

RESEARCH LETTER

ONLINE FIRST

Communicating With Physicians About Medical Decisions: A Reluctance to Disagree

Effective patient-physician communication is essential for shared decision making, considered by some to be the “pinnacle” of patient-centered care.¹ Many health care decisions have multiple options and no correct choice. These are called *preference-sensitive decisions*, and the optimal decision is one that takes into account patient preferences and values in a collaborative process with the physician, known as *shared decision making*. We sought to describe patients’ intentions to engage in shared decision-making communication behaviors in response to a hypothetical preference-sensitive clinical scenario and to examine the effects of underlying patient beliefs on these behaviors.

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Methods. An online panel of 1340 patients older than 40 years who had visited a physician within the last year read a hypothetical scenario about treatment of heart disease and were surveyed about 3 behaviors key to reaching a shared decision: (1) asking questions, (2) discussing preferences, and (3) voicing disagreement, when relevant. The survey was theoretically grounded and drew on the psychosocial constructs of the Integrative Model of Behavioral Prediction,^{2,3} which posits that 3 respondent characteristics influence, for purposes of our study, a patient’s intention to engage in a health-related communication behavior: (1) patient attitudes, (2) patient-perceived social norms, and (3) patient self-efficacy. *Patient attitudes* reflect the patient’s expectation, or lack thereof, that a communication behavior will result in a positive outcome. *Patient-perceived social norms* indicate whether the patient considers a communication behavior to be socially acceptable to peers and important others. Finally, *patient self-efficacy* reflects the patient’s belief that he or she has the skills and capacity to carry out the communication behavior if desired. Questions were formulated from extensive qualitative focus group data and tested and refined through iterative cognitive interviews.⁴

Behavioral intentions and attitudes were measured with 2 items each. Perceived social norms and self-efficacy were measured with 3 items each. Each survey question response was measured on a 7-point Likert scale and

weighted equally. All subscales had acceptable reliabilities (Cronbach $\alpha \geq .75$). Average scores of 5 or more on each subscale were categorized as positive, and scores below 5 were categorized as negative.

For the dichotomous variables, we used the related-samples Cochran Q test to assess within-group differences. We used logistic regression to test whether any of the covariates predicted intention to engage in shared decision-making communication behaviors.

Results. Participants were mostly white, most between 40 and 60 years old, with roughly an even mix of men and women. Survey respondents were highly educated, 42.6% having completed college or graduate study. Many were retired, and only 46.9% were currently employed. Nearly all were currently insured (89.6%), with most having been seen by a physician within the last 6 months (80.3%). Thirty-eight percent had a chronic ailment, and 16% of the sample reported a history of heart disease. A minority held either an autonomous or passive decision-making role preference: 11.1% felt that they should be mostly responsible for treatment decision making, while 19.3% felt that the physician should be mostly responsible. Almost 70% preferred a shared decision-making role, with patients and physicians contributing equally to treatment decision making.

Nearly all patients could envision asking questions (93.1%) and discussing preferences (94.0%); few, however, would voice disagreement with their physician if their preferences conflicted with physician recommendations (14.0%) ($P < .001$) (**Figure**). While most felt that they had the ability to disagree (79.0% reported self-efficacy for disagreeing), few thought that disagreement with their physician was socially acceptable (14.0%) or would lead to good outcomes (15.2%) ($P < .001$).

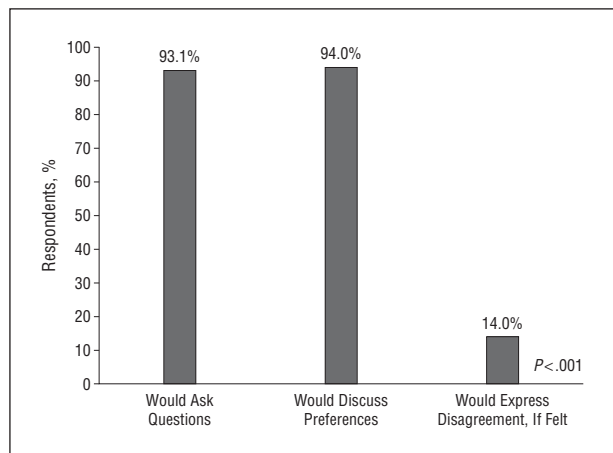


Figure. Percentage of participants who would ask questions of, discuss preferences with, or express disagreement to their physician when relevant.

In logistic regression analyses, demographic characteristics—including age, race, education, income, Charlson comorbidity index,⁵ and heart disease—did not predict a reluctance to disagree. Despite considerable statistical power, only global preference for decision-making roles significantly correlated with a participant's intention to disagree. Participants who preferred to make their own medical decisions (an autonomous decision-making role) were twice as likely to intend to express their disagreement with preference-incongruent recommendations from their physician. Several beliefs, however, were found to underpin the reluctance to disagree. Among participants who would not disagree with their physician, 47.2% feared being seen as a difficult patient; 40.0% thought that disagreement would damage their relationship with their physician; and 51.5% worried that it might interfere with getting the care that they wanted.

Comment. A reluctance, indeed a fear, to disagree appears to be a significant barrier to shared decision making that is present across all sociodemographic strata. To our knowledge, a patient-held fear to voice disagreement has not been found or examined in previous research, and yet it is a major challenge to making progress toward shared decision making. Reluctance to express disagreement in the office may correlate with poor adherence outside the office.⁶ Limitations of this study include the use of a large convenience sample and a hypothetical scenario. The findings point to the need to test interventions that explicitly allow patients to voice disagreement with their physicians. This may well require attitude changes as well as behavior change.

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Published Online: July 9, 2012. doi:10.1001/archinternmed.2012.2360

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Financial Disclosure: None reported.

Author Contributions: *Study concept and design:* Elwyn, Légaré, and Frosch. *Acquisition of data:* Frosch. *Analysis and interpretation of data:* Adams, Légaré, and Frosch. *Drafting of the manuscript:* Adams. *Critical revision of the manuscript for important intellectual content:* Adams, Elwyn, Légaré, and Frosch. *Statistical analysis:* Adams. *Obtained funding:* Elwyn, Légaré, and Frosch. *Study supervision:* Frosch.

Funding/Support: This work was funded by unrestricted grant 0140 from the Informed Medical Decisions Foundation (Dr Frosch).

Previous Presentation: This research was presented in part at the 33rd Annual Meeting of the Society for Medical Decision Making; October 24, 2011; Chicago, Illinois.

1. Barry MJ, Edgman-Levitan S. Shared decision making: pinnacle of patient-centered care. *N Engl J Med.* 2012;366(9):780-781.
2. Fishbein M. The role of theory in HIV prevention. *AIDS Care.* 2000;12(3):273-278.
3. Frosch DL, Légaré F, Fishbein M, Elwyn G. Adjuncts or adversaries to shared decision-making? applying the Integrative Model of behavior to the role and design of decision support interventions in healthcare interactions. *Implementation Sci.* 2009;4:73.
4. Frosch DL, May SG, Rendle KA, Tietbohl C, Elwyn G. Authoritarian physicians and patients' fear of being labeled "difficult" among key obstacles to shared decision making. *Health Aff (Millwood).* 2012;31(5):1030-1038.
5. Charlson ME, Pompei P, Ales KL, MacKenzie CR. A new method of classifying prognostic comorbidity in longitudinal studies: development and validation. *J Chronic Dis.* 1987;40(5):373-383.
6. Lin GA, Trujillo L, Frosch DL. Consequences of not respecting patient preferences for cancer screening: opportunity lost. *Arch Intern Med.* 2012;172(5):393-394.