OPTION

Rater Manual

Observing patient involvement
Evaluating the extent that clinicians involve patients in decisions

Glyn Elwyn, Adrian Edwards, Michel Wensing and Richard Grol

2005 version

In collaboration with:
Jill Bourne, Wales
Richard Byng, England
Evelyn Chan, USA
Wai Yee Cheung, Wales
Elizabeth Cox, USA
John Dowell, Scotland
Tina Eriksson, Denmark
Ellen Fischer, USA
Guido Goelen, Brussels
Claudia Goss, Verona
Wolfgang Himmel, Germany
Margaret Holmes Rovner, USA
Kerry Hood, Wales
Amanda Howe, England
Hayley Hutchings, Wales
Christoph Kindler, Switzerland
Alex Krist MD, USA
Wolf Langewitz, Switzerland
Tara Lawn, England
France Légaré, Canada
Cathy Lisles, Wales
Young Mi Kim, USA
Matthias Nuebling, Germany
Charlene Pope, USA
Frances Rapport, Wales
Mike Robling, Wales
Angela Towle, Canada
Trudy van der Weijden, the Netherlands
Myrra Vernooy, the Netherlands
Heidi Weber, Switzerland
Marjorie Weiss, England
Clare Wilkinson, Wales
Hub Wollersheim, the Netherlands

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1. General issues

This scale is designed to measure the extent to which clinicians (medical, nursing or other relevant professional) involves patients in decisions within consultations. The authors recognise that these interactions are complex and involve contributions from parties, patients and clinicians. A consultation where there is clear evidence of participation in the decision will as likely have contributions from patients in equal measure to the contributions of the professional. Nevertheless, when developing the scale we recognised the difficulty of designing a scale that assessed the contribution of both agents simultaneously and decided to concentrate the OPTION scale on assessing the skills exhibited by the clinician. This approach is also justified by the differential power relationship that exists in patient-professional interactions, and that if professionals do not offer opportunities, and promote patient involvement in decision making, then the process is highly unlikely to be observed. Nevertheless, we concede that the patient contribution to the process of participation in decision needs to be evaluated in parallel and are making efforts to support the development of such as scale.

Research education etc

The scale is designed so that it can be applied to all types of consultations, it is therefore intended to give an involvement score for all 'types' of consultations, whether the encounter is one that involves a first consultation about a problem or a review of a previously discussed problem, reassurance, or any of a range of possible categories of encounters. It is recognised however, that patient involvement in decisions is going to be dependent on the *type* of consultation, so it is important to record the overall consultation *type* and to record the *index* clinical condition that the rater uses as the basis for the assessment of involvement in the decision making process. These variables are added to the rating dataset so that the analysis can assess the degree of involvement achieved in differing types of consultations and with respect to the topic or conditions discussed (see Table 1). Often there is more than one problem in the consultation. A practical decision should be taken to score the process for an *index problem*. An index problem is the problem where the highest degree of involvement occurs within the overall consultation, as the aim is to identify the practitioner's *ability* to involve patients. Where there is more than one OPTION rater, they will need to agree the *index problem* for the rating.

Raters should therefore use the total duration of the consultation to score the OPTION scale, recognising that involvement in decision making can be at the level of involvement in problem solving decisions (e.g. there are two possible diagnoses here, here are the options and possible ways of investigating them…), involvement in treatments (there are a range of possible treatments for this problem, let me explain a bit more about them…), or involvement in further management (there are a number of ways in which this problem could be managed, lets consider them in more detail…). If the clinician involves the patient in any of these types of decision, then the OPTION score would be used to assess the proficiency of the skills exhibited. It is recognised that often, some of the skills may have taken place in previous encounters, but this data will be correlated with the consultation type (new, review or composite).

Table 1. Consultation data: index problem and consultation categories

Index problem	
	In new and review consultations, the index problem will be relatively easy to identify, unless there are multiple unrelated new problems presented for diagnosis (and / or review). Where multiple problems are presented, the index problem should be chosen on the basis of the highest degree of patient involvement in decision making achieved by the clinician. For composite type consultations, the index problem is the one where the clinician provides most evidence of involving the patient in decision making. A broad description of the *index problem* should be provided, e.g. headache, indigestion, heavy period, depression, chest pain. The terms used should describe the main issue(s) presented or discussed and use terms used in the actual consultations. Diagnostic accuracy is not required unless there is evidence that this has been achieved within the interaction.
Consultation type	
New	The main focus is on the presentation of a new problem for diagnosis or advice. The focus in this type of consultation is on taking the patient's story and taking steps to arrive at a diagnosis, i.e. requesting investigations or arranging follow up.
Review	Main focus is follow-up of a recently presented new problem, e.g. results of investigations are investigated and decisions are made regarding further management or treatment. Patients returning to report ineffective treatment would be categorised as a review consultation, unless they also had new problems to present.
Composite	New problem(s) and action or review(s) of previous problems. e.g. a respiratory infection plus request for repeat medication for high blood pressure.

In addition to data about the rater identity, consultation type and condition considered, information about the patient and the practitioner is collected (age, gender and information about additional postgraduate qualification, such as Membership of a professional college. These variables are part of the OPTION dataset and are used to evaluate construct validity.

Consultations often involve more than two individuals and when obtaining consent a record should be made of the ages and gender of the individuals who are involved in the consultation. A parent presents a child for instance, or two people consult about a mutual concern (husband, wife, mother, daughter and so on). These consultations are often of a complex nature, and the interaction involves many conversations about problems and decisions. In most adult-child consultations, it will be clear that the decision making discourse will occur between the adult and the practitioner, and it is the age and gender of the person engaged in the consultation process that should be recorded on the OPTION scale, although a note of the age of the child can also be made under the index problem. Where an adult accompanies a teenager, the age of the person to engage in the consultation process should be recorded (i.e. a rater judgement). In consultations where more than one adult is present, the rater should indicate which individual takes the primary role in the consultation process and the clinician behaviour should be judged in relation to this interaction.

2. Scale design and item definitions

A five-point scale is used to assess the existence of a communication behaviour (competence). The first point on the scale, namely 0, is used when the behaviour is not observed in the consultation. Details about how each scale point should be given to differing skill levels of behaviours observed are provided in this manual. In general terms, the five levels (0-4) will correspond to the following general outline:

Score	Description
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The behaviour is observed and a minimum skill level achieved.
3	The behaviour is exhibited to a good standard.
4	The behaviour is exhibited to a very high standard.

Raters should use the scale points when a behaviour observed corresponds to the descriptions provided in this manual. A set of calibration audiofiles is available from the OPTION Group for those who want to become OPTION raters.

The Scale Items

Item 1	**The clinician *draws attention to* an identified problem as one that requires a decision making process.**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The clinician draws attention to a problem that requires a decision making process.
3	The behaviour is observed and the clinician puts emphasis on the decision making process required.
4	The behaviour is observed and executed to a high standard.

To embark on a decision making process, there has to be clarity about a specific problem or problems. In order to involve the patient in a decision, it should be clear that a decision making process is taking place. The skill to be observed therefore is the ability to identify, emphasise, draw attention to a problem (e.g. high blood pressure, menopausal symptoms, atrial fibrillation etc), as one where a decision exists about further action, and that it needs to be considered by both clinician and patient. In other words, the patient's attention is focused on the fact that the consultation is one where a decision making process is being considered and that the clinician is going to involve the patient, if they so wish, in considering the problem.

For this behaviour to occur there has to be a degree of agreement about the nature of the problem. The problem need not necessarily be a diagnosis where there are choices between treatments or form of management. It is also possible to share a decision about whether or not to take a test, order an investigation or send off a referral. The item therefore assess the clarity with which the clinician draws the patients attention to the 'problem' that needs a decision making process.

This item does not attempt to cover the issue of diagnosis as such – for example a patient with a headache may want to be reassured that this symptom is not due to a tumour (we expect that such tasks have been completed before a discussion about what to do (problem management) can occur. So in the instance of a patient with a headache where the clinician is not unduly concerned about the possibility of serious pathology, the clinician could proceed by saying, "so we agree that you have a headache, and that it is unlikely to be due to a serious problem. There are a number of ways in which we could proceed, and I will explain these to you so that you can let me know your views about what would suit you best". This type of statement, where the agreed problem is 'headache symptom' could then proceed to the behaviour of drawing attention to the

making process, and would be given a score of 4. No attempt to draw attention to a need for a decision making process should be scored as 0. Attempts to draw attention to the need to embark on a decision making process, should thereafter be scored on the degree of skill exhibited. A score of 1 should be given if the attempts is very brief or perfunctory; a score of 2 if the clinician draws attention to a problem that requires a decision making process (baseline skill level); a score of 3 should be given when the clinician puts emphasis on the decision making process required; score of 4 given when the skill is exhibited to a high standard, e.g. supplementary explanations and evidence of patient recognising the need to engage in the process of decision making.

Often there is no clarity about problems, or at least no clarity about the decisions to be taken about the problem or problems identified. If this is the case, this item is given a score of 0. In other words, the skill of drawing attention to the need for a decision making process is not observed. Despite a score of 0 for item 1, the rest of the scale should be completed for the consultation.

Item 2	**The clinician *states* that there is more than one way to deal with the identified problem ('equipoise').**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The clinician conveys the sense that the options are valid and need to be considered in more depth.
3	The clinician explains 'equipoise' in more detail, that options have pros and cons that need to be considered
4	The behaviour is observed and executed to a high standard.

More than one way of managing problems exist in many (if not most) clinical situations, and there is always the choice between providing an intervention and not doing so, i.e. acting conservatively or making a conscious decision to review the need to intervene at a further consultation. Where there is a perfunctory attempt to convey the existence of more than one option then a score of 1 should be give. A score of 2 should be given when the clinician conveys the sense that the options are valid and need to be considered in more depth (baseline skill level). A score of 3 should be given when the clinician explains 'equipoise' in more detail and that options have pros and cons that need to be considered. Where the clinician also explains 'why' choices are available e.g. there is genuine professional uncertainly as to the 'best' way of managing the problem (clinical equipoise) the behaviour will have been executed to a high standard and a score of 4 is given.

Item 3	**The clinician *assesses* the patient's preferred approach to receiving information to assist decision making (e.g. discussion in consultations, read printed material, assess graphical data, use videotapes or other media).**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The clinician asks the patient about their preferred way of receiving information to assist decision.
3	The behaviour is exhibited to a good standard.
4	The behaviour is observed and executed to a high standard.

Although it is entirely feasible for a clinician to exhibit all the behaviours outlined in this framework in one consultation, it is also recognised that the level of information exchange required to prepare patients for

participation in decision making is time consuming and requires reflection about the implications. There are therefore many different approaches that can be used to achieve this purpose. In many instances, clinicians and patients wish to discuss the options and their characteristic in the relevant consultation so that decisions can be made and action taken. But there are also many other possible approaches, and the arrival of decisions aids that range from paper-based data to digital interactive methods are transforming the degree to which the process of information exchange, and therefore, decision making, is undertaken. Practitioners are becoming aware of these tools, and as they become more readily available to patients, clinicians will need to assess if patients wish to engage with these methods in order to participate more fully in decisions. A score of 2 (baseline skill level) would be given to the clinician who asks about the patient's preferred method of receiving information. A score of 3 would be given for doing this behaviour well e.g. the clinician who states that there are many ways in which information can be conveyed, many of which need the patient to read outside the consultation, and who then assesses the patient's preferred method. A score of 4 would be given for giving many examples of the types of information formats and media available for the patient, and then providing an opportunity for the patient to select their preferred method or methods.

Item 4	**The clinician *lists* 'options', which can include the choice of 'no action'.**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The clinician lists options.
3	The behaviour is exhibited to a good standard.
4	The behaviour is observed and executed to a high standard.

Listing options is different to providing details about each option. The listing of options allows the patient to get an overview of the decision structure, i.e. "This problem has three possible solutions, A or B or C. Let's now consider these options in more detail". This item should receive a score of 1 if a minimal or perfunctory attempt is made to exhibit the behaviour. This item should receive a scores of 2 if the clinician *lists* the options as distinct possibilities that are available, e.g. using 'either / or' phrasing to describe the existence of options (baseline skill level). Careful listing of all possible options, including the choice of taking no action, or deferring the decision should be given a score of 3. If the clinician exhibited this behaviour to a high standard, a score of 4 should be given.

Item 5	**The clinician *explains* the pros and cons of options to the patient (taking 'no action' is an option).**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The behaviour is observed and information about pros and cons are provided.
3	The behaviour is exhibited to a good standard.
4	The behaviour is observed and executed to a high standard.

Item 5 should be scored according to the extent that each option is described. A score of 1 should be given if the clinician fails to provide information about more than one option. A score of 2 should be given if the clinician provides details about the pros and cons of the options (baseline skill level). A score of 3 requires the behaviour is exhibited to a good standard. Scores of 4 are given to a clinician who does this task to a high standard.

Item 6	**The clinician explores the patient's *expectations* (or ideas) about how the problem(s) are to be managed.**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The clinician explicitly asks the patient what they expected (thought) about the actions required to manage the problem(s).
3	The behaviour is performed to a good standard.
4	The behaviour is observed and executed to a high standard.

Item 6 judges the proficiency of the clinician at exploring the patient's perspective on how the problem was going to be managed. The clinician needs to assess what did the patient think was going to happen (expect) and what ideas might they have had about the *management* of the problem. These ideas are typically difficult to assess. Patients are known to find it difficult to respond to these concepts and are often reluctant to share their views about these issues, for a range of reasons. However, skilled clinicians are able to find ways to explore these views by using open ended questions, suggesting a range of common fears, using pauses, being alert to verbal and physical cues and so on. It is skills such as these that should be assessed in item 6. For example, a patient who thought that she had a menopausal problem might have *expected* further tests or to be prescribed some medication. To assess this expectation, clinicians have to ask patients about their prior conceptions about problem management. Skilled practitioners use phrases such as, 'Patient commonly expect to be sent for an operation or to have tablets provided for this kind of problem, I wonder what you thought might be offered to you?' If the clinician does not attempt to ascertain the patient's views about their *expectations* then this item should receive a score of 0. Unskilled or perfunctory attempts to uncover a patient's ideas or expectations about management should be given a score of 1. Doing this task in a skilled way (using some of the outlined techniques) should be given a score of 2 (baseline skill level). If this behaviour is exhibited and leads to supplementary questions to clarify expectations or ideas, a score of 3 should be given (i.e. exploration of expectations takes place). A score of 4 should be given where this behaviour is achieved to high standards and where the patient's views are discussed and addressed.

Item 7	**The clinician explores the patient's *concerns* (fears) about how problem(s) are to be managed.**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The clinician explicitly asks the patient to voice their fears or concerns about the possible actions required to manage the problem(s).
3	The behaviour is exhibited to a good standard.
4	The behaviour is observed and executed to a high standard.

Item 7 judges the proficiency of the clinician at exploring the patient's *concerns* and *fears* regarding how the problem was going to be managed. Asking about *concerns* and *fears* requires clinicians to ascertain worries or anxieties that patients may have held. For example, a man who has 'prostatism' (a condition where prostate gland enlargement causes urinary flow obstruction) might have discussed the problem with peers and is worried about the future risk of surgery. These fears are often difficult to assess unless they are explicitly sought. Patients find question about fears and concerns difficult to address, and are often reluctant to share their views about these issues. Skilled clinicians are able to explore these fears and ideas (using open ended questions, suggesting a range of common fears, using pauses, being alert to verbal and physical cues and so

on) and it is these skills that should be assessed in item 7. For example, a clinician might ask, 'Many patients have concerns and fears about treatments or tests, side-effects and so on. Do you have concerns of this sort?' If the clinician does not attempt to ascertain the patient's views about their fears or concerns then this item should receive a score of 0. Unskilled or perfunctory attempts to uncover a patient's fears or concerns about management should be given a score of 1. Exhibiting this behaviour should be given a score of 2 (baseline skill level). If this behaviour is exhibited and leads to supplementary questions to clarify concerns, a score of 3 should be given (i.e. exploration of fears takes place). A score of 4 should be given where this behaviour is achieved to high standards and where the patient's fears or concerns are discussed and addressed.

Item 8	**The clinician checks that the patient has *understood* the information.**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The clinician checks the patient's understanding of information provided in the consultation (or assimilated by the patient from other potential sources).
3	The behaviour is observed to a good standard (e.g. exploration of understanding)
4	The behaviour is observed and executed to a high standard.

Item 8 judges whether the clinician actively explores the patient's understanding of the information that has been provided by the clinician (or assimilated by the patient from other potential sources). A perfunctory attempt to check that the patient has understood the relevant information should be given a score 1. To score 2 on this item, an explicit question would have to be posed to the patient asking whether they had understood the information provided or obtained from other sources (baseline skill level). A score of 3 should be given for the clinician that explores the nature of the patients understanding by using statements like: 'I'd like to check that you have understood the information about the possible options. Would you like to let me know what you now understand about this issue?' A score of 4 should be given if the behaviour is executed to a high standard.

Item 9	**The clinician offers the patient explicit *opportunities* to ask questions during the decision making process.**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The clinician explicitly asks the patient to voice a question, using phrases such as: 'Do you have any questions?
3	The behaviour is exhibited to a good standard.
4	The behaviour is observed and executed to a high standard.

Item 9 judges whether the clinician provides opportunities for the patient to ask questions and to clarify issues in the consultation that may be broader than that of understanding information. If the clinician provides pauses or other opportunities for queries to be raised, such as appropriate pace within the discourse for example, a score of 1 should be given. If the clinician explicitly asks the patient to voice a question, using phrases such as, 'Do you have any questions?', then a score of 2 should be given (baseline skill level). If the clinician is more specific and asks the patient whether they have questions about the options and the management of the identified problem(s) then a score of 3 should be given. The clinician who achieves this task to a high standard will allow time for the patient to respond and will check if there are any other or supplementary questions and

should be given a score of 4. Patients often ask questions in consultations and these questions cannot be attributed to a behaviour or statement by the clinician. Evidence in the consultation of patient asking questions should be taken into consideration when scoring this item and attention given to the climate and pace of the interview. If the rater judge that the clinicians has created the climate for patient queries, then the behaviour is met and high scores should be given.

Item 10	**The clinician elicits the patient's *preferred level of involvement* in decision making.**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The clinician asks the patient about their preferred role in the decision making process.
3	The behaviour is exhibited to a good standard.
4	The behaviour is observed and executed to a high standard.

Item 10 judges whether the clinician actively explores the patient's wishes about the role they want to play in making the decisions in the consultation, i.e. a communication about the type of communication. It may be that patients want to be actively involved but are denied the opportunity. Perhaps other patients do not wish to take any part in the decision making process but the clinician assumes that they prefer involvement and acts against their preferred role. It is difficult to assess a patient's preferred role and the rater is not asked to make judgements about this but to assess if an attempt is made to clarify this issue.

A score of 1 should be given if the attempt to elicit the patients preferred role (active or passive) in decision making is perfunctory or rushed. If the clinician explicitly asks the patient about their preferred role then a score of 2 should be given (baseline skill level). Patients often do not understand this question and if the clinician provided further explanation and continues to assess their role preference a score of 3 should be given. A score of 4 should be given to the clinician who asks this question in a way that is easy for patients to understand and which signals that the clinician is sensitive to the decisional responsibility that is being expected of the patient.

Item 11	**The clinician indicates the need for a *decision making* (or *deferring*) stage.**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The clinician indicates that a time has come where a decision (or deferment) is required.
3	The behaviour is exhibited to a good standard.
4	The behaviour is observed and executed to a high standard.

Item 11 judges whether the clinician indicates the need to make, or defer, a decision. This stage can involve a short summary of the options and perhaps an exchange of views, i.e. both clinician and patient views are made explicit and summary statements are elicited, e.g. 'Have you come to a view about this issue?'. Note that the issue of decisional agency (i.e. whether paternalism or not is the *modus operandi*, how the decision is made between the participants and who takes 'control' is not evaluated in this scale). It is also possible the decision point involves deferment, an acceptance that time is required for further information to be obtained, further views explored or for further reflection to occur. If the clinician does not clearly indicate that a time has come where a decision (or deferment) is required, then a score of 0 should be given. A perfunctory or unclear

attempt to indicate the need for a decision making state should be given a score of 1. A clear statement such as, 'Perhaps its time now to make a decision about what should be done', should be given a score of 2 (baseline skill level). Exhibiting this behaviour to good standard should be given a score of 3. A clinician that achieves this task to a high standard will have signalled the transition from consideration of information and views to one of deliberation and closure should be given a score of 4. Note that it is assumed that the decisions considered are not 'urgent' or 'life-threatening' and that it is reasonable in clinical terms to allow sufficient time for a decision making process.

Item 12	**The clinician indicates the need to review the decision (or *deferment)*.**
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The behaviour is observed.
3	The behaviour is exhibited to a good standard.
4	The behaviour is observed and executed to a high standard.

Item 12 judges whether the clinician provides an opportunity to review the decision or deferment, i.e. to allow time for a decision to be reconsidered and if necessary revised or altered. A perfunctory (e.g. that the patient should be seen again) or rushed attempt should be given a score of 1. If the clinician indicates that the patient should be seen again to re-consider the decision, then a score of 2 should be given (baseline skill level). If this behaviour is performed to a good standard a score of 3 should be given. A clinician that exhibits this behaviour to a high standard, e.g. makes it very explicit and encourages this approach should be given a score of 4.

3. OPTION Observing patient involvement (Research Version)

Rater Name		**Clinician Code**		**Date of rating**	**DD**		**MM**		**YY**
				Consultation number					
				Consultation duration (m, s)					
				Practitioner (M = 1, F = 2)	**Age**		**Sex**		
				Patient (M = 1, F = 2)	**Age**		**Sex**		
				New Consultation		1			
				Review Consultation		2			
				Composite Consultation		3			
Description of index problem									

1	The clinician *draws attention to* an identified problem as one that requires a decision making process.	0	1	2	3	4
2	The clinician *states* that there is more than one way to deal with the identified problem ('equipoise').	0	1	2	3	4
3	The clinician *assesses* the patient's preferred approach to receiving information to assist decision making (e.g. discussion, reading printed material, assessing graphical data, using videotapes or other media).	0	1	2	3	4
4	The clinician *lists* 'options', which can include the choice of 'no action'.	0	1	2	3	4
5	The clinician *explains* the pros and cons of options to the patient (taking 'no action' is an option).	0	1	2	3	4
6	The clinician explores the patient's *expectations* (or ideas) about how the problem(s) are to be managed.	0	1	2	3	4
7	The clinician explores the patient's *concerns* (fears) about how problem(s) are to be managed.	0	1	2	3	4
8	The clinician checks that the patient has *understood* the information.	0	1	2	3	4
9	The clinician offers the patient explicit *opportunities* to ask questions during the decision making process.	0	1	2	3	4
10	The clinician elicits the patient's *preferred level of involvement* in decision-making.	0	1	2	3	4
11	The clinician indicates the need for a *decision making* (or *deferring*) stage.	0	1	2	3	4
12	The clinician indicates the need to review the decision (or *deferment)*.	0	1	2	3	4

Score	Description
0	The behaviour is not observed.
1	A minimal attempt is made to exhibit the behaviour.
2	The behaviour is observed and a minimum skill level achieved.
3	The behaviour is exhibited to a good standard.
4	The behaviour is exhibited to a very high standard.

4. OPTION Observing patient involvement (Educational Feedback Version)

Rater Name		**Clinician Code**		**Date of rating**	**DD**		**MM**	**YY**
				Consultation number				
				Consultation duration (m, s)				
				Practitioner (M = 1, F = 2)	**Age**		**Sex**	
				Patient (M = 1, F = 2)	**Age**		**Sex**	
				New Consultation	1			
				Review Consultation	2			
				Composite Consultation	3			
Description of index problem								

1	The clinician *draws attention to* an identified problem as one that requires a decision making process.	Yes 1	No 0
2	The clinician *states* that there is more than one way to deal with the identified problem ('equipoise').	Yes 1	No 0
3	The clinician *assesses* the patient's preferred approach to receiving information to assist decision making (e.g. discussion, reading printed material, assessing graphical data, using videotapes or other media).	Yes 1	No 0
4	The clinician *lists* 'options', which can include the choice of 'no action'.	Yes 1	No 0
5	The clinician *explains* the pros and cons of options to the patient (taking 'no action' is an option).	Yes 1	No 0
6	The clinician explores the patient's *expectations* (or ideas) about how the problem(s) are to be managed.	Yes 1	No 0
7	The clinician explores the patient's *concerns* (fears) about how problem(s) are to be managed.	Yes 1	No 0
8	The clinician checks that the patient has *understood* the information.	Yes 1	No 0
9	The clinician offers the patient explicit *opportunities* to ask questions during the decision making process.	Yes 1	No 0
10	The clinician elicits the patient's *preferred level of involvement* in decision-making.	Yes 1	No 0
11	The clinician indicates the need for a *decision making* (or *deferring*) stage.	Yes 1	No 0
12	The clinician indicates the need to review the decision (or *deferment)*.	Yes 1	No 0