

Shared Decision Making and the Importance of Time

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Uncertain evidence and the uniqueness of a patient's health care issues often make it difficult to identify the best course of care. These instances are becoming increasingly common as more people live longer with multiple chronic conditions and care becomes more complicated. Clinical decisions may involve screening or treatment with new toxic drugs in older patients; timely use of adjuvant, palliative, or pain care; or prioritizing care at the end of life. Shared decision making is essential in the care of patients in these complicated situations. For clinicians, being able to and choosing to spend time on understanding what truly matters to patients when making decisions together is an achievement that makes the work of clinicians meaningful and rewarding.¹ Yet many clinicians have insufficient time to engage in shared decision making.

The most common barrier to shared decision making, cited by patients and clinicians, is time.^{2,3} Time can be considered an organizing tool that controls what happens and when. It is a constrained resource that makes caring for patients possible or not. Time starts, becomes available, can be wasted, and runs out. Regardless of whether shared decision making was planned to take place at a scheduled clinical encounter or needs to be improvised at the bedside when a patient's condition deteriorates, the shared decision-making clock sometimes starts earlier than expected. Patients may consult with family and friends, other trusted clinicians, or online resources. Clinicians may review the relevant evidence and discuss their patient's situation with colleagues, all processes that may take place before, within, or in between clinical encounters. Time for shared decision making is most limited during clinical encounters.

Clinical encounters, although uncommon in the lives of many patients, offer a place and time for clinicians to gather insight into what matters to each patient and for patients and clinicians to co-create care that fits each patient's situation. Time during encounters is usually set by the schedule, which is the result of algorithms that prioritize meeting the demand for access to available clinicians over offering enough time for unhurried consultations. The completion of recommended tasks and of clinical and administrative documentation further taxes the time in consultations. Clinicians often feel hurried and interrupt the conversation with a patient, on average, within 11 seconds.⁴ When lacking time, clinicians may present information with a complexity or tempo that may easily overwhelm the attention of patients who are ill and worried. Information is then lost on patients, and time is wasted. Clinicians may not allow for a silent pause and miss key patient disclosures or questions. Conversely, wresting unhurried visits from a system that overbooks clinicians occurs

by accident, such as, for example, when a patient does not show up for a visit, or requires a conspiracy between patients and clinicians to lengthen the visit and spend the necessary time together. The resulting delay may offend other patients who are waiting and frustrate the staff who will have to stay late at work.

Not Evidence Based, Yet True

Evidence shows that more shared decision-making processes are completed during longer encounters, but evidence is lacking on when clinicians and patients perceive that time has run out, and how better to allocate adequate time to these processes. It is also not clear to what extent clinicians' "lack of time" reflects their lack of control about how the time available should be used. Despite the absence of reliable evidence about time in consultations acting as a barrier to shared decision making and about the efficacy of strategies proposed to overcome it, it remains commonplace to conclude that there is no time for shared decision making. Although not "evidence based," to busy clinicians this conclusion rings true.

Also, little evidence exists about how patients and clinicians spend time on decision-making activities outside of clinical encounters. Sometimes, the task of learning and understanding is laborious for patients, and it may be tempting to ask patients to prepare ahead of time. Patient decision support tools for use at home, in particular patient decision aids and question prompt lists, have demonstrated effectiveness, but their implementation is lagging for unclear reasons. Patient-reported outcome measures are increasingly monitored, but it is not clear yet if they can support care decisions. These requests for patients to do work outside of the clinical encounter must consider that time is precious, particularly for people who live complex lives with illness. It is not always obvious how much of their time patients should spend reviewing information and completing questionnaires instead of pursuing their lives and loves. Clinician decision support tools may facilitate ways to care efficiently with evidence but seldom help clinicians ahead of time to become aware of available choices or to notice when a more deliberate discussion may be needed.

Overcoming the Barrier: From Attitudes to Practice Innovations to Policies

Time will continue to act as a barrier as long as aspects intrinsic to care, such as shared decision making, remain nice-to-have extras for which new time needs to be found. Clinicians must be curious, learn, and appreciate what is their patient's human situation, and in sufficient detail not only about the biology of the condition but also about its effect on patients, and the effects of possible treatments on activities and relationships that patients value. Patients cannot assume that clinicians will know without a conversation. Clinicians must learn to expect and appreciate differences in what they and each of their patients prioritize. Identifying those differences and negotiating through them are intrinsic to high-quality care. What if clinicians felt just as comfortable asking questions as providing answers? What if patients were allowed more time on their own to reflect on what their clinician explained? What if clinicians more often were *present* during consultations: sit down, make direct eye contact, give undivided attention, clearly signaling "This is my time with you,"⁵ to take

away perceived time pressure from patients and give them room to focus on what they need to think about.

Changing attitudes alone will not create time for shared decision making. Because the science of allocating time for care is in its infancy, medicine must innovate. New scheduling algorithms should be developed and evaluated to accommodate encounters (whether in person or virtually, in real time or asynchronously) that support care that fits each patient. Information systems are needed that actively support clinicians in finding alternative management options that would be reasonable, identifying essential information about them, and presenting it clearly. Health care practices need to outsource non-care tasks to moments, attention, and people without direct care responsibility.

Policy makers must understand the trade-offs between optimizing access and productivity and develop policies that allocate meaningful time for care. These trade-offs must be interpreted in light of an increasing number of patients with multimorbidity and complexity of care, of unconscious bias and health care disparities, the waste of “nonadherence,” and the challenges of clinician burnout.

Health care professionals, patient advocates, health care systems, and policy makers need to recognize that time is not simply a resource, its minutes indifferent and interchangeable like dollars or euros. A minute spent in providing information may turn out to be less important than a minute spent waiting silently for patient questions, or a minute responding empathically to angst and loss, or a minute discussing when the plan will be reviewed and revised if necessary. Time for care is precious. The health care system must place a much higher value on and invest in innovations that create time and realize the possibility of time for patient care.

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