

MEDICINE AND SOCIETY

What's the Role of Time in Shared Decision Making?

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Abstract

Shared decision making (SDM) is a desirable process and outcome of patient-clinician relationships. Ideally, patients and clinicians have sufficient time to engage in SDM. In reality, time is often insufficient. This article explores time as a barrier to SDM, alternative ways clinicians can think about time, and steps they can take to have fulfilling SDM interactions despite time constraints. Although discussions of time typically focus on time quantity, redirecting attention to the ethical significance of time in establishing patient-clinician relationships suggests the importance of also considering time quality.

Time as a Barrier

Shared decision making (SDM)—the process by which clinicians and patients work together to make health care decisions that align with patients' goals, preferences, and values—is an ideal outcome of patient-clinician relationships.¹ Yet multiple **potential barriers** obstruct SDM in real-life clinical practice.^{2,3,4,5,6} Chief among these is time, particularly the amount and quality of face-to-face time clinicians and patients spend together. Studies have shown that both patients and clinicians view time constraints as a frequent and substantial barrier to SDM.^{7,8,9,10,11} Prevailing sentiment among clinicians and patients is that there is an inherent tension between time and SDM.

Clinicians face substantial time pressure to efficiently accomplish clinic visits or other patient-related duties, making their time a valuable and scarce resource. They routinely deem the quantity of time they have with patients inadequate,^{12,13} and this perceived time shortage is compounded by mounting **burdens of documentation** and other administrative duties.^{12,13} In fact, physicians' satisfaction with the perceived amount of time they have with each patient has decreased over the past few decades.^{12,14,15,16,17} Clinicians perceive that truly fulfilling requirements for SDM necessarily adds time to encounters with patients.⁸ Moreover, differing opinions exist among clinicians regarding the value of engaging patients in SDM, even though facilitating SDM has been associated with improved **patient outcomes** and quality of life.^{18,19,20,21,22}

Patients, too, are aware of clinicians' busy schedules, which can affect the extent to which they actively participate in decision making.²³ If patients view SDM as requiring more time, they might consider it less important than other parts of a clinic visit, and the

importance they give SDM can diminish further when faced with a clinician who seems pressed for time. Patients might elect not to elaborate on their goals and preferences for any number of reasons, including a desire to take up less time, a feeling of being rushed or pressured to speak succinctly, and not wanting to ask too many questions.^{23,24} Conversing with clinicians under time pressures can also alienate some patients who feel that they are not being treated as individuals.²³

Does SDM Add Significant Time?

Both patients and clinicians desire more time during visits, and longer encounters have been shown to increase patient satisfaction.²⁵ That said, a number of studies indicate that SDM does not have to add prohibitive length to patient encounters.^{26,27,28,29,30} A study of SDM discussions with surgical patients showed that reaching appropriate levels of SDM could be achieved in a median time of 17.8 minutes vs 15.4 minutes for meetings that failed to reach what the authors deemed a “reasonable minimum” amount of SDM.³¹

Efficient SDM might be achieved when appropriately tailored questions or **decision aids** are used to aid SDM. Decision aids are standardized, validated tools that can be used to better facilitate SDM by augmenting—rather than replacing—interpersonal exchanges.³² Decision aids can come in several different forms—for instance, printed text, audio recordings, or videos—and assist patients in personalizing uncertainties and the risks and benefits of interventions.³²

Furthermore, asking the same questions of every patient has been shown to increase patient understanding and enhance SDM without increasing the duration of encounters.³³ Two Cochrane review articles examining uses of decision aids to facilitate SDM found that they can improve communication, information sharing, and risk assessment, thereby helping patients feel more satisfied with their choices, knowledge base, and decisions.^{34,35} Importantly, across all studies, decision aids’ use added a median of 2.6 minutes to clinical encounters.^{34,35}

Quality vs Quantity of Time

Notably, discussions of SDM and time tend to consider time in terms of objectively calculated quantities.^{26,28,31,35} By quantitative measures, SDM requires more time than might be available. Theoretically, by substantially increasing the amount of time per day devoted to patient care (for instance, by scheduling longer clinics or by compelling physicians to increase the number of daily rounds), clinicians would almost always have adequate time for SDM. This solution, however, is not practical given the myriad obligations that clinicians and patients have. Additionally, attempting to make patients’ time with clinicians more efficient through methods such as revamping schedules and scheduling systems, creating algorithms to provide optimal time for encounters with different patients, or giving patients “homework” between interactions is logistically challenging.

An alternative is to focus on ways clinicians can enhance the *quality* of time they spend with patients. This approach could help clinicians meet ethical obligations to patients without adding significant time to encounters. For example, thoroughly structuring communication to be patient centered, such that clinicians actively listen to patients; solicit questions, fears, and goals; and focus on emotional dimensions of patients’ illness experiences could help emphasize quality and mitigate perceptions of how time is limited in quantity. SDM, as we describe below, can be accomplished by adding a few

minutes. Although clinicians may feel as though they do not have sufficient time for each patient, increasing the quality of their time with patients can augment the SDM process by allowing for stronger relevant discussions within the same time limits.

How to Increase Quality

Clinicians can draw on decision aids, among other methods, to improve the quality of time they spend with patients and improve patient understanding of complex clinical information, which improves both SDM during a clinical encounter and patients' adherence to treatment plans.³⁶ Nevertheless, clinicians should not become overly dependent on decision aids, as patients still prefer organic interpersonal discussions over those driven by decision tools.³⁷ Clinicians can also streamline conversations by asking a standard set of questions of each patient or by directly asking the patient to clarify the main reason for their visit.^{38,39,40,41} One study found that a patient's purpose for visiting a physician was discussed in only 36% of encounters.³⁸ Since eliciting goals is part of SDM, this finding suggests that SDM was taking place in fewer than 36% of visits.

The need to quickly learn about patients' goals or preferences should be balanced with the need to address each patient as an individual. Improving how clinicians listen to patients is another critical step in including patients in decision making, and this skill should be emphasized in education and training. In one study, clinicians interrupted patients after a median time of 11 seconds, which was partially due to their feeling rushed.³⁸ Since most patients prefer to play active roles (variously defined) in making health decisions, it is crucial that clinicians learn streamlined approaches to managing the quality and quantity of time devoted to SDM.^{42,43,44}

Clinicians should cultivate awareness of how their subtle forms of communication and body language, as well as their words, might be perceived by patients. For example, clinicians should verbally convey their recognition of the value of a patient's time, apologize for tardiness, make eye contact, and shake hands to begin a visit on good terms. Along these lines, clinicians should then avoid sitting behind a computer screen for most of the encounter. Managing time to allow adequate time for patients to voice concerns, sitting at the patient's level, and trying to make patients feel comfortable in exam rooms can be important expressions of a clinician's commitment to being present with the patient and setting a positive tone during encounters.^{45,46} Crucially, these small actions need not add substantial quantities of time to the encounter, but they enhance quality.

Ethics and Time

A number of articles have focused on the tension that might exist between SDM and limited clinician time.^{5,7,8,9,10} As we have suggested, focusing on ways to improve the quality of time clinicians spend with patients can help resolve this tension. Emphasizing quality becomes easier after acknowledging the ethical components of time, a subject that has received little attention in the literature.^{47,48,49} When time is narrowly conceived in terms of quantity, it diminishes potential solutions to what appears to be an intractable problem. Being attuned to the ethical significance of time, however, directs attention to one's duty to enhance the quality of time. Time is not just a barrier to obtaining histories and physicals, health record charting, or educational opportunities; it is a common obstruction to fulfilling basic ethical obligations to facilitate SDM.

Both time quantity and quality are necessary to **build therapeutic capacity** in patient-clinician relationships and to maintain focus on the virtues of compassion, trustworthiness, integrity, discernment, and conscientiousness.⁵⁰ Time is crucial to clinicians' establishing proper rapport with patients, fostering trust, being a patient advocate, and getting to know a patient. Cultivating strong patient-clinician relationships improves outcomes,^{18,51} patient satisfaction,²⁵ and expresses a clinician's moral character.⁵⁰ It is in this type of relationship that SDM can be accomplished.

Conclusion

Clinicians need to value SDM and should strive to practice it even when time is limited—a goal we believe is achievable if they become more aware of how they perceive and use time. When the debate over time is framed solely as a quantitative issue, clinicians lose sight of time's ethical significance and their obligation to maximize time quality to address time shortages. They should focus on restructuring how they navigate visits instead of defaulting to trimming minutes from encounters. Understandably, this approach may not always be feasible, but clinicians simply becoming more cognizant of how they spend their time may pay dividends for patients and clinicians alike.

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