then.

(The interview lasts for another 8 min. During that time, the doctor completes the examination and they talk about other subjects: a change of treatment for asthma, haemorrhoids and a treatment for a skin problem).

(s: seconds)

Comments on the vignettes

Two aspects stand out in both these clinical scenarios from the perspective of the DM process. The first one is the lack of an exhaustive exposition of possible options of treatment with their pros and cons; the second, a proposal by the doctors for treatment at the end and the beginning of the encounters respectively. According to one of the most popular definitions of shared decision making, it is necessary to fulfil several requirements, such as providing and discussing a list of available options.[9,10,26] On this definition, we would not classify either encounter as shared decision making. However, the doctors in both encounters attempt to involve patients in DM. The extracts show that general communication skills (e.g. building trust and rapport) were more important for this than the discussion of options.

From a more general communicative perspective, in the first dialogue the doctor tries to explore the patient's experience of her disease and her opinion about the diagnosis. The doctor also tries to clarify the woman's fears and expectations about the diagnosis and possible treatment. The way the doctor deals with her patient's concerns, tends to her fears and expectations, and gives his opinion creates this atmosphere of bi-directionality, responsibility and reciprocity that moves the conversation away from a paternalistic style to a more participatory one where patient autonomy is enhanced.[27] It is while the dialogue flows and through implicit invitations that the most relevant aspects arise, dealing with the patient's possible options to manage the problem and her wish to participate.

The second scenario can be considered as just one episode within a process that goes beyond the limits of this consultation. The setting of the encounter (primary care consultation), the chronic nature of the problem and a doctor–patient relationship that goes back many years are aspects necessary to contextualize the way DM is being performed.[2] The physician may seen abrupt when he puts forward a proposal for treatment. Yet, the encounter shows enough clues to classify the DM process as participatory; namely: (i) the patient is already familiar with the options (B16); (ii) the patient's capacity to reject the doctor's offer and suggest his own; (iii) the doctor's willingness to accept it and adjust himself to the patient in a seemingly unconditional way, and (iv) the subsequent exploration of values and ideas about it. Despite some tension from the moment when the doctor sets out his proposal until he accepts the patient's, the prevailing atmosphere in the negotiation is predominantly caring, empathetic and bidirectional.

The behaviours of each physician can reasonably be considered as realistically adjusted to the constraints and potentialities of each

specific context, reflecting knowledge of the patient and degree of uncertainty and risk of each problem at stake.[28,29] Table 1 lists the general communication strategies I consider a doctor should carry out to assess their patients' wish to participate and involve them in the most appropriate manner and identifies examples of these strategies within the two transcripts. The list is not intended to be exhaustive.

The two encounters presented here suggest several aspects are especially important to achieve patient's involvement:

1. Making decisions about the nature of the problem is making decisions about the action plan. Patients' participation takes place in these two levels of decision, which are interrelated. The first part of scenario A (from A04 to A26) transcribes a dialogue whose aim is to agree on the diagnosis of the clinical problem. This is not accomplished through a one-way informative process from doctor to patient, but through the patient's participation in an exchange of experiences and points of view that clarifies meanings. The resulting clear agreement on the nature of the problem (A26) entails tacit agreements about the inappropriateness of some therapeutic options (for example, sending the patient to see a specialist, ordering a resonance test, medicating the patient with injectable corticoids…).

2. How options arise and are chosen. The way doctors and patients determine and discover an appropriate range of options to make a decision at consultations has rarely been studied, despite the importance of the exploration of options for patient participation in DM models, and the difficulty doctors have in presenting them.[30–33] To define the possible options, first, it is important to agree on the nature of the problem. Factors that affect the doctor's view of treatment options include knowledge of the patient's values and preferences.[6] An active exploration of these would enable the doctor to adapt to the expectations and needs of the patient[34] and also, to propose some alternatives that, even though they were initially discarded, could seem quite suitable after considering the patient's values. This is what happens in both encounters, though in different ways. In the first, there is not a comprehensive exploration of options but both the doctor and patient weigh up the acceptability of some meaningful options in a particular interaction where the patient is encouraged to give her ideas. Likewise, the discussion about the pros and cons of the options is subordinate to the importance the options gain along

Table 1 Specific communication strategies that could facilitate patient-family participation in decision making (modified from Epstein and Street[41])

Communication strategy	Some utterances in the transcripts
Setting an explicit agenda	A: 02
	B: 11
Facilitating patient discourse	A: 03, 05, 07, 09, 11, 13, 15, 17, 23, 33
	B: 07, 12, 13, 14, 17, 20, 21, 22, 23, 24, 25, 26, 30, 39, 41, 43, 45
Attending and responding to patients' clues	A: 05, 07, 09, 11, 15, 21, 23, 27, 35, 41
	B: 07, 09, 13, 17, 21, 23, 25, 29, 33, 35, 36, 41, 43, 45, 47, 49
Communicating empathy and warmth	A: 17, 19, 21, 23, 37
	B: 09, 33, 35, 36, 39, 43
Offering opportunities for involvement	A: 27, 29, 31, 33, 37, 39, 45
	B: 07, 09, 13, 17, 21, 23, 25, 26, 29, 30, 39
Encouraging patient' involvement	A: 31, 45
in the discussions and decision	B: 07, 09, 17, 21, 23, 25, 39
Exploring patients' wishes about	A: 31, 33, 39
involvement in discussions	B: 07, 09, 12, 13, 14, 17, 20, 21, 23, 24, 25, 29, 30, 39, 45, 49
(and respecting)	
Exploring patients' preferences	A: 27, 29, 31, 33, 37, 39, 41, 43, 45
(and accommodating)	B: 07, 09, 12, 13. 14, 17, 21, 23, 24, 25, 26, 30, 39, 45, 49

the discussion. In the context of this dialogue, we can understand why the doctor does not raise the possibility of sick leave or muscle relaxant medications. Other options are not explored that might possibly be valid in this situation – such as not prescribing anti-inflammatory medication, taking conservative measures exclusively, combining work and physiotherapy, other physical therapeutic options, manipulations or even doing nothing. Yet this reveals the necessarily incomplete nature of this type of process. This is especially so in contexts with limited time when dealing with low risk problems. Nevertheless, the fact that the doctor has not proposed these or other possible alternatives does not diminish the value of his final proposal. On the contrary the doctor suggests options within a bidirectional discussion process, the patient has accepted, the reasoning is logical and the process is ethically acceptable. In scenario B, the alternative wished by the patient comes up after the doctor has suggested a new treatment option. The patient's capacity to express a strategy contrary to the doctor's can be related to the context of mutual trust and knowledge where the encounter takes place, the chronic nature of the problem, and a certain familiarity of the patient with the situation and most relevant options. But undoubtedly, the doctor allows the patient to make such suggestions by communicational skills (such as catching clues, using silence, making specific requirements, as illustrated in B11 to B33. At the beginning, the physician accepts the proposal without exploring the thinking underlying it, but the patient gives this later on (B40, B42 and B44). The fact that the doctor explicitly backs up the patient's choice (B39) almost certainly contributes to mutuality.

3. A specific behaviour can meet different communicational aims (multi-(pluri)-potentiality of communicative behaviours). I have highlighted this concept of communication by defining it as a semiotic-rizomatic space where its different components relate to each other in a non-hierarchical or linear way.[21] This means that, if used adequately, a particular behaviour can achieve different communicational goals. This makes reductionistic analysis of this behaviour inadequate – in Eco's words: unlimited semiosis or meanings.[35] Here are some instances from the first scenario:

When the doctor says, 'Tell me what happened, P' (A11), he takes advantage of a clue to get more information, but he also shows interest in the patient's experience and opens up the possibility for the woman to tell him not only what she thinks about her problem but about the possible treatment options, too. The expression the doctor uses, 'Of course!' (A23), prompts the patient to talk, but it is also a sign that the doctor is very likely to take into account her worries about her job (he does, actually) and a way of conveying warmth. In A33 when the doctor remains silent and listens to what is being said at the moment, his silence encourages the patient to go on talking and helps him assess her wish to get involved or express her possible preferences, as is finally the case. In the second scenario, we can identify several silences of this sort with similar effects. In the context of the negotiation that is taking place, the doctor's comment in B39 is empathetic, but it also helps the patient become more involved in the discussion by giving information about his values and ideas about his decision. This enables the doctor to better assess the suitability of the chosen alternative and offers a possibility to discuss further alternatives and risks in the future.

4. The roles of non-verbal language and paralanguage in general are important but difficult to assess in the involvement process. In the transcripts, non-verbal language comes through pausing, nodding, visual contact or body position. These non-verbal components can be important indicators of the patient's involvement. In the first scenario, the silence in A33 illustrates this. The second scenario is full of communicational moments such as these. Using certain words and verbal tenses is also a subtle way of joining the patient in, like for example, using the pronoun 'we' when proposing treatment in A41 ('…well then, if you agree, we can try…') or the conditional tense for the same purpose in A43 ('Well… I could advise you also

not to make…'). In the process of DM, doctors say that they use non-verbal signs and observe those in their patients to find out about their ideas, fears and expectations about the proposed option or options, and wish to participate.[13,36] This is particularly relevant in the second scenario. Following the principles of neuro-linguistic programming, Neighbour identified this as the key feature of the rapport or 'connection' between the doctor and the patient.[37] Besides, rapport is a key ingredient in every 'sharing' process.

5. *Capturing and responding to the possible clues of whatever nature that may come up along the interview*. Patients often give clues embedded in the context of discussion about their health problem, and they do so in a subtle, non-overt way: the clues are hidden in the fabric of the discussion itself. These clues can be opportunities for physicians to express empathy, understand their patients' experiences[38] and include them in the DM process. Attending to some of these clues is a way of involving patients in decisions. Here are two examples: in the first scenario, A27, the doctor recovers a clue that leads to the patient eventually expressing a wish relevant to the treatment decision (A34): not taking anything that may cause weakness. In scenario B, the doctor's hesitation about the suitability of his own option (B17, B21) is based on his patient's non-verbal clues, mainly (B14, B15, B20). In an ambience where the conversation flows in both directions – whenever the nature of the problem or the possibilities of treatment allow for it[29] – paying attention to the patient's clues can help focus on their worries and the ideas that are most relevant to their involvement. Furthermore, together with other advantages,[38] it helps to avoid de-contextualized explorations of other possible alternatives and saves time.

6. *Decision making as an on-going process*. Scenario B shows that the encounter is a part of a process that started in previous interviews and – due to the chronic nature of the patient's illness – may not have a formal end. What we should analyse here is not the interview itself as much as the series of interviews that tackle the process and close it eventually. In this context, many of the options that may work out are unknown beforehand. Besides, the patient's ability and inclination to suggest options may depend on their past experiences – and interpretations – of clinical interviews.[39] In this 'health production process', patients provide individual information and doctors general information. The former are not customers but co-producers, and this turns them into the latter's partners.[40] This approach should make physicians (i) feel more relaxed about their 'obligation' to state 'all possible options' and (ii) focus more on improving those communicational aspects that help patients express their own ideas at their own pace. This perspective is also valid when the problem is acute and apparently unimportant, like in scenario A. Here, if the issue addressed were not solved, this encounter might become the first one in a series. In scenario B, events can be viewed as the doctor giving in intentionally to reintroduce the pills issue in a future consultation if the patient fails to meet the weight loss objective set in this one. Unless you know what has happened in this interview, it will be very difficult or impossible to assess how much the patient's involvement has influenced the decision that will be made in the next consultation. Likewise, we would not understand what happens in this interview if we did not know in detail what happened in previous interviews.[2]

Discussion

Both vignettes illustrate how family physicians can use relational skills in different situations to enable patients to become 'active partners' in DM. Both physicians display appropriate behaviours in response to patient values, requests, expectations and needs. This is what finally determines the quality of their communication and ability to be patient-centred.[20,22] Both scenarios show how in DM contexts, the interpretation by doctors of their patient's behaviour should make them decide at each particular consultation whether they should offer or keep information, share more or less uncertainty and manage their authority properly. This seems to be more important than the exploration of possible

treatment options, an exploration that seems less suitable in either of these two encounters. Such communication skills guide the doctor as to what extent the alternatives should be exposed and discussed,[34,41] and if they were analysed with enough perspective, they would allow us to better assess the doctor–patient relationship.

Qualitative studies performed with patients have highlighted the crucial role of both a good doctor–patient relationship and a clear and open communication-information process in DM. For many patients, involvement means the doctor cares about them, uses a person-centred approach and gives them information, regardless of whether they have the desire or ability to participate.[17] Likewise, providing adequate information to patients and discussing a single option with them in a significant way may be enough for them to feel involved.[14,15] Perhaps more important: patients tend to think that they are involved in decision making if their doctor listens to *them* and understands *them*, rather than the converse.[15] Many patients view involvement in DM as an on-going process, and this emphasizes that creating a progressive range of meanings adapted to each particular person and moment is much more important than taking part in a particular decision.[16] This set of varied communicative elements as illustrated by both scenarios above is basic to foster people's involvement in clinical decisions in a more realistic way. From this perspective, communication is viewed as a way of mindful 'being in relation' to the other that highlights the perceived effects of the relationship.[42] Some patients and physicians have experienced collaboration in DM even though there were few communicative behaviours explicitly oriented towards 'Shared DM' (as usually defined) in the encounters. Even if a consultation meets the formal criteria for objective 'Shared DM', it does not ensure that the DM process will be subjectively collaborative.[43] Both in medical education and clinical care, this conflict between specific communicative behaviour and subjective experience limits the value of a pure behavioural model based only on a set of specific observed communication skills. Therefore, good communication is a decisive factor to enhance the subjective experience of collaboration and it should contribute to the physician engaging in communicative behaviours more specifically oriented towards shared-DM. Finally, this perception of the relationship seems to determine the consultation outcomes more strongly. Patients' perception of patient-centred communication is directly associated with positive consultation outcomes.[44] Likewise, a randomized clinical trial carried out with patients suffering from benign chronic pain and fibromyalgia highlighted the following: When patients perceived (i) they had had an open discussion of the problem with their doctor, (ii) had received a clear explanation and (iii) had felt that their doctor had taken into account their opinions and suggestions about the management plan, this positive perception related positively with clinical outcomes.[45]

Entwistle and Watt[7] proposed a conceptual framework for involvement in DM beyond the patients' preferences in relation to the list of options and even doctor–patient communication. They highlighted the importance of the subjective aspects of the participants (how both feel about their respective roles and relationship) as well as the efforts and contributions they make to the process. My proposal could also be classified as an instance of what these authors call 'the clinicians' efforts and contributions relating to decision making'. Thus, patient involvement in DM could be alternatively defined as 'a long-term process to elicit patient preferences and needs and enable them to take an active role in caring for their health accordingly'. Trying to define patient involvement by the use of a series of behaviours and specific steps could be unreal in practice. In this respect, I propose the name 'participatory DM' to emphasize the relational component. In Spanish, 'share' means 'divide, distribute things in equal parts, share out in a fair evenhanded manner', and this requires you name whatever is being shared. Instead, 'participate' means 'take part in something (in whatever way)' and 'communicate (something)' (*Dictionary of the Spanish Royal Academy of Language. Madrid: RAE, 2001*). This word has a more general

meaning that is affected by the determining factors in each situation.

From an external evaluation perspective, this broader concept of involvement should be reflected in the measuring instruments designed to capture the efforts to involve patients in DM. External assessment with tools that are based on the concept of exhibiting options has revealed very low rates of SDM consultations, even with doctors who are motivated and communicatively competent.[18,31,32] Those rates seem to remain the same even if the consultation lasts longer.[33,46] Measurements based on these criteria may not reflect the effort some doctors make. This is the case especially when an exhaustive exploration of options may not be appropriate and/or when the DM process occurs throughout successive consultations but the measurement concentrates on one particular encounter. An analysis of 161 encounters between family physicians and patients with different problems found that professionals actively involved patients in DM by using a list of options in only 18 consultations (11%). In 13 (8%) other consultations, although only one option was discussed, there did seem to be some participative interaction.[47]

From the view advocated here, it becomes clear that, if we want to assess a doctor's behaviour correctly and completely and find out whether they involve patients to an appropriate level, we should take into consideration all the factors present in the doctor–patient relationship. We should also take into account all factors associated with the patients themselves, the type of problem they have and the organization where care is provided. Only in this way, it will be possible to approach more clearly the degree of ethical responsibility the professional takes on when they involve their patients in a particular decision.

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