

# Good practice in shared decision-making and consent

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The Scottish Government's [Health and Social Care Delivery Plan](#) contains a commitment to reviewing the consent process for patients in Scotland with the General Medical Council and Academy of Medical Royal Colleges. This report supports that work, by setting out the findings of a review on the practice of consent and shared decision-making within NHS Scotland.

## Main findings

Although many examples of excellent practice exist across NHS Scotland, effective shared decision-making between clinicians and patients is not yet universally embedded. The current challenge is to devise effective ways for supporting cultural transformation, engaging the public and embedding best practice within mainstream clinical processes.

## Background

The project is underpinned by the recognition that people should be regularly involved in, and responsible for, their own health and wellbeing.

The lawfulness of patients' consent to medical treatment has been a consistent feature of clinical negligence cases. The 2017 Scottish Public Services Ombudsman (SPSO) report on [Informed Consent](#), identified that inadequate medical consent was the most frequently recurring issue identified in its complaints investigations and recommendations to NHS Boards over the last 5 years.

The overarching aim of this research was to increase understanding of the current consent systems and processes within NHS Boards and explore the challenges the Boards are facing whilst preparing to adapt to future changes in the guidance. More specifically:

- To establish whether the current consent process forms part of a wider culture of person-centred care and supported decision-making with patients;
- To identify how existing processes and tools support good practice (or not);
- To identify support needs at an individual and organisational level;
- To identify examples of good practice that could be shared across NHS Scotland;
- To provide recommendations for future improvement.

## Methods

This project was conducted using a sequential mixed-methods exploratory design. It consisted of 3 phases:

1. A literature review on current policy and guidance;
2. A group consultation with the Person-Centred Stakeholder Group, comprising of eight participants;
3. An online survey for NHS Scotland Health Board Medical Directors and Clinical Governance leads, followed by face-to-face and telephone interviews with respondents who agreed to be contacted for further information.

The project has undergone an internal ethical assessment process.

## Key findings

The findings describe a common recognition amongst most participants in this research that all healthcare professionals should adopt a personalised and individualised approach within their practice. The need to provide patients with context-specific information was seen as a priority. Whilst the Person-Centred Stakeholder Group recognised the challenges that healthcare professionals face in their everyday practice, they were also concerned that patients are not given adequate time to fully understand, digest and reflect upon the information about their care and treatment. They also questioned the implications of declining or changing their mind about the treatment options without any judgement or repercussions. Their view was that, in order to enable true shared decision-making, patients need to be actively encouraged to ask questions about their care and feel able to discuss the options.

The Person-Centred Stakeholder Group in particular suggested that more emphasis must be placed on shifting the balance towards the patient having a greater say in their care, and all participants recognised that patients need to be informed and educated about their responsibility in shared decision-making. The paradigm shift away from the 'doctor knows best' is dependent on two experts working together, where the patient's personal expertise and knowledge of their

preference is of equal value to medical expertise. However, for true shared decision-making to take place, there first needs to be trust between the individual and healthcare professionals so the people involved feel that they can openly and honestly discuss different options and work in partnership towards an agreed goal. In order to achieve this, there needs to be true collaboration between the professional and the patient, and the involvement of families, carers and significant persons needs to be fully supported.

There was a general perception among all participants that there is often a lack of time for good person-centred conversations to take place. This might be due to organisational constraints and a lack of resources, but also due to poor, or a lack of, forward planning. These constraints can prevent clinicians from practising Realistic Medicine and truly understanding the values, needs and preferences of individual patients.

The approach to designing and implementing consent policy was subject to debate. Whilst some Board leads suggested a standardised Scotland-wide approach, others pointed out that in order to improve practice of shared decision-making, the priority for the NHS is not a new consent policy but changing the ingrained attitudes and behaviours of healthcare professionals so that talking about the patients' preferences, values and needs becomes the norm.

Reflecting on the narratives that have emerged from the interviews, it appears that an essential step in implementing shared decision-making is to improve the current systems and processes at each individual NHS Board level in order to fully support both patients and clinicians. More emphasis needs to be placed on putting prompts in place to encourage healthcare staff to ask about and record specific concerns raised by the patient, together with any advice or options offered in view of the patient's particular priorities. Moreover, all healthcare professionals should be offered training in health literacy techniques such as 'teach back'. There is also a requirement for a system that enables a further conversation with the patient when there is a change in the planned treatment.

## Recommendations

This research highlights a number of areas of future work related to involving and engaging the patient more in the conversations around their own healthcare and providing better support to health and social care practitioners. The associated recommendations highlighted below should help to create a more solid backdrop for better consent processes and shared decision-making that underpin the current health and social care practices in NHS Scotland.

These recommendations range from the broad to the specific and will necessitate a range of actions from policymakers as well as other relevant stakeholders at a local and national level.

## **1. Bring the conversation back to the room**

Ensure mechanisms are in place to allow a rich and meaningful dialogue built on partnership to be placed at the heart of every interaction between those providing, and receiving, treatment and care. Suggested ways that this could be achieved include:

- Provide more guidance on the effective ways of communication (including evidence-based methods and resources) to enable health professionals to clearly explain risks, benefits, outcomes and alternative treatments;
- Develop a national standardised repository of validated evidence-based information about treatments and procedures and the associated risks, in a range of formats;
- Provide clear guidance on the appropriate use of and better access to high-quality decision-making aids for both healthcare professionals and patients to guide shared decision-making;
- Provide staff with education and adequate skills to both communicate information clearly to the patient and to ensure the patient has understood the information (e.g. the 'teach-back' technique);
- Provide staff with training on how to build a more supportive relationship with the patient to enhance person-centred consultations in which the patient feels more actively involved in their own treatment plans.

## **2. Promote cultural transformation**

Transformation is needed within the healthcare system in Scotland to promote and subsequently accept a more personalised and less hierarchical model. Patients must be recognised as equal partners in their care and treatment, feeling supported to express their own needs and priorities through a process of information-sharing, goal-setting and action-planning. This could be supported by the following actions:

- Encourage NHS Boards to share examples of good practice in consent and shared decision-making across NHS Scotland;
- Increase training opportunities and embed shared decision-making into undergraduate education for all healthcare staff;
- Promote peer review of good consenting practice across NHS Scotland.

## **3. Engage the public**

In addition to transforming the role of the healthcare professional, it is important to recognise the changing role of the patient as a more active partner in their own healthcare where possible. Individuals need to be made aware of their responsibility in managing their health and wellbeing, and to feel more empowered to take an active role in their own healthcare decisions. Suggested ways to do this include:

- Create clear guidance for healthcare professionals on how to most effectively involve people in decisions about their health and care, with respect to individual needs and capabilities;

- Create patient/public campaigns to increase people’s knowledge, understanding, skills and confidence to use health information and navigate health and social care systems;
- Make information and training on shared decision-making publicly available to encourage people to become actively involved in decisions about their health and care.

#### **4. Improve local systems and processes around consent and shared decision-making**

To support implementation of the other recommendations, it is important to improve the local systems and processes around consent and shared decision-making to enable more meaningful conversations around healthcare with the patient and to necessitate more collaborative and supportive ways of working between health and social care practitioners. This could be achieved by the the following suggested actions:

- NHS Boards should encourage healthcare professionals to ask about (and record) any specific priorities and concerns raised by the patient;
- Consent discussions should encompass a range of options, including the option of no treatment;
- Create a system, across all NHS Boards, which enables a further conversation with the patient when there is a change in the planned treatment;
- Provide greater support from advocates to ensure patients with learning disabilities receive appropriate help and support. Provide support and guidance to help patients with low health literacy.

#### **5. Support effective ways of working**

Supporting and promoting effective ways of working for health and social care staff is key in enabling better processes of consent and shared decision making with patients:

- Improve the consent process by making better use of technology to record care-planning and shared decision-making conversations;
- Create a national set of principles of good consent practice;
- Consider an effective Scotland-wide approach to consent and standardised patient leaflets;
- Provide more electronic resources for healthcare staff on the benefits and risks of common treatments or procedures.

#### **How to access background or source data**

The data collected for this social research publication may be made available on request, subject to consideration of legal and ethical factors. Please contact [patientexperience.gov.scot](mailto:patientexperience.gov.scot) for further information.



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