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WORKS-IN-PROGRESS

Learning patient collaboration: how do primary care doctors learn to empower patients in decision-making?

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Apprendre la collaboration avec les patients : comment les médecins généralistes apprennent-ils à responsabiliser les patients dans la prise de décision ?

Introduction

This study explores the learning journey family doctors take from technical skills over which they have control to non-technical skills required for integrated patient perspectives in their care. Researchers and clinicians are increasingly committed to patient-centered care. Patient-centered care can be regarded as responsiveness to individual patient needs, values, and preferences, ensuring these factors guide all clinical decisions.[1] Shared decision-making (SDM) has emerged as a central approach to enact patient-centered care.[2,3] The diverse patient population and wide range of health conditions managed in primary healthcare make lifestyle counseling in primary care an ideal environment for investigating SDM.[4,5]

While strategies to achieve desired lifestyle behavioural changes may be agreed upon during clinical consultations, responsibility for lifestyle changes rests primarily on the patient after the consultation. This creates a unique challenge, as the outcomes of the clinical consultation lie largely beyond the doctor's direct control, highlighting the importance of doctors' ability to work together to provide the appropriate levels of support.[6] The clinical consultation provides a platform for SDM, enabling collaborative discussions of care options, evidence sharing, and patient value-driven decisions. However, we know little about how physicians learn to navigate and empower patient agency in healthcare decision-making.

SDM research has primarily concentrated on views and definitions, with little attention to how doctors

learn to collaborate with patients.[7,8] To enable this, we draw on insights from transformative learning theory, which emphasises fundamental changes in how one practices as well as how one perceives oneself and one's profession.[9] To optimize understanding of such transformation, we include in our study both residents and physicians to enable comparison across different stages of the learning journey, providing diverse perspectives on experience, transformation, and practice.

Medical training often prioritizes technical skills (e.g., clinical examination skills, procedures and diagnostic reasoning) over non-technical skills (e.g., communication and teamwork), which are also essential for effective practice.[10-12] The distinction between technical and non-technical skills highlights the difference between tasks doctors control (e.g., procedures) and those they do not (such as communication and negotiation with patients). The latter often requires the need to make changes and take actions within the context of patients' busy lives, such as discussions on lifestyle behaviours.[13] In the complex work environment, SDM, though valued, can be challenging to implement, and clinicians interpret the idea of SDM in different ways.[14] Therefore, this study aims to explore how doctors learn to engage patient decision-making input, in order to improve understanding of and adherence to agreed plans and desired health outcomes.

Methods

We propose to conduct a qualitative study to investigate the meanings people give to their experiences, how they interpret the world, and how they deal with particular circumstances.[15,16] We will adopt interpretive description, which holds that empirical knowledge is subjective, context-dependent, able to combine theory and practicability, and shaped by social interactions.[17,18] The theory of "post-bureaucracy" will inform the study, accounting for the distinction between role-based versus fluid and non-hierarchical modes of work.[19] Post-bureaucracy emphasizes decentralized decision-making, teamwork, and a strong focus on innovation and creativity.[20] It aligns with SDM by democratizing power and decision-making through collaboration and shared power.

Data will include 30 semi-structured interviews with family physicians and family medicine residents (15 physicians and 15 residents), who will be purposively sampled in a manner that ensures diverse representation.[21] The interviews will explore SDM teaching and learning experiences, addressing how doctors at these different stages of their career develop skills in attempts to engage patient decision-making. Thematic analysis will be used for data analysis in this study as it aligns with the inductive nature of interpretive description.[22] This study is under review for IRB approval. Participants will only be interviewed with written consent.

Summary

The adoption of a shared decision-making model in healthcare challenges the traditional hierarchical model, where doctors have given less weight to patients' values and preferences in clinical decisions. Understanding how doctors learn to shift from a top-down approach to one that more actively involves patients is essential. Transformative learning, Post-bureaucracy and Interpretive Description guide the study to have practical suggestions in addition to advancing the theory of SDM. Thematic analysis will enable us to identify SDM teaching best practices, informing training strategies. This understanding can provide valuable insights for training doctors on how best to collaborate with patients and follow through on recent efforts to involve them in decisions. Specifically, the research will advance family medicine curricula by pinpointing effective strategies for teaching SDM, fostering patient-centered care competencies. This research will also enable increasingly customized medical advice that aligns with individual patient needs, which has important implications for those marginalized and experiencing chronic conditions, leading to more patient-centered and empowering healthcare interactions.

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