THE INFLUENCE OF SHARED DECISION MAKING ON THE SATISFACTION OF BOTH PATIENTS AND DOCTORS

A case study in the healthcare sector

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Management summary

This research investigated the way in which shared decision making, with the use of option grids, influences the satisfaction of both patients and doctors. The research is conducted at the urology department of the Canisius-Wilhelmina hospital in Nijmegen. In October 2017, the urology department started with the option grid for patients with prostate cancer whose illness can be cured.

Up to now, a lot of research focused on the effects of shared decision making on patient-related outcomes like health benefits, increased patients' knowledge and higher patient satisfaction. But little research focused on the effects of shared decision making on doctor-related outcomes like doctor satisfaction. In contrast to the relationship between shared decision making and patient satisfaction, the exact relationship between shared decision making and doctor satisfaction is unclear. In order to understand the exact nature of the relationship between shared decision making and doctor satisfaction, this explorative research has been conducted. The research question of this research is: "In what way does shared decision making, with the use of option grids, influence the satisfaction of both patients and doctors?" By doing qualitative research, the needed data could be obtained. Semi-structured interviews with patients, a nursing specialist and an urologist were conducted and a short questionnaire for the nursing specialist and the urologist was used to formulate an answer to this research question.

The results of this research showed that, as expected based on the existing literature, shared decision making, with the use of option grids, positively influences patient satisfaction. In contrast to the expectations, shared decision making, with the use of option grids, has only a positive influence on the satisfaction of doctors. The idea from the current literature that patient satisfaction directly leads to doctor satisfaction has been confirmed by this research. Following the "Job Demands-Resources" reasoning, shared decision making does not lead to the expected high workload and less work control and autonomy. In that way, shared decision making does not negatively influence doctor satisfaction. Instead, because of shared decision making and the changed work design, the degree of work control and autonomy is quite high, there is a high degree of interaction between doctor and patient, the workload is low, the content of work is good and work is pleasant. There are thus many job resources and few job demands and therefore shared decision making only positively influences doctor satisfaction.

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1. Introduction

Shared decision making is a process whereby patients and doctors work together to make choices in health care. This process is fundamental to informed consent and patient-centered care (Towle & Godolphin, 1999; Weston, 2001). With shared decision making, doctors and patients take into account the medical options and the patient's preferences (Butcher, 2013). Elwyn et al. (2010) define shared decision making as an approach where patients and doctors share the best available evidence when making health care decisions and where patients are supported to consider options, to achieve informed preferences. Charles, Gafni and Whelan (1997) suggest as key characteristics of shared decision making that at least two participants – patient and doctor be involved, that they share information, that they take steps to build a consensus about the preferred treatment and that they reach an agreement on the treatment to implement.

Within shared decision making, patient decision support tools are regularly used. These tools have been designed to support the active involvement of patients in decision making (Elwyn et al., 2013; Marrin et al., 2014). When these tools are available, clinicians find it easier to undertake shared decision making (Elwyn et al., 2013). 'Option grids' are an important example of patient decision support tools and can be used to facilitate shared decision making between practitioners and patients (Elwyn et al., 2013). "Option grids are summary tables, using one side of paper to enable rapid comparisons of options, using questions that patients frequently ask (FAQs) and designed for face-to-face clinical encounters" (Elwyn et al., 2013, p. 207).

In recent years, the number of shared decision making publications in scientific journals has strongly increased (Légaré & Thompson-Leduc, 2014). Greater involvement of patients in decisions about their treatment or care (shared decision making) is increasingly advocated (Brock & Wartman, 1990; Gray, Doan, & Church, 1990; Emanuel & Emanuel, 1992; Levine, Gafni, & Markham, 1992; Deber, 1994; Coulter, 1997). There is increasing empirical evidence about the benefits of shared decision making for patients, like satisfaction with decision making and decisions made and certainty or confidence about making the best choice (O'Connor et al., 1999; Edwards & Elwyn, 1999). Shared decision-making approaches can lead to many of health care and health benefits like more psychological well-being, weight loss and less anxiety and depression (Benbassat, Pilpel, & Tidhar, 1998; Griffin et al., 2004; Guadagnoli & Ward, 1998). In addition, Stacey et al. (2011) showed that patient

decision support tools have many positive effects: reduced rates of elective surgery, increased patients' knowledge, choices that are more in line with patients' preferences and improved patients' perception of risks. "Option grids, used in a collaborative way, enhance patients' confidence and voice, increasing their involvement in collaborative dialogs" (Elwyn et al., 2013, p. 207). Furthermore, doctors and patients generally respond positively to sharing decisions (Davis et al., 2003; Edwards et al., 2005). They are positive about decision-making, discussion of risks, patient involvement, patient satisfaction and treatment priorities. Moreover, shared decision making does justice to the right of the patient to complete information about the treatment options and care options, the possible benefits and risks (Elwyn et al., 2012). When patients have the possibility to make a decision, many patients choose less-intensive, less costly treatments and patients are more satisfied with their care. Shared decision making is seen as a way to lower costs while improving patient satisfaction (Butcher, 2013). Further, if taken carefully, shared decision making may lead not only to decisions that better fit the individual patient and as a result provide more satisfaction, but also to better doctor-patient relations, fewer repeat consultations, fewer requests for second opinions, and, in the long term better treatment adherence and outcomes (Stiggelbout, Pieterse, & De Haes, 2015). Thus, it is no surprise that shared decision making has been making headway in health care policy (Légaré & Thompson-Leduc, 2014).

Up to now, a lot of research focused on the effects of shared decision making on patient-related outcomes like health benefits, increased patients' knowledge and higher patient satisfaction (Benbassat et al., 1998; Griffin et al., 2004; Guadagnoli & Ward, 1998; Stacey et al., 2011; Butcher, 2013; Stiggelbout et al., 2015). But little research focused on the effects of shared decision making on doctor-related outcomes. Since the NHS Staff Survey report (2011) states that doctor satisfaction is directly related to patient satisfaction, an effect of shared decision making on doctor satisfaction is expected. An effect of shared decision making on doctor satisfaction is also expected, because shared decision making affects the working conditions of doctors and many researchers (Herzberg, 1973; Weisman & Nathanson, 1985; Linzer et al., 2009; Casalino & Crosson; 2015) found that working conditions influence the satisfaction of doctors. The job demands-resources (JD-R) model suggests that working conditions can be categorized into 2 broad categories, job demands and job resources, that are differentially related to specific outcomes (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001). Sharing the decision making with the patient lowers the degree of work control and autonomy of doctors, which are important aspects of working

conditions. With lower degrees of work control and autonomy, the doctor has fewer job resources. Lower degrees of work control (Linzer et al., 2009; Friedberg et al., 2013) and autonomy (Linzer et al., 2009; Friedberg et al., 2013; Konrad, 2015; Weisman & Nathanson, 1985) of doctors lead to lower doctor satisfaction. In this way, a negative influence of shared decision making on doctor satisfaction can be expected. But, with shared decision making, doctor and patient collaborate on making health care decisions (Butcher, 2013), so there is a high degree of interaction between doctor and patient, which is another important aspect of working conditions. A high degree of interaction at work can be seen as a job resource. A high degree of interaction between doctor and patient leads to higher doctor satisfaction (Linzer et al., 2009). In this way, a positive influence of shared decision making on doctor satisfaction can be expected. In contrast to the relationship between shared decision making and patient satisfaction, the exact relationship between shared decision making and doctor satisfaction is thus unclear. Therefore, this research not only focuses on how shared decision making influences patient satisfaction, but also on how shared decision making influences doctor satisfaction. In order to understand the exact nature of the relationship between shared decision making and doctor satisfaction, explorative research is needed.

The goal of this explorative research is to: provide insight into the way in which shared decision making, with the use of option grids, influences the satisfaction of both patients and doctors. The research question of the research is: “In what way does shared decision making, with the use of option grids, influence the satisfaction of both patients and doctors?” The research will be conducted at the urology department of the Canisius-Wilhelmina hospital in Nijmegen.

This research has both theoretical and practical relevance. There are several reasons as to why this research is theoretically relevant. Firstly, this research contributes to the existing body of knowledge about the effects of shared decision making on patients, because it investigates the influence of shared decision making on patient satisfaction. In addition, this research contributes to reducing the existing knowledge gap because it also focuses on doctor satisfaction, a doctor-related outcome of shared decision making. Furthermore, it will focus on the nature of the relationship between shared decision making and doctor satisfaction by showing the implications of shared decision making for the working conditions of doctors and the consequences for the number of job demands and job resources. Examining the satisfaction of both patients and doctors is relevant, since there is a recognized need to assess the effects of shared decision-making (Edwards, Elwyn, Smith, Williams, & Thornton, 2001).

There are several reasons as to why this research is practically relevant. Firstly, it is important to know how the implementation of the option grids improves shared decision making and how patients and doctors experience shared decision making at the urology department of the Canisius-Wilhelmina hospital in Nijmegen. When there is shared decision making, the patient is informed better and has better insight in the diagnosis and possible options of treatment. In this way, the doctor can effectively adjust the consult. Then, patient and doctor can make more considered choices that fit the wishes and situation of the patient, whereby unnecessary treatments can be prevented (CWZ, 2017a). Furthermore, focusing on doctor satisfaction is relevant because doctor satisfaction affects the quality of care (Firth-Cozens, 2015). Focusing on patient satisfaction is relevant because patient satisfaction has a positive influence on the profitability of the hospital (Ruyter, Wetzels, & Bloemer, 1998). Exploration of how to improve shared decision making and thereby satisfaction of both patients and doctors, can contribute to better organizational performance.

In order to answer the research question, the way in which shared decision making influences the satisfaction of both patients and doctors, needs to be examined, which is done in chapter 2. Furthermore, to provide an empirically founded answer to the research question, data is collected. The data collection is presented in chapter 3. The data collection produced results which are discussed in chapter 4. Based on the results, a conclusion is made. Both the conclusion and discussion are presented in the final chapter, chapter 5.

2. Theoretical background

In this chapter, academic literature about the concepts within the research question, the relationships between these concepts and the underlying mechanisms behind these relationships will be examined. The way in which shared decision making influences satisfaction of both patients and doctors will be discussed. Based on existing knowledge, a theoretical conclusion can be formulated. Firstly, in order to understand shared decision making, the concept will be discussed (2.1). Next, the use of option grids aimed at facilitating shared decision making will be explained (2.2). Then, the concept of satisfaction will be discussed. Also, an understanding is formed on the influence of shared decision making on satisfaction of both patients and doctors (2.3). Lastly, a theoretical conclusion is presented clarifying how the theoretical findings serve the rest of the thesis (2.4).

2.1 Shared decision making

Elwyn et al. (2012) describe three key steps of shared decision making in health care, namely: choice talk, option talk and decision talk. During this process, the doctor supports deliberation. Deliberation is a process where patients become aware of choice, understand their options and have the time and support to consider what is important for them (Elwyn et al., 2012). "*Choice talk* refers to the step of making sure that patients know that reasonable options are available. Components of choice talk include: step back, offer choice, justify choice – preferences matter, check reaction and defer closure. *Option talk* refers to providing more detailed information about options. Components of option talk include: check knowledge, list options, describe options – explore preferences, harms and benefits, provide patient decision support and summarize. *Decision talk* refers to supporting the work of considering preferences and deciding what is best. Components of decision talk include: focus on preferences, elicit preferences, moving to a decision and offer review" (Elwyn et al., 2012, p. 1363). Despite the widespread reference made to these phases, Stiggelbout et al. (2015) prefer to use four steps. Especially the third phase (decision talk) contains two quite distinct processes and they therefore distinguish the following steps. "Firstly, the doctor informs the patient that the patient's opinion is important and that a decision has to be made. Secondly, the doctor explains the options and the (dis)advantages of every relevant option. Thirdly, the patient and the doctor discuss the patient's preferences; the doctor supports the patient in

deliberation. Fourthly, the patient and doctor discuss patient's decisional role preference, make or defer the decision and discuss possible follow-up" (Stiggelbout et al., 2015, p. 1172).

The different steps of shared decision making are relevant because they are needed for an optimal shared decision making process. It depends on the specific decision making situation, whether the different steps are discussed during the decision making process. The use of the different steps determines whether and to what extent the patient experiences shared decision making. The discussed steps will also affect how the shared decision making is experienced by both patient and doctor. The experience of shared decision making may lead to a certain level of satisfaction. In this way, the use of the different shared decision making steps may influence the relationship between shared decision making and satisfaction of both patients and doctors. So, different shared decision making situations, in which different steps are used, may lead to different levels of satisfaction. For example, when many shared decision making steps are discussed, patients may experience shared decision making to a higher extent then when just a few shared decision making steps are discussed. In such a situation, patients really experience that they are involved in the decision making process and that the decision making is shared and this may positively influence their satisfaction about shared decision making. Also, when the shared decision making is experienced well because of the used steps, this may positively affect the satisfaction about shared decision making.

The extent to which a decision is shared varies widely in terms of the condition, the treatment options and the personality of the patient, with self-efficacy systematically being a high predictor of engagement in shared decision making (Hagbaghery, Salsali, & Ahmadi, 2004). In addition, characteristics of patients, like cultural background, health skills and character, strongly influence the way in which patients are involved in decision making (CWZ, 2017b).

In every shared decision making situation, the condition, the treatment options and the personality and characteristics of the patient are different. Since these factors affect the extent to which the decision is shared or the way in which patients are involved in decision making, the shared decision making process depends on these factors. The shared decision making process will determine how the shared decision is experienced by both patient and doctor and this will lead to a certain degree of satisfaction. In this way, the condition, the treatment options and the personality and characteristics of the patient may influence the relationship between shared decision making and satisfaction of both patients and doctors. So, different

shared decision making situations may lead to different levels of satisfaction. For example, patients with high levels of self-efficacy will be more engaged in shared decision making. Therefore, they may really experience that they are involved in the decision making process and that the decision making is shared. Probably, this will positively influence their satisfaction about shared decision making.

2.2 Option grids

Option grids can be used to facilitate shared decision making between practitioners and patients (Elwyn et al., 2013). “In an option grid, the questions that patients frequently ask (FAQs), derived from patients’ common concerns, form the table rows. These questions are simple, e.g. ‘‘What are the common side effects?’’ and ‘‘When can I return to work?’’ The features of the selected options are presented across the table columns, in a way that allows horizontal comparison” (Elwyn et al., 2013, p. 208).

Option grids are used in different ways (Elwyn et al., 2013). “Clinicians emphasize the value of following these key steps: (1) describe: that the goal of the grid is to initiate a conversation about options, that it is organized as a table to enable comparison, using questions that many other patients found useful; (2) check: ask if the patients wish to read it themselves or whether they prefer the comparisons to be vocalized; (3) handover: give the option grid to the patients and also provide a pen so that they can mark their copy and jot questions, if they wish; (4) create space: ask permission to perform other tasks if the patients wish to read the grid, so that they do not feel ‘observed’ as they take time to assimilate the information; (5) ask: encourage questions and discussion; (6) gift: the patients should be told that they should take the option grid with them, so that they have a reminder and an opportunity to discuss their options with others, as well as look for more information (referral to specific sources encouraged)” (Elwyn et al., 2013, p. 210).

These different steps are important because they are needed for an optimal use of option grids. It depends on the specific situation, whether the different steps are used. Since option grids facilitate shared decision making between practitioners and patients (Elwyn et al., 2013), the use of the different steps can make the shared decision making easier. Because the option grids influence the shared decision making process, they will also affect how the shared decision making is experienced by both patient and doctor. The experience of shared

decision making may lead to a certain level of satisfaction. In this way, the use of option grids may influence the relationship between shared decision making and satisfaction of both patients and doctors. So, different situations, in which different steps of the option grid are used, may lead to different levels of satisfaction. For example, when the goal of the option grid is described, the option grid is handed over to the patient and the patient is given the opportunity to ask questions, the shared decision making will be more facilitated then when only the option grid is handed over to the patient without any explanation. In such a situation, the shared decision making may be easier and patients and doctors will probably experience shared decision making more positively. This may lead to higher levels of satisfaction.

2.3 Satisfaction

2.3.1 Patient satisfaction

Linder-Pelz (1982) characterizes patient satisfaction as a positive attitude which is related to both the belief that the care possesses certain attributes and the patient's evaluation of those attributes. Patient satisfaction is defined as the individual's positive evaluations of distinct dimensions of health care (Linder-Pelz, 1982). The attributes are distinct dimensions of health care, such as convenience, access, cost and efficacy (Pascoe, 1983). Patient satisfaction is thus based on two pieces of information: measures of belief strength about attributes and measures of evaluation of care dimensions (Williams, 1994). Patient satisfaction is identified as an important quality outcome indicator of health care in the hospital setting. Hospitals evaluate health care quality by collecting outcome data including data on patient satisfaction (Yellen, Davis, & Ricard, 2002).

Patient satisfaction can be caused by several factors. (1) Taking patient's **preferences** into account positively influences patient satisfaction (Conway & Willcocks, 1997). Also, Fowdar (2005) states that customization of care leads to patient satisfaction. (2) When patients **choose** what they want, many choose less-intensive, less costly treatments and they report higher satisfaction with their care (Butcher, 2013). (3) Studies show that when hospital **costs** are low, patient satisfaction is high (Andaleeb, 1988). Naidu (2009) also states that cost of care affect patient satisfaction. (4) According to Ware, Davies-Avery, and Stewart (1978) **confidence** positively affects patient satisfaction. (5) Ware et al. (1978) showed that **efficiency** of care positively affects patient satisfaction. (6) Ware et al. (1978) assume a

positive relationship between positive care **outcomes** and patient satisfaction. (7) Tucker and Adams (2001) found that a good **relationship** between doctor and patient has a positive effect on patient satisfaction. (8) Billing, Newland, and Selva (2007) identified a positive relationship between the amount of care **information** given and patient satisfaction. According to Edwards and Elwyn (2006), a doctor's reported commitment to sharing information frequently leads to patient satisfaction because patients value doctors who explain carefully. Also, Naidu (2009) showed that the way diagnosis, treatment and care are explained and the amount of information provided influence patient satisfaction. Conway and Willcocks (1997) also found that patient knowledge positively influences patient satisfaction. Furthermore, if communication about care is good, which includes information from the doctor to the patient on the type of care he or she will receive, thereby alleviating uncertainty that increases his or her awareness and sensitivity about what to expect, then patient satisfaction is higher (Andaleeb, 1988). Further, according to Fowdar (2005), communication about care positively influences patient satisfaction. (9) Socio-demographic **characteristics** of patients like age, education, health status, race, marital status and social class affect patient satisfaction (Naidu, 2009). Factors positively associated with patient satisfaction are health and education. Younger, less educated, lower ranking, married and poorer health were associated with lower satisfaction (Tucker, 2002).

2.3.2 Relationship between shared decision making and patient satisfaction

Shared decision making has different characteristics. (1) With shared decision making, patients and physicians collaborate on making health care decisions, taking into account the patient's **preferences** (Butcher, 2013). Further, Stacey et al. (2011) showed that patient decision support tools lead to choices that are more congruent with preferences of patients (Stacey et al., 2011). Also, shared decision making may lead to decisions that better fit the individual patient (Stiggelbout et al., 2015). In this way, with shared decision making, care is customized to the preferences of patients. (2) With shared decision making, patients can largely **choose** the treatment option they want. (3) Shared decision making is seen as a way to lower **costs** (Butcher, 2013). With shared decision making, patients choose less costly treatments (Butcher, 2013). (4) There is increasing empirical evidence about the benefits of shared decision making for patients, like certainty or **confidence** about making the best choice (O'Connor et al., 1999; Edwards & Elwyn, 1999). Also, patient decision support tools like option grids enhance patients' confidence (Elwyn et al., 2013). (5) Stacey et al. (2011) showed that patient decision support tools lead to reduced rates of elective surgery. Further,

shared decision making lead to fewer repeat consultations and fewer requests for second opinions (Stiggelbout et al., 2015). In this way, shared decision making leads to higher **efficiency** of care. (6) Shared decision making can lead to better treatment **outcomes** (Stiggelbout et al., 2015). Also, shared decision-making approaches can achieve a range of positive health care and health outcomes like more psychological well-being, weight loss and less anxiety and depression (Benbassat et al., 1998; Griffin et al., 2004; Guadagnoli & Ward, 1998). (7) According to Stiggelbout et al. (2015), shared decision making leads to better doctor-patient **relations**. (8) Shared decision making does justice to the right of the patient to complete **information** about the treatment options and care options, the possible benefits and risks (Elwyn et al., 2012). Also, Stacey et al. (2011) showed that patient decision support tools lead to increased patient knowledge. (9) Patients who participate in shared decision making all have different socio-demographic **characteristics**.

Since the discussed characteristics of shared decision making possibly influence patient satisfaction, they can explain the relationship between shared decision making and patient satisfaction. According to the discussed literature, shared decision making may have a positive influence on patient satisfaction in several ways.

2.3.3 Doctor satisfaction

Doctor satisfaction is a form of job satisfaction. Job satisfaction is how people feel about their jobs and different aspects of their jobs (Spector, 1997). It is the extent to which people like (satisfaction) or dislike (dissatisfaction) their jobs. Job satisfaction is an attitudinal variable (Spector, 1997). Doctor satisfaction is the degree of satisfaction related directly to the doctor's work (Casalino & Crosson, 2015).

Doctor satisfaction can be caused by several factors. (1) A good **relationship** between doctor and patient positively influences doctor satisfaction (Herzberg, 1973; McMurray et al., 1997; Friedberg et al., 2013; Konrad, 2015). (2) Casalino and Crosson (2015) assume a positive relationship between positive care **outcomes** for patients and doctor satisfaction. (3) Doctor satisfaction is positively related to **patient satisfaction** (National Health Service, 2011; Firth-Cozens, 2015; Casalino & Crosson, 2015). (4) **Working conditions** influence the satisfaction of doctors (Herzberg, 1973; Weisman & Nathanson, 1985; Linzer et al., 2009; Casalino & Crosson; 2015). Examples of working conditions are the degree of work control and the degree of work autonomy. Work control (Linzer et al., 2009; Friedberg et al., 2013) and autonomy (Linzer et al., 2009; Friedberg et al., 2013; Konrad, 2015; Weisman &

Nathanson, 1985) positively influence doctor satisfaction. Also, a doctor's freedom to choose his own method of working positively influences doctor satisfaction (Cooper, Rout, & Faragher, 1989; Rout & Rout, 1997). Another example of working conditions is the degree of interaction between doctor and patient. According to Linzer et al. (2009) the degree of interaction between doctor and patient positively influences doctor satisfaction.

The JD-R model states that employee perceptions of job demands and job resources have an impact on individual well-being like job satisfaction (Bakker & Demerouti, 2007; Demerouti et al., 2001). Job demands are those aspects of the job that require sustained physical or psychological effort that may be associated with certain physiological or psychological costs (Schaufeli and Bakker, 2004). Job demands will lead to lower job satisfaction. Job resources are those aspects of the job that are functional in achieving work goals, and stimulate personal growth, learning and development (Schaufeli and Bakker, 2004). Job resources will lead to higher job satisfaction.

2.3.4 Relationship between shared decision making and doctor satisfaction

Shared decision making has different characteristics. (1) Shared decision making leads to better doctor-patient **relations** (Stiggelbout et al., 2015). (2) Shared decision making can lead to better treatment **outcomes** for patients (Stiggelbout et al., 2015). Also, shared decision-making approaches can achieve a range of positive health care and health outcomes for patients like more psychological well-being, weight loss and less anxiety and depression (Benbassat et al., 1998; Griffin et al., 2004; Guadagnoli & Ward, 1998). (3) Shared decision making leads to **patient satisfaction** (O'Connor et al., 1999; Edwards & Elwyn, 1999; Butcher, 2013; Stiggelbout, 2015). (4) Shared decision making has implications for the **working conditions** of doctors like their degree of work control and autonomy and the degree of interaction between doctor and patient. With shared decision making, doctors make health care decisions together with patients. Their work control and autonomy are lower since they only partly control the decision making, the decision making outcomes, the care the patient will get and thus, their work. The doctor's freedom to choose his own method of working is thus limited. With lower degrees of work control and autonomy, the doctor has less job resources. Furthermore, with shared decision making, doctor and patient collaborate on making health care decisions (Butcher, 2013), so there is a high degree of interaction between doctor and patient. Also, patient decision support tools like option grids are often interactive (Marrin et al., 2014). A high degree of interaction at work can be seen as a job resource.

Since the discussed characteristics of shared decision making possibly influence doctor satisfaction, they can explain the relationship between shared decision making and doctor satisfaction. According to the discussed literature, shared decision making has different implications for the working conditions of doctors and therefore the exact relationship between shared decision making and doctor satisfaction is unclear. Shared decision making may lead to lower doctor satisfaction because of the lower work control and autonomy which lead to less job resources. But, shared decision making may also lead to higher doctor satisfaction because of the higher interaction between doctor and patient which leads to more job resources.

2.4 Theoretical conclusion

In every shared decision making situation, the condition, the treatment options and the personality and characteristics of the patient are different. Since these factors affect the extent to which the decision is shared or the way in which patients are involved in decision making, the shared decision making process depends on these factors. The shared decision making process will determine how the shared decision is experienced by both patient and doctor and this will lead to a certain degree of satisfaction. In this way, the condition, the treatment options and the personality and characteristics of the patient may influence the relationship between shared decision making and satisfaction of both patients and doctors. So, different shared decision making situations may lead to different levels of satisfaction.

The different steps of shared decision making are relevant because they are needed for an optimal shared decision making process. It depends on the specific decision making situation, whether the different steps are discussed during the decision making process. The use of the different steps determines whether and to what extent the patient experiences shared decision making. The discussed steps will also affect how the shared decision making is experienced by both patient and doctor. The experience of shared decision making may lead to a certain level of satisfaction. In this way, the use of the different shared decision making steps may influence the relationship between shared decision making and satisfaction of both patients and doctors. So, different shared decision making situations, in which different steps are used, may lead to different levels of satisfaction.

These different steps of option grids are important because they are needed for an optimal use of option grids. It depends on the specific situation, whether the different steps are used. Since option grids facilitate shared decision making between practitioners and patients, the use of the different steps can make the shared decision making easier. Because the option grids influence the shared decision making process, they will also affect how the shared decision making is experienced by both patient and doctor. The experience of shared decision making may lead to a certain level of satisfaction. In this way, the use of option grids may influence the relationship between shared decision making and satisfaction of both patients and doctors. So, different situations, in which different steps of the option grid are used, may lead to different levels of satisfaction.

According to the literature, there are different ways in which shared decision making influences patient satisfaction. Since the discussed characteristics of shared decision making possibly influence patient satisfaction, they can explain the relationship between shared decision making and patient satisfaction. Shared decision making may have a positive influence on patient satisfaction in several ways.

Also, according to the literature, there are different ways in which shared decision making influences doctor satisfaction. Since the discussed characteristics of shared decision making possibly influence doctor satisfaction, they can explain the relationship between shared decision making and doctor satisfaction. Shared decision making affects for example the working conditions of doctors and many researchers (Herzberg, 1973; Weisman & Nathanson, 1985; Linzer et al., 2009; Casalino & Crosson; 2015) found that working conditions influence the satisfaction of doctors. Shared decision making leads to lower degrees of work control and autonomy of doctors. With lower degrees of work control and autonomy, the doctor has less job resources and this leads to lower doctor satisfaction (Linzer et al., 2009; Friedberg et al., 2013; Konrad, 2015; Weisman & Nathanson, 1985). But, with shared decision making, there is a high degree of interaction between doctor and patient. A high degree of interaction between doctor and patient can be seen as a job resource and leads to higher doctor satisfaction (Linzer et al., 2009). Furthermore, shared decision making can lead to an increase in doctor's workload and thus to more job demands and lower doctor satisfaction for several reasons. For example, doctors may need more time to prepare their consult since they have to work out more scenarios, the consults between doctor and patient may take more time because of the increased consultation and argumentation, doctors may have to make a greater effort to convince patients and the higher interaction between doctor

and patient may lead to work intensification. The exact relationship between shared decision making and doctor satisfaction is thus unclear and that is why explorative research is needed.

As a result, the existing literature shows many factors and mechanisms that possibly explain the relationship between shared decision making and satisfaction of both patients and doctors, but there may be alternative explanations for this relationship that have not already been discussed. We are also interested in possible other factors that can explain the influence of shared decision making on satisfaction of both patients and doctors. We aim to get some new insights into the relationship between shared decision making and satisfaction. Therefore, explorative research is needed.

3. Methodology

In this chapter, the methodology of the research is discussed. Firstly, the used research method is discussed (3.1). Secondly, information about the research situation is provided (3.2). Thirdly, the operationalization is presented (3.3). Fourthly, the procedure of data analysis is presented (3.4).

3.1 Research method

To answer the research question in an explorative way, qualitative research was an appropriate research strategy, for several reasons. To provide insight into the way in which shared decision making, with the use of option grids, influences the satisfaction of both patients and doctors, detailed, in-depth information from patients and doctors about their use of option grids, their experience of shared decision making and their satisfaction was needed. By doing qualitative research, such detailed, in-depth information could be obtained. Furthermore, to answer the research question, statements had to be made about phenomena in reality, namely about shared decision making and satisfaction of both patients and doctors. Qualitative research is aimed at collecting and interpreting linguistic material, in order to make statements about phenomena in reality (Bleijenbergh, 2013). In addition, this research was interested in the relationship between shared decision making and satisfaction of both patients and doctors. Qualitative research is suitable to make statements about the relationships between different variables (Bleijenbergh, 2013). Also, to provide insight into how patients and doctors experience shared decision making and the way in which this affects their satisfaction, a better understanding of their perspective on shared decision making and satisfaction was needed. Qualitative research leads to a better insight into/understanding of the perspective of others (Lucassen & Olde Hartman, 2007). In this research, qualitative research was thus an appropriate research strategy.

For this qualitative research, a case study approach was used and semi-structured interviews were conducted. A case study is the studying of a social phenomenon to be able to make statements about the patterns and processes that underlie this phenomenon (Swanborn, 2003). In this research, the phenomenon that we were interested in is the satisfaction of both patients and doctors and we expected shared decision making to influence this. We wanted to make statements about the patterns and processes that explain satisfaction, because the exact

relationship between shared decision making and satisfaction of doctors is unclear. In order to understand the exact relationship between shared decision making and doctor satisfaction, detailed, in-depth information about this relationship was needed. A case study is appropriate since it is an intensive approach and enables gaining in-depth information about shared decision making and satisfaction of both patients and doctors (Swanborn, 2003). By conducting semi-structured interviews with patients, a nursing specialist and an urologist, the needed detailed, in-depth information could be obtained. In semi-structured interviews, respondents can give a large amount of detailed information in a short period of time and because of the variation in the answers, they produce varied information (Bleijenbergh, 2013). Furthermore, the context of this research was complex because all patients had different needs and preferences, experienced shared decision making differently, behaved differently during the shared decision making process and were satisfied for different reasons. This research used a case study approach, because a case study enables getting a clear picture of a complex context (Swanborn, 2003). To understand the various perspectives and opinions, the semi-structured interviews were useful. Since the interview questions were open, respondents could formulate their own answers. The way in which respondents formulate their answers gives insight into how they experience the discussed topics (Bleijenbergh, 2013). In addition, in this explorative research, we were interested in alternative explanations for and new insights in the relationship between shared decision making and satisfaction of both patients and doctors. The semi-structured interviews were relevant since they offer space to collect data about factors that are not related to the already examined literature.

There have been conducted 10 semi-structured interviews with patients with prostate cancer, one semi-structured interview with the nursing specialist and one semi-structured interview with the urologist. The interviews with the patients have been conducted soon after the last consult with the urologist, in which the decision about the treatment was made. In this way, the patients could give their opinion of the whole shared decision making process and since they were still able to remember the process well, they could share a lot of relevant information. The nursing specialist and the urologist have been interviewed in the end, after all the patients have decided about their treatment. In this way, they were able to take their experiences with all the different patients into account and provide a complete view. The nursing specialist and the urologist have not been interviewed directly after every consult, because this did not fit in their schedules.

Furthermore, a short questionnaire for the nursing specialist and the urologist is used. This questionnaire had to be filled in by the nursing specialist and urologist directly after the consult with the patient. The additional questionnaire is used to obtain information that served as input for the interview with the nursing specialist and the urologist. In the interview, the answers from the questionnaire could be further explained and substantiated. The questionnaire had to be filled in directly after the consult with the patient since then, the nursing specialist and the urologist were still able to remember the consult and the shared decision making well.

All patients, the nursing specialist and the urologist were asked if they wanted to participate in the research. The permission form for the patients is presented in appendix 1. Also, permission for recording the interviews has been given by all the respondents. Further, anonymity was assured. This is very important since the discussed information is confidential and sensitive. In addition, the hospital is asked permission for the research. The manager of the urology department has agreed with the research. Furthermore, the hospital wanted the "Commissie Mensgebonden Onderzoek" (CMO) to check whether this research is subject to the "Wet Medisch-wetenschappelijk Onderzoek" (WMO). This was not the case. Thereafter, the Research Support Office (RSO), who is concerned with scientific research within the hospital, had to check whether this research complied with the procedure for medical scientific research. After checking the research in advance, permission for conducting the research was given. The letter of approval can be found in appendix 2.

3.2 Research situation

The research is conducted at the urology department of the Canisius-Wilhelmina hospital in Nijmegen. The Canisius-Wilhelmina hospital is a top clinical hospital with 28 medical specialisms, 8 paramedical departments, 5 specific departments and almost 4.000 employees (CWZ, n.d.). The key activities of the hospital are patient care, education and research. The hospital has several important ambitions: top care, the right care at the right place, valuable care and the involvement of patients (CWZ, n.d.). The hospital wants that patients feel treated as unique persons with individual needs and wishes. The hospital helps people to take control over their own health and care. They are increasingly focusing on shared decision making and the implementation of option grids. (CWZ, n.d.).

In October 2017, the urology department started with the option grid for patients with prostate cancer whose illness can be cured. When patients are diagnosed with prostate cancer, they get access to the online option grid. The option grid consists of information about prostate cancer, information about the different possible treatment options (operation, radiation, no treatment) and several questions about the preferences of the patient. After approximately two weeks, the patient has a consult with the nursing specialist, in which the option grid, the information about prostate cancer, the information about the different possible treatment options and the preferences of the patient are discussed. After this, there is a multidisciplinary consultation about the specific situation of the patient, the patient's preferences and the different possible treatment options. During a consult later on, the urologist and the patient together, make a decision about the treatment.

The research is conducted at this department in particular because most patients with prostate cancer have the possibility to choose between different treatment options. This is important when a decision has to be made together. Otherwise, the option grid and the shared decision making between doctor and patient would be of no use.

3.3 Operationalization

From the examined literature (Chapter 2), important concepts about option grids and shared decision making have been selected. Based on these concepts, some interview questions were formulated. Thereafter, some open questions about the degree of satisfaction and the reasons for satisfaction were asked. This fits the explorative nature of this research. In this way, factors that can explain the influence of shared decision making on satisfaction of both patients and doctors, not based on existing literature, could be found which lead to alternative explanations and new insights. Also, this helped to clarify the exact relationship between shared decision making and doctor satisfaction. Then, factors that, according to the discussed literature (Chapter 2), explain the relationship between shared decision making and satisfaction of both patients and doctors, have been selected. Based on these factors, some interview questions were formulated. Sometimes, some of the factors were already discussed, so these questions were used as a kind of checklist. The questions are thus largely formulated in advance, but there was also room for extra questions that came up during the interview, related to the answers a particular respondent gave.

Two employees from the Canisius-Wilhelmina hospital who are familiar with option grids, shared decision making and investigating patient and doctor satisfaction, helped to formulate relevant interview questions and questionnaire questions.

Table 1 provides an overview of the operationalization of the different concepts to the interview questions for the patients. Table 2 provides an overview of the operationalization of the different concepts to the interview questions for the nursing specialist and the urologist. Table 3 provides an overview of the operationalization of the different concepts to the questionnaire questions for the nursing specialist and the urologist. The interview guides are presented in appendix 3 and 4. The interviews have been recorded and transcribed. The questionnaire for the nursing specialist and the urologist is presented in appendix 5.

Table 1: Operationalization interview patients

Option grid	Used steps	*Elwyn et al. (2013)*	1. Heeft u toegang gekregen tot de keuzehulp? Is het doel van de keuzehulp door de arts toegelicht? 3. Heeft u de keuzehulp gelezen? 4. Heeft u de vragen in de keuzehulp beantwoord? 5. Heeft de arts de keuzehulp en de bijbehorende vragen naderhand met u besproken?
	Opinion	*CWZ*	6. Wat vindt u van de keuzehulp? 7. Zou u de keuzehulp aanraden aan andere patiënten? Waarom zou u de keuzehulp wel/niet aanraden aan andere patiënten?
	Tool	*Elwyn et al. (2013)*	Maakte het gebruik van de keuzehulp samen beslissen makkelijker en waarom?

Shared decision making	Experienced?		10. Heeft u samen beslissen ervaren tijdens de consulten?
	SDM-Q-9	*AMC (n.d.)*	. Mijn arts heeft mij duidelijk gemaakt dat er een beslissing genomen moet worden. 2. Mijn arts heeft mij precies gevraagd hoe ik betrokken zou willen worden bij het nemen van de beslissing. . Mijn arts heeft mij precies verteld dat er voor mijn klachten verschillende behandelmogelijkheden zijn. 14. Mijn arts heeft mij de voor- en nadelen van de behandelingsmogelijkheden precies uitgelegd. 15. Mijn arts heeft mij geholpen alle informatie te begrijpen. 6. Mijn arts heeft mij gevraagd welke behandelingsmogelijkheid mijn voorkeur heeft. 17. Mijn arts heeft met mij de verschillende behandelingsmogelijkheden grondig afgewogen. 18. Mijn arts en ik hebben samen een behandelingsmogelijkheid uitgekozen. 9. Mijn arts en ik hebben een afspraak gemaakt over het verdere vervolg.
	How experienced?		. Hoe heeft u samen beslissen ervaren?

	Opinion	*CWZ*	21. Wat vindt u van samen beslissen? 2. Welk cijfer zou u de behandeling tot nu toe geven?
	Consequences	*CWZ*	3. Welk effect heeft samen beslissen op u? 24. Wat zijn volgens u de gevolgen van samen beslissen? 25. Denkt u dat het traject anders was gegaan zonder samen beslissen?
Satisfaction		*Butcher (2013); Stiggelbout et al. (2015); O'Connor et al. (1999); Edwards and Elwyn (1999); Elwyn et al. (2012)*	26. Hoe tevreden bent u? 27. Waarom bent u wel/niet tevreden? . Is samen beslissen van invloed op uw tevredenheid en waarom?
Factors	Preferences patient	*Conway and Willcocks (1997); Fowdar (2005); Butcher (2013); Stacey et al. (2011); Stiggelbout et al. (2015)*	29. Is het voor uw tevredenheid belangrijk dat er bij de keuze voor de behandeling rekening werd gehouden met uw voorkeuren en waarom?
	Choice patient	*Butcher (2013)*	30. Is het voor uw tevredenheid belangrijk dat uiteindelijk de

			behandelingsoptie is gekozen die u wilde en waarom?
	Costs care	*Andaleeb (1988); Naidu (2009); Butcher (2013)*	1. Spelen kosten van de zorg een rol in uw tevredenheid en waarom?
	Confidence patient	*Ware et al. (1978); O'Connor et al. (1999); Edwards and Elwyn (1999); Elwyn et al. (2013)*	2. Is de mate waarin u zeker/overtuigd bent van de gemaakte beslissing van invloed op uw tevredenheid en waarom?
	Efficiency care	*Ware et al. (1978); Stacey et al. (2011); Stiggelbout et al. (2015)*	3. Speelt efficiency van de zorg een rol in uw tevredenheid en waarom?
	Outcomes patient	*Ware et al. (1978); Stiggelbout et al. (2015); Benbassat et al. (1998); Griffin et al. (2004); Guadagnoli and Ward (1998)*	4. Zijn eventuele positieve uitkomsten van de behandeling voor u en uw gezondheid van invloed op uw tevredenheid en waarom?

	Relationship doctor-patient	*Tucker and Adams (2001); Stiggelbout et al. (2015)*	5. Speelt de relatie tussen u en de arts een rol in uw tevredenheid en waarom?
	Information & knowledge	*Billing et al. (2007); Elwyn (2006); Naidu (2009); Conway and Willcocks (1997); Andaleeb (1988); Fowdar (2005); Elwyn et al. (2012); Stacey et al. (2011)*	36. Is de hoeveelheid informatie die u heeft gekregen over de aandoening en de behandelingsopties belangrijk voor uw mate van tevredenheid en waarom? 37. Is de hoeveelheid kennis die u momenteel heeft over de aandoening en de behandelingsopties belangrijk voor uw mate van tevredenheid en waarom?
	Socio-demographic characteristics patient	*Naidu (2009); Tucker (2002)*	38. Hoe oud bent u? 39. Wat is uw afkomst? 40. Wat is uw burgerlijke staat? 41. Wat is uw hoogst afgeronde opleiding? 42. Hoe is uw gezondheid?

Table 2: Operationalization interview nursing specialist and urologist

Option grid	Opinion	*CWZ*	. Wat vindt u van de keuzehulp? Zou u de keuzehulp aanraden aan andere artsen? 3. Waarom zou u de keuzehulp wel/niet aanraden aan andere artsen?
	Tool	*Elwyn et al. (2013); CWZ*	4. Maakt het gebruik van de keuzehulp samen beslissen makkelijker voor u en waarom? 5. Maakt het gebruik van de keuzehulp samen beslissen makkelijker voor de patiënt en waarom? 6. Verschilt het per patiënt of de keuzehulp samen beslissen makkelijker maakt en waarom?
Shared decision making	Extent to which	*Hagbaghery et al. (2004)*	Wat bepaalt de mate waarin een beslissing samen wordt gemaakt met de patiënt? 8. Hoe beïnvloeden de behandel opties de mate waarin een beslissing samen wordt gemaakt met de patiënt? 9. Hoe beïnvloedt de persoonlijkheid van de patiënt de mate waarin een beslissing samen wordt gemaakt met de patiënt?
	Way in which	*CWZ (2017b)*	. Wat bepaalt de manier waarop de patient wordt betrokken bij het maken van de beslissing?

			1. Hoe bepalen kenmerken van de patient (culturele achtergrond, gezondheidsvaardigheden, karakter, opleidingsniveau, leeftijd) de manier waarop de patient wordt betrokken bij het maken van de beslissing?
	Applied?		12. Heeft u samen beslissen toegepast tijdens de verschillende consulten? ? (Bespreek vragenlijsten)
	How experienced?		13. Hoe heeft u samen beslissen ervaren tijdens de verschillende consulten? (Bespreek vragenlijsten) 14. Hoe ging het samen beslissen tijdens de verschillende consulten (Bespreek vragenlijsten) 15. Wat bepaalt of het samen beslissen goed gaat tijdens een consult? (Bespreek vragenlijsten)
	Opinion	*CWZ*	. Wat vindt u van samen beslissen?
	Consequences	*CWZ*	. Welk effect heeft samen beslissen op u? . Welk effect heeft samen beslissen op de patiënt, denkt u? 9. Wat zijn de gevolgen van samen beslissen voor u, de patiënt, het ziekenhuis of anderen? 0. Wat zijn de nadelen van samen beslissen? (Kost het meer tijd per

			consult of vanwege extra consulten?) . Wat zijn de voordelen van samen beslissen/wat levert samen beslissen op? (Zorgt het voor minder telefoontjes en een beter geïnformeerde patiënt?)
	Costs care	*Andaleeb (1988);* *Naidu (2009);* *Butcher (2013)*	22. Zorgt samen beslissen voor hogere/lagere zorgkosten?
	Efficiency care	*Ware et al. (1978); Stacey et al. (2011); Stiggelbout et al. (2015)*	23. Zorgt samen beslissen voor efficiëntere zorg? (Minder electieve chirurgie, minder herhaalconsulten, minder verzoeken voor een second opinion?)
Satisfaction			24. Hoe tevreden bent u? 25. Waarom bent u wel/niet tevreden? . Is samen beslissen van invloed op uw tevredenheid en waarom?
Factors	Relationship doctor-patient	*Herzberg (1973); McMurray et al. (1997); Friedberg et al. (2013); Konrad (2015);*	7. Speelt de relatie tussen u en de patiënt een rol in uw tevredenheid en waarom?

		Stiggelbout et al. (2015)	
	Outcomes patient	*Casalino and Crosson (2015); Stiggelbout et al. (2015); Benbassat et al. (1998); Griffin et al. (2004); Guadagnoli and Ward (1998)*	28. Zijn eventuele positieve uitkomsten van de behandeling voor de patiënt en zijn/haar gezondheid van invloed op uw tevredenheid en waarom?
	Patient satisfaction	*National Health Service (2011); Firth-Cozens (2015); Casalino and Crosson (2015); O'Connor et al. (1999); Edwards and Elwyn (1999); Butcher (2013); Stiggelbout et al. (2015)*	9. Beïnvloedt de tevredenheid van de patiënt uw tevredenheid en waarom?
	Working conditions: work control & work autonomy	*Linzer et al. (2009); Friedberg et al. (2013); Konrad (2015); Weisman and Nathanson (1985); Cooper*	. Is samen beslissen van invloed op de controle en autonomie die u heeft over het werk? 31. Hoe beïnvloedt dit uw tevredenheid?

		et al. (1989); Rout and Rout (1997)	
	Working conditions: interaction patient & doctor	*Linzer et al. (2009); (Marrin et al. (2014)*	. Is samen beslissen van invloed op de mate van interactie die u heeft met de patiënt? 33. Hoe beïnvloedt dit uw tevredenheid?
	Working conditions: workload		34. Is samen beslissen van invloed op de werkdruk? (meer tijd om consult voor te bereiden omdat meer scenario's moeten worden uitgewerkt, consulten duren langer vanwege toegenomen consultatie en argumentatie, meer consulten, meer moeite doen om patiënten te overtuigen, intensivering van het werk door meer interactie met patiënt) 35. Hoe beïnvloedt dit uw tevredenheid?

Table 3: Operationalization questionnaire nursing specialist and urologist

Shared decision making	Applied?		Heeft u samen beslissen toegepast tijdens dit consult?
	SDM-Q-doc	*AMC (n.d.)*	2. Ik heb mijn patiënt duidelijk gemaakt dat er een beslissing genomen moet worden. 3. Ik wilde precies van de patiënt weten hoe hij/zij betrokken zou willen worden bij het nemen van de beslissing. 4. Ik heb de patiënt verteld dat er voor zijn/haar klachten verschillende behandelmogelijkheden zijn. 5. Ik heb de patiënt de voor- en nadelen van de behandelingsmogelijkheden precies uitgelegd. 6. Ik heb de patiënt geholpen alle informatie te begrijpen. . Ik heb de patiënt gevraagd welke behandelingsmogelijkheid zijn/haar voorkeur heeft. 8. De patiënt en ik hebben de verschillende behandelingsmogelijkheden grondig afgewogen. De patiënt en ik hebben samen een behandelingsmogelijkheid uitgekozen.

			10. De patiënt en ik hebben een afspraak gemaakt over het verdere vervolg.
	How experienced?		11. Hoe heeft u samen beslissen ervaren tijdens dit consult? (Heel positief – Heel negatief) 12. Hoe ging het samen beslissen tijdens dit consult? (Heel goed – heel slecht) 3. Waarom ging het samen beslissen goed/niet goed tijdens dit consult?

3.4 Data analysis

3.4.1 Interviews

After recording and transcribing the interviews, the interviews have been coded and analysed. Coding of the text is done to select relevant fragments from the text and combine different fragments with similar codes. By doing this, the text could be interpreted (Bleijenbergh, 2013). Firstly, deductive codes, based on the existing literature about shared decision making, option grids, satisfaction and factors that can explain the relationship between shared decision making and satisfaction, were used. Secondly, inductive codes, were used. The inductive codes were created and assigned during coding. By using inductive codes, any alternative explanations for and new insights in the relationship between shared decision making and satisfaction of both patients and doctors were also taken into account. This emphasizes the explorative nature of this research. Both the deductive and inductive codes can be found in appendix 6.

3.4.2 Questionnaires

Also, the answers to the questions of the questionnaire have been analysed. The coding of these texts is also done both deductively and inductively.

4. Results

This chapter shows the findings of the research. Firstly, the expected factors that explain the way in which shared decision making influences patient satisfaction are discussed (4.1). Secondly, other factors that play a role in the relationship between shared decision making and patient satisfaction are presented (4.2). Thirdly, the expected factors that explain the way in which shared decision making influences doctor satisfaction are discussed (4.3). Fourthly, other factors that play a role in the relationship between shared decision making and doctor satisfaction are presented (4.4). Finally, the implications of shared decision making for the working conditions of doctors, the consequences for the number of job demands and job resources and the effect on doctor satisfaction are discussed (4.5).

4.1 Shared decision making and patient satisfaction: expected factors

As expected in the existing literature, shared decision making, with the use of option grids, leads largely to more satisfied patients. All the interviewed patients are satisfied or even very satisfied. The different patients felt that shared decision making, with the use of the option grids, positively influenced their satisfaction. All patients experienced shared decision making positively. Patients described the shared decision making process as pleasant, open, transparent, constructive, good, clear, important, easy, useful, engaged, extensive, respectful, valuable and essential. The explanations from the patients during the interviews showed how shared decision making influenced patient satisfaction. These different ways in which shared decision making influenced patient satisfaction will be discussed.

4.1.1 Costs

In contrast to the expectations based on the existing literature, the costs of care did not have an effect on the satisfaction of the patients. According to the patients, costs of care are not important for them since the costs are paid by insurance companies.

4.1.2 Choice

In explaining the relationship between shared decision making and patient satisfaction, choice of the patient appeared to be less important than expected based on the existing literature. Thanks to shared decision making, most patients could choose the treatment option they

wanted. Half of the patients were more satisfied because they had the possibility to make a choice. One of them explained his satisfaction as follows:

"Because you made the choice yourself. And the choice you made has also been carried out. Look, if they are going to do something that you do not support, you are dissatisfied." (Omdat je gewoon zelf mee de keuze gemaakt hebt. En de keus die je gemaakt hebt ook gedaan is. Kijk, als ze iets gaan doen waar je niet achter staat dan ben je ontevreden.) (patient 10)

But for the other half of the patients this did not lead to higher satisfaction. They would have been equally satisfied if another decision had been made and thus another treatment option had been chosen. They explain this by telling that the opinion of the urologist is particularly important for them since he has the knowledge and the expertise. They believe that they need the knowledge of the nursing specialist/urologist to choose the best treatment option. So, the patients assume that the urologist knows what is best for them. One of the patients even wonders if patients have the necessary knowledge to draw the right conclusions and therefore if they are in the position to make the right choices.

A few patients felt that they had no choice to make and the decision was directed in a certain way, after new medical research results. Based on that, only one treatment option was left to choose and this was a disappointment for them. But, because these patients were quite positive about the other aspects of the shared decision making process, they were still satisfied.

4.1.3 Efficiency

The efficiency of the care process appears to be relatively important in explaining the relationship between shared decision making and patient satisfaction. All patients believed that their care process up to now was efficient. Most patients think that the process is more efficient thanks to shared decision making. In the first place, because of the given information in the option grid, patients can find out a lot themselves and that saves explanation time during the consults. Secondly, patients know a lot about the disease, the chosen treatment and the possible consequences and therefore they may have fewer questions later in the process. Thirdly, choosing together may increase the chance of making the right decision and patients expect that this saves extra consults or treatments in the future. Fourthly, without shared decision making patients may not support the decision about the treatment. The patients expect that this eventually leads to negative feelings like worrying and that this negatively

influences the recovery of the patient later on. In such a situation, more aftercare is needed. For these reasons, patients believe that shared decision making positively influences the efficiency of care. Most of the patients said that they were more satisfied because of the efficient care process. For one of the patients this could be explained by a feeling of reassurance.

For two patients, the efficiency of the care had no effect on their satisfaction.

Only one patient thinks that the process may be less efficient due to shared decision making. Because the doctor had to take his preferences into account, two extra consults were needed. But, this does not have to be seen as a disadvantage since it does not make him less satisfied.

"With regard to the satisfaction that this brings about, I find it a very desirable investment, two consultations." (Ten opzichte van de tevredenheid die dat teweeg brengt bij de patiënt, vind ik dat een hele wenselijke investering, twee consulten.) (patient 1)

4.1.4 Outcomes

The expectations from the existing literature about the importance of health outcomes in explaining satisfaction of patients are largely confirmed. The patients think that the made decision, resulted from the shared decision making process, will lead to positive health outcomes. Eight out of nine patients will be even more satisfied if the chosen treatment will actually lead to positive health outcomes.

"And that satisfaction also has to do with the idea that it can be fixed. Yes, and … it depends on the outcome." (En die tevredenheid heeft natuurlijk ook te maken met het idee dat het gerepareerd kan worden. Ja, en… die hangt af van de uitkomst.) (patient 2)

If these positive health outcomes occur, the patients will be able to live a happier life. Also, the positive health outcomes would reconfirm that they made the right decision and this would give them a feeling of confidence.

Two out of nine patients think that eventual negative health outcomes will not make them less satisfied about shared decision making.

4.1.5 Preferences

The fact that the preferences of patients are taken into account during a shared decision making process leads in almost all cases to more satisfied patients. This is thus in line with

existing theories about this topic. According to eight out of ten patients, their preferences were really taken into account during the decision making process and this positively influenced their satisfaction. According to the patients, shared decision making ensures that they are in control of their own body. That is exactly why it is important to involve patients and take their preferences into account.

Only one of the patients had his doubts about this relationship since he believed that one of the possible treatment options was inevitable in the end. For another patient, taking his preferences into account had no effect on his satisfaction because the opinion of the doctor was more important for him.

4.1.6 Confidence

As expected, confidence appeared to be important in explaining the relationship between shared decision making and patient satisfaction. Because of the shared decision making process, the patients felt confident or even very confident about the made decision. There are several reasons why shared decision making makes patients more confident. Firstly, because of the shared decision making, patients felt that the made decision is the best possible solution. Secondly, during the shared decision making process, patients got confirmation for their choice from the doctor. Thirdly, during the shared decision making process, patients received a lot information and therefore they were informed better and had more knowledge about the disease, treatment options and (dis)advantages. Fourthly, because of the shared decision making everything was clear for the patients. Fifthly, because of the shared decision making, patients had the possibility to choose the treatment option they wanted. These different aspects gave the patients a feeling of confidence. The feeling of confidence satisfied the patients.

Only one of the patients explained that the shared decision making did not especially led to a feeling of confidence. When the decision would not have been made together he would not be less confident.

"No, because then you are dependent on the knowledge of the doctor and he has, I think, enough knowledge to make the right choice." (Nee, want dan ben je afhankelijk van de kennis van de arts en die heeft mogelijk, denk ik, wel genoeg kennis om de goede keuze te maken.) (patient 10)

Thus, the knowledge of the doctor is enough to make this patient confident. Furthermore, this patient said that he will only be very confident if the health outcomes turn out to be positive.

4.1.7 Relationship

As the literature predicted, the relationship between doctor and patient appeared to be important in explaining the relationship between shared decision making and patient satisfaction. All patients felt that they had a good relationship with the nursing specialist and the urologist. The patients described the relationship as good, open, fine, pleasant, excellent, professional and respectful. One of the patients said that the nursing specialist/urologist really wanted to help him and wanted the best for him.

"Yes, everything was negotiable, all possibilities were negotiable. There were no thresholds, you could also ask everything." (Ja, alles was bespreekbaar, alle mogelijkheden waren bespreekbaar. Er waren geen drempels, je kon ook alles vragen.) (patient 3)

According to almost all patients, the shared decision making process made a positive contribution to their relationship with the nursing specialist and urologist. This can be explained by the fact that the patient and the doctor are involved in the decision making process together.

"You are involved in everything and that is of course important when you have a serious disease. The doctor is also involved and that gives a different feeling. It is less distant." (Je wordt overal in betrokken dan en dat vind je natuurlijk belangrijk als je iets ernstigs hebt. Die arts is er uiteindelijk dan ook bij betrokken en dat geeft toch een ander gevoel dan. Het is dan niet zo afstandelijk.) (patient 9)

Furthermore, they have to talk a lot about the disease, the different treatment options and the (dis)advantages so that the patients become well informed. Both patient and doctor need to be very open to each other to make a considered choice. In this way, they learn to understand each other and that helps to improve to the relationship. The interaction and reflection during the consult with the nursing specialist/urologist were also important.

Only one patient did not think that the shared decision making influenced the relationship between him and the nursing specialist or urologist.

All patients were more satisfied because of the good relationship between them and the doctor. The good relationship satisfied the patients for various reasons. Especially the good

contact between the patient and the doctor, the openness of the relationship and the feeling of reassurance that the patients get from the good relationship lead to higher levels of satisfaction.

4.1.8 Information

Consistent with existing theories, the informative option grid and the information given by the nursing specialist and urologist lead to more satisfied patients. Thanks to the shared decision making process, all the patients got a lot of information about the disease, the different treatment options, the (dis)advantages of the treatment options and the possible consequences and risks. Almost all the patients felt that the information in the option grid was extensive and clear and therefore they gained more insight into these aspects. The patients also believed that the explanations from the nursing specialist/urologist were extensive and clear. The nursing specialist/urologist helped all the patients to understand all the information. Facts were substantiated and questions were answered very well. All this led to well prepared patients with good knowledge and understanding of what to expect. The patients were aware of their situation and knew where they stand. This gave the patients a feeling of reassurance and it satisfied them. Most patients felt that the different treatment options were thoroughly evaluated and they were informed better. Because of this, they were better able to make the right decision and this made them more satisfied.

“Because you are going to make the right choice for yourself. Because if you have to make a blind choice without getting a good explanation, you may make the wrong choice.” (Omdat je dan voor jezelf de juiste keus gaat maken. Want als je zo blind een keuze moet maken, zonder dat je goede uitleg krijgt, dan doe je het misschien verkeerd.) (patient 10)

Because of the containing information and questions, the option grid is seen as a useful tool for patients to make the right choice. The option grid led to patients with improved understanding and therefore to a better communication between patient and doctor. This made it easier for them to come to a decision together with the doctor.

Furthermore, since it is hard to process all the important information during the consult, the patients liked that the option grid offered them the opportunity to read everything carefully again afterwards.

Also, the information made them more confident about the made decision and this led to higher satisfaction.

"That information is very important, of course, because otherwise you can not decide together. Because the doctor has all the knowledge and you have some knowledge yourself but you do not know the details. You need the doctor for that." (Die informatie is heel erg belangrijk natuurlijk want anders kun je niet samen beslissen. Want de arts heeft alle kennis en zelf heb je wel wat kennis natuurlijk maar je weet nooit het fijne ervan. Daar heb je die arts voor nodig.) (patient 9)

Although the patients were generally positive about the option grid, some of them had a few points of criticism. Some patients felt that the information in the option grid was not complete enough. Some of them needed more in-depth information about for example the disease, the risks, the consequences and the possibilities. Fortunately, the patients were able to look up this information themselves. Some other patients would have liked the information to be more extended and more adjusted to the specific situation. But the consults offered the possibility to inform the patients about this. In the end, the questions of the patients have been answered and unclarities have been clarified. So, only the option grid does not always lead to a clear conclusion and may be not enough to reach a decision, but in combination with the consult afterwards, it is very useful.

4.2 Shared decision making and patient satisfaction: other factors

The just discussed factors that do (not) explain the relationship between shared decision making and patient satisfaction were already expected based on the existing literature. The results of this research thus mainly confirm the current literature. Also, during this research more factors that play a role in this relationship were found. These other ways in which shared decision making positively influences patient satisfaction will now be discussed. Some of the new factors are mainly complementary to the existing factors, some others can be seen as a deepening.

4.2.1 Involvement

It was very pleasant for the patients to be really involved in the decision making process because in that way they were able to decide about their own body and what will happen to them. This involvement in the decision making process appeared to be an important reason for the patients to be satisfied.

"And during the process, you find out the considerations and dilemmas of the medical team, that is very valuable and gives me a feeling of satisfaction about the process." (En de manier waarop dit proces dan loopt, dat je daarmee gekend wordt in de afweging en dilemma's die het team zelf heeft, dat vind ik heel waardevol en dat leidt tot een tevreden gevoel over het proces.) (patient 1)

The fact that the nursing specialist/urologist did a good job using the different steps to involve the patients in the decision making process also had a positive influence on their satisfaction. Patients emphasized the added value of the connection and collaboration between doctor and patient that came along with this involvement. In this way, patients believed that it was really a shared process and they felt that they were listened to.

Since this factor is not similar to the discussed factors, it can be seen as complementary.

4.2.2 Acceptance

With shared decision making patients largely get the possibility to choose the treatment option they want and they mostly agree with the made decision. Furthermore, because of shared decision making, patients are better informed about for example the risks and they know what may happen. Patients believe that this ensures higher levels of acceptance. In this way, shared decision making may lead to less complaints and reduces the chance that patients blame their doctor when things go wrong or negative side effects occur.

"But if you reach a decision in the end, based on good considerations, the acceptance of the remaining process and the consequences can be greater. Because you came to a decision together." (Maar als je uiteindelijk tot een keuze komt op basis van goede afwegingen samen, dat dan de acceptatie van het vervolgtraject en de consequenties hoger kan zijn. Omdat je gezamenlijk tot een afweging gekomen bent.) (patient 1)

Patients' acceptance of the chosen treatment option and the feeling that they will accept the possible consequences make them more satisfied.

Since this factor is not similar to the discussed factors, it can be seen as complementary.

4.2.3 Confirmation

During the different consults, many patients got confirmation for their choice from the doctor. Also, for some patients, the option grid confirmed their made decision. Because of this, the patients had the feeling that they made the right choice and they were more satisfied.

Of course it was good that the doctor confirmed that it was the best solution. That gives a feeling of satisfaction. Because you have the idea that you made the right choice." (Het was natuurlijk wel goed dat die arts bevestigt dat dat de beste oplossing is. Dus dat geeft wel een gevoel van tevredenheid. Omdat je dan voor jezelf het idee hebt van nou ik heb dan toch de goede keuze gemaakt.) (patient 2)

For most of the patients, the confirmation from the doctor for their choice appeared to be even more important than the possibility to choose the treatment option they want. One of the patients believes that if the chosen treatment leads to positive health outcomes this will reconfirm that he really made the right decision and he will be even more satisfied.

Since many patients felt confident because of the confirmation, the factor confirmation is a deepening of the factor confidence. The factor is discussed separately because many patients explicitly referred to it.

4.2.4 Reassurance

Because of the shared decision making process, patients felt reassured and therefore they were more satisfied. This feeling of reassurance is caused by the amount of knowledge the patients have because of the given information about the disease and the treatment options. Since the information and the possibilities are examined together, the patients felt that they did not overlook anything.

"Well, that has to do with the feeling of reassurance because of the option grid and discussing it with each other." (Nou, dat heeft te maken met dat stuk geruststelling wat je gekregen hebt door die keuzehulp en door het op die manier met elkaar te bespreken.) (patient 8)

Furthermore, one of the patients was reassured by the efficiency of the shared decision making process.

Since many patients felt confident because of the reassurance, the factor reassurance is a deepening of the factor confidence. The factor is discussed separately because many patients explicitly referred to it.

4.2.5 Openness

The high degree of openness between the patient and the nursing specialist/urologist does also explain why patients are satisfied. During the different consults, patients experienced open conversations, intensive contact and a lot of interaction. This openness led to feelings of satisfaction.

Since this factor is about the openness of the relationship between doctor and patient, the openness factor can be seen as a deepening of the relationship factor. The factor is discussed separately because the term was mentioned so often.

4.2.6 Clarity

The clarity about the disease, the treatment options, the (dis)advantages of the treatment options, the risks, the consequences and the possibilities does also explain patient satisfaction. The given information and the explanations from the nursing specialist/urologist were clear. Also, the option grid gave the patients a structured overview of information. Since the option grid offers the information in a clear way and is "to the point", it makes the patients understand what exactly is going on. By using the option grid, the patients could test whether they understood everything correctly. The asked questions encouraged the patients to think about their needs and wants. Furthermore, the option grid ensured a good consideration of the different criteria and therefore it was clear which treatments to choose and which not.

"So in my opinion, it was a pretty good tool and also clear. It is a tool to make the right choice." (Dus het was wel een behoorlijk goed hulpmiddel vond ik, en duidelijk ook. Het is gewoon een hulpmiddel natuurlijk om een goede keuze te maken.) (patient 6)

Because of the clarity of the information the patients were better able to make a well-considered choice and they were more confident about the made decision. This gave a lot of patients a feeling of satisfaction.

Since this factor is about the clarity of the information, the clarity factor can be seen as a deepening of the information factor. The factor is discussed separately because the term was mentioned so often.

So, as expected, shared decision makings has a mostly positive influence on the satisfaction of patients. Existing factors as well as new factors were found that can explain the relationship between shared decision making, with the use of option grids, and patient satisfaction.

4.3 Shared decision making and doctor satisfaction: expected factors

While the exact relationship between shared decision making and doctor satisfaction was unclear because of different findings in existing literature, the results of this research indicate that shared decision making, with the use of option grids, positively influences doctor satisfaction. Both the nursing specialist and the urologist experienced shared decision making positively. They felt that shared decision making, with the use of the option grid, positively influenced their satisfaction. The explanations from the nursing specialist and the urologist during the interviews showed how shared decision making, with the use of the option grid, influenced doctor satisfaction. These different ways in which shared decision making influenced doctor satisfaction will be discussed.

4.3.1 Relationship

The expectations from the existing literature about the importance of a good relationship between patient and doctor in explaining satisfaction of doctors are partly confirmed. Both the nursing specialist and the urologist think that shared decision making leads to a good relationship between patient and doctor. According to the nursing specialist, the interpersonal contact during the shared decision making process, the feeling of patients that they are listened to by the doctor, the fact that the doctors inform the patients, the emotional topics that are discussed in detail and the built trust positively influence this relationship. The urologist explained that in this situation of the shared decision making, he has only one consult with a patient but the duration of this consult is quite long. In the previous situation there were more contact moments between doctor and patient, but the consults were much shorter. In his opinion, the content of the contact is more important than the frequency of the contact and therefore shared decision making improves the relationship between patient and doctor. A good relationship between the nursing specialist and his patients positively influences his satisfaction. On the other hand, the urologist acknowledges that a good relationship between doctor and patient is important but that this does not make him more satisfied.

"Relationship is very important in our work, but it is not my goal. It is not very important for me to maintain a good relationship." (*Relatie is heel belangrijk in het werk wat we doen, maar het is voor mij geen doel an sich. Ik heb daar zelf niet het gevoel bij dat het voor mij zelf heel belangrijk is om de relatie goed te houden.) (Urologist)*

4.3.2 Characteristics

The nursing specialist and urologist experienced the shared decision making with the patients mainly as positive or even very positive and in most conversations the shared decision making with the patients went well or even very well. Consistent with the current literature, patient (socio-demographic) characteristics like personality, age and education appeared to have an effect on how the shared decision making went and how the nursing specialist and urologist experienced shared decision making. In this way, the characteristics of patients influenced the satisfaction of the doctors.

First of all, the personalities of patients differ. Some patients really want to be involved in making the decision, while other patients want the doctor to decide what is best for them. Both the nursing specialist and the urologist explain that they really try to involve all kind of patients and they always try to make the decision together with the patient, but in the end, the patient decides the extent to which he participates.

"You can always try to involve them to some extent, but that is not necessarily always successful." (Je kan ze natuurlijk altijd tot op zekere hoogte proberen te betrekken maar dat is niet per definitie altijd succesvol.) (Urologist)

Some patients clearly know and tell what they want, other patients must be asked further questions to find out what is important for them and what their preferences are. These patients need more help than others when making a decision. Because of the different personalities, the extent to which a decision is shared with different patients varies and the way in which different patients are involved in the decision making differs. According to the nursing specialist, the patients who are not so involved and who need a lot of help to make a decision are the biggest challenge for him. Furthermore, the nursing specialist and urologist explained that shared decision making during the consults went well when patients were involved, motivated, well prepared, clear about their preferences and thought carefully about the different options. This made the shared decision making easier than when patients had a lot of doubts and found it difficult to make a decision. When the shared decision making went well, this satisfied the doctors.

Secondly, the age of patients differs. The urologist said older people are more used to a situation in which the doctor decides. The nursing specialist thought that younger people are

more involved in the decision. Since the shared decision making went well with really involved patients, this satisfied the doctors.

Thirdly, the level of education of patients differs. In general, higher educated patients want to be actively involved in the decision since it concerns their body and their life. However, for lower educated patients, the opinion of the doctor is very important and they find it more pleasant when the doctor makes the decision. The shared decision making went especially well with highly educated patients since they want to be actively involved in the decision and they have high levels of understanding and high capacity to process information. When the shared decision making went well, this satisfied the doctors.

4.3.3 Outcomes

As expected based on the current theories, positive health outcomes for patients positively influence doctor satisfaction. The nursing specialist and urologist want positive health outcomes because it is the main goal of their job to cure patients. Also, they want to avoid negative health outcomes since these lead to more trouble. Therefore, the nursing specialist and the urologist are more satisfied when shared decision making leads to positive health outcomes for patients.

4.3.4 Patient satisfaction

The idea from the current literature that patient satisfaction directly leads to doctor satisfaction has been confirmed by this research. Both the nursing specialist and the urologist believe that shared decision making leads to more satisfied patients. Also, they both said that they are more satisfied when patients are satisfied. This relationship between patient satisfaction and doctor satisfaction can be explained in different ways. The ultimate goal of the nursing specialist is to satisfy patients. He likes his job because he can help patients, inform them and listen to them. According to the urologist, it is more pleasant to work with satisfied patients than to work with unsatisfied patients because unsatisfied patients take a lot of his time and energy.

4.4 Shared decision making and doctor satisfaction: other factors

The just discussed factors that do explain the relationship between shared decision making and doctor satisfaction were already expected based on the existing literature. The results of

this research thus largely confirm the current literature. Also, during this research more factors that play a role in this relationship were found. These other ways in which shared decision making positively influences doctor satisfaction will now be discussed.

4.4.1 Self-determination

Self-determination of patients because of shared decision making does partly explain doctor satisfaction. According to the nursing specialist, shared decision making guarantees the self-determination of patients and this is really important for him. The nursing specialist feels that patients must be in control of their own health and that they need to be able to decide about their own body. Shared decision making ensures this since the patients are involved in the decision making. The nursing specialist is happy because with shared decision making patients can give their opinion and make a choice. According to the nursing specialist, this makes the patient more powerful. In his current work situation, the nursing specialist can contribute to this and this satisfies him.

4.4.2 Informed patients

As a consequence of the shared decision making process, with use of the option grid, patients were better informed. This appeared to be an important reason for the doctors to be satisfied.

The nursing specialist and urologist are positive about the option grid because it is an important tool that helps both the patient and the doctor. According to the nursing specialist and urologist, the information in the option grid is complete and well-structured. The information and questions in the option grid enhance the knowledge of the patients and this leads to better informed and well prepared patients. Therefore, patients are better able to make a considered choice, it is easier for the doctor to involve patients in the decision making and it improves the conversation between doctor and patient. The nursing specialist and the urologist believe that in this way, the option grid makes shared decision making easier.

“For me, the most important value of the option grid is that, of course I have a certain professional level and substantive knowledge and that the patient also reaches a certain level, so we can exchange thoughts on the same level and make a decision.” (Voor mij, de belangrijkste waarde van de keuzehulp is dat, kijk ik heb natuurlijk een bepaald professioneel niveau, inhoudelijke kennis en dat de patiënt ook op een bepaald niveau komt, zodat je op een wat meer gelijk niveau van gedachte kan wisselen en die beslissing kan nemen.) (Urologist)

Also, in the shared decision making situation, one additional informative consult is planned. This consult takes place after the patients have read the option grid. During this consult, the nursing specialist is able to give more customized information to the patients because they already read the more general information in the option grid. The urologist believes that the quality of information provision is higher because of the use of the option grid and the additional informative consult.

The nursing specialist and urologist explained that shared decision making during the consults went especially well with patients that were better informed and prepared than other patients. In these situations, they experienced shared decision making particularly positive and pleasant and this satisfied them.

"It is nice to work with people, patients, who know what they are talking about when you have to make a decision. And with prostate cancer there are decision to make, this is different for some other diseases. But there are really different choices with different content. When you have to make such decisions with people it is pleasant when they are well informed." (Het is prettig te werken met mensen, patiënten, die een beetje weten waar ze het over hebben als je beslissingen moet nemen. En bij prostaatkanker zijn er beslissingen te nemen, dat is voor sommige aandoeningen natuurlijk anders. Maar er zijn echt keuzes te maken die ook op inhoud relevant verschillend zijn zeg maar. Als je die keuzes met mensen moet maken is het prettig als ze goed geïnformeerd zijn.) (Urologist)

4.5 Shared decision making and doctor satisfaction: job demands and job resources

Following the "Job Demands-Resources" reasoning in existing literature, the influence of shared decision making on doctor satisfaction can either be positive or negative. This research confirms that shared decision making has implications for the work control of the doctor, the interaction between doctor and patient and the workload of the doctor. Some relationships appeared to be the same as we expected, some appeared to be different.

4.5.1 Work control

Opposed to expectations based on current literature, the nursing specialist and urologist do not feel that shared decision making leads to less work control and autonomy and in that way it does not negatively influence their satisfaction. The nursing specialist thinks this has to do

with the fact that he is not an urologist and therefore he does not operate. So, the choice of the patient does not have an effect on him directly. The urologist explains this by telling that when he does not support the decision of the patient, he does not carry out that treatment. In such a situation, the patient is referred to another urologist. So, in that way his professional autonomy is guaranteed.

Both the nursing specialist and the urologist believe that they do have work control and autonomy for different reasons. According to the nursing specialist he has autonomy in his current role because he informs the patients completely and he prepares them for making the decision. It satisfies the nursing specialist that he has his own consults with patients, he is in control of his own planning and he can manage the care process of the different patients. Therefore, the degree of work control and autonomy in his work is quite high and this is important for him. According to the urologist the control and autonomy in his work concerns offering the right treatment to the patient. With shared decision making, it is more likely that the decision is appropriate. Furthermore, he experiences high levels of work control and autonomy because of the content of his work. He has to think extensively about problems of patients, figure out how to solve these problems and actually solve the problems, for instance by operating. The fact that he is in control of all these things makes his work more satisfying.

Thus, the nursing specialist as well as the urologist feel that the degree of work control and autonomy in their work is quite high thanks to shared decision making. With these higher degrees of work control and autonomy, they have more job resources and this leads to higher doctor satisfaction. These findings contradict the expectations.

4.5.2 Interaction

As expected in the existing literature, the nursing specialist and urologist feel that because of shared decision making there is a high degree of interaction between doctor and patient and this positively influences their satisfaction. Shared decision making, with the use of the option grid ensures a high quality of information provision. This leads to better informed patients with enhanced knowledge about the disease, the treatment options and the possible risks and consequences. Both the nursing specialist and the urologist believe that this causes more as well as better interaction between doctor and patient. The nursing specialist and urologist really like the contact and the interaction with patients and this satisfies them. The urologist explains that because the patient is informed better, they can have an exchange of thoughts at

the same level. In this way, the urologist is really challenged intellectually and therefore the conversations are more interesting and the content of his work is better.

"Yes the better informed patient and you can exchange thoughts at a better level, it leads to consults with a better content." (*Ja de beter geïnformeerde patiënt en dat je daardoor op een beter niveau van gedachten kan wisselen, dat maakt de inhoud van de consulten leuker.)* *(Urologist)*

Thus, according to the nursing specialist and the urologist, with shared decision making, there is a high degree of interaction between doctor and patient. This high degree of interaction between doctor and patient can be seen as a job resource and leads to higher doctor satisfaction. These findings are in line with the expectations based on earlier research.

4.5.3 Workload

In contrast to the expectations based on the current literature, the nursing specialist and urologist do not feel that shared decision making leads to an increase in their workload and in that way it does not negatively influence their satisfaction. The nursing specialist and urologist mentioned several reasons to explain this. First of all, they do not need more time to prepare consults because of shared decision making. Furthermore, according to the nursing specialist, the higher interaction between doctor and patient does not lead to work intensification. Also, according to the urologist, he does not have to make more effort to convince patients. Thus, shared decision making does not lead to an increase in doctors' workload.

Both the nursing specialist and the urologist even believe that there is less workload because of shared decision making and this satisfies them. The nursing specialist explains this by telling that in a situation without shared decision making, he would expect more ad hoc questions from patients because they are less informed. The urologist explains the low workload by telling that with shared decision making situation, certain parts of the care path, for example the preparation, are outsourced to the nursing specialist and the patient. Therefore, the urologist needs fewer consults with the patients.

"And the relatively scarce time of a medical specialist can be used more efficiently." (En de relatief schaarse tijd van een medisch specialist, die kan je dan efficiënter inzetten.) *(Urologist)*

In addition, the option grid, used as a tool, ensures that less work remains for the nursing specialist and urologist. According to the urologist, the low workload can also be explained by the fact that the duration of the consult between him and the patient is longer because of shared decision making. The increased consultation and argumentation because of shared decision making has been taken into account when planning the consults. Now, the urologist has sufficient time to make a decision with the patient and this gives a feeling of peace. According to the urologist, time and peace are needed for good shared decision making and therefore of great importance.

"So, I think that time and peace are two very important conditions for good shared decision making." (Dus ik denk dat tijd en rust dat dat twee hele belangrijke voorwaarden zijn voor goed samen kunnen beslissen.) (Urologist)

Also, because there is enough time to discuss everything in detail, the quality of the consults is higher and the content of work improves. In this way, the urologist experiences his work as more pleasant and this positively influences his satisfaction.

Thus, according to the nursing specialist and the urologist, shared decision making and the changed work design leads to a decrease in doctors' workload. Low workload can be seen as fewer job demands and thus leads to higher doctor satisfaction. These findings are in not line with the expectations based on existing literature. In addition, with shared decision making and the changed work design, the content of work is good and work is pleasant. These working conditions can be seen as job resources and also lead to higher doctor satisfaction.

So, partly opposed to expectations based on the existing literature, shared decision making has only a positive influence on the satisfaction of doctors. Existing as well as new mechanisms were found that explained the relationship between shared decision making, with the use of option grids, and doctor satisfaction.

5. Conclusion and discussion

This chapter presents the conclusion and discussion of the research. In the conclusion, an answer to the research question is formulated (5.1). In the discussion, the theoretical implications (5.2) and limitations (5.3) of the research are discussed (5.2) and practical recommendations are given (5.3).

5.1 Conclusion

In this research, all patients experienced shared decision making positively. As expected based on the existing literature, the different patients felt that shared decision making, with the use of the option grid, positively influenced their satisfaction. The results of this research show that there are different ways in which shared decision making influences patient satisfaction. Some factors that do explain the relationship between shared decision making, with the use of the option grid, and patient satisfaction were already expected based on the existing literature. The results of this research thus mainly confirm the existing literature, but some factors appeared to be more important than others. Choice of patients partly explains the relationship, but appeared to be less important than expected. Efficiency of the care process appeared to be relatively important in explaining the relationship, positive health outcomes were largely important in explaining satisfaction of patients and taking preferences into account led in almost all cases to more patient satisfaction. The feeling of confidence, the good relationship between doctor and patient and the given information appeared to be especially important in explaining the relationship. Also, during this research more factors that play a role in the relationship between shared decision making and patient satisfaction were found. The fact that patients are involved in the decision making process, the high degree of openness between doctor and patient, the confirmation patients get for the made choice, the feeling of reassurance that patients have, the clarity of the given information and the acceptance of the chosen treatment option appeared to be important in explaining the relationship between shared decision making and patient satisfaction.

The nursing specialist as well as the urologist have a very positive opinion of shared decision making and the use of the option grid. In contrast to expectations based on the existing literature, both the nursing specialist and the urologist felt that shared decision making, with the use of the option grid, had only a positive influence on their satisfaction.

The results of this research show that there are different ways in which shared decision making influences doctor satisfaction. Some factors that do explain the relationship between shared decision making, with the use of the option grid, and doctor satisfaction were already expected based on the existing literature. A good relationship between patient and doctor partly explains the relationship, since it appeared to be important for the nursing specialist and less important for the urologist. Furthermore, (socio-demographic) characteristics of patients and positive health outcomes for patients appeared to be important in explaining the relationship between shared decision making and the satisfaction of the doctors. Also, patient satisfaction appeared to have a direct influence on doctor satisfaction. During this research, more factors that play a role in the relationship between shared decision making and doctor satisfaction were found. Firstly, self-determination of patients because of shared decision making does partly explain doctor satisfaction. Secondly, the better informed patients because of shared decision making appeared to be an important reason for the doctors in explaining the relationship.

This research confirms that shared decision making has implications for the work control of the doctor, the interaction between doctor and patient and the workload of the doctor. There appeared to be different ways in which shared decision making influences doctor satisfaction via these working conditions. The nursing specialist and the urologist feel that because of shared decision making and the changed work design, the degree of work control and autonomy is quite high, there is a high degree of interaction between doctor and patient, the workload is quite low, the content of work is good and work is pleasant. Work control and autonomy, interaction, good work content and pleasant work can be seen as job resources and low workload can be seen as few job demands. In this research, following the "Job Demands-Resources" reasoning, shared decision making only leads to higher doctor satisfaction. These findings are not in line with the expectations based on the existing literature, in which the exact relationship between shared decision making and doctor satisfaction was unclear. In the existing literature, both positive and negative influences of shared decision making on doctor satisfaction were expected. But in this research, some of these relationships appeared to be different than expected and only positive influences of shared decision making on doctor satisfaction were found.

5.2 Discussion

5.2.1 Theoretical implications

This research contributed to the existing body of knowledge about the effects of shared decision making on patients (Benbassat et al., 1998; Griffin et al., 2004; Guadagnoli & Ward, 1998; Stacey et al., 2011; Butcher, 2013; Stiggelbout et al., 2015) by investigating the influence of shared decision making, with the use of option grids, on patient satisfaction. Furthermore, since little research focused on the effects of shared decision making on doctor satisfaction, this research contributed to the knowledge gap in the existing literature by investigating the influence of shared decision making on doctor satisfaction. Since there is a recognized need to assess the effects of shared decision making (Edwards et al., 2001), this research is theoretically relevant.

The positive influence of shared decision making, with the use of option grids, on the satisfaction of both patients and doctors may be explained by the fact that the investigated department was really appropriate for implementing shared decision making. Namely, with prostate cancer, patients mostly have the opportunity to choose between different treatment options and this is a requirement for making a decision together. So, this turned out to be an important condition for shared decision making to lead to higher patient and doctor satisfaction. For future research, it is therefore interesting to investigate the influence of shared decision making, with the use of option grids, in situations where patients have less choice. In that way, researchers can find out if in that situation, the same mechanisms apply to explain the relationship between shared decision making and doctor or patient satisfaction.

According to the existing literature, shared decision making has different implications for the working conditions of doctors and these working conditions influence doctor satisfaction either positively or negatively (Herzberg, 1973; Weisman & Nathanson, 1985; Linzer et al., 2009; Casalino & Crosson; 2015). Therefore the exact relationship between shared decision making and doctor satisfaction is unclear. The results of this research help to clarify the exact relationship by concluding that shared decision making has only a positive influence on the satisfaction of doctors via these working conditions. The research shows the implications of shared decision making for the working conditions of doctors and the consequences for the number of job demands and job resources. In this way, this research adds value to the existing literature about job demands and job resources (Demerouti et al.,

2001) and the way these job demands and job resources explain the relationship between shared decision making and doctor satisfaction.

At the urology department of the Canisius-Wilhelmina hospital in Nijmegen they changed the work design of the doctors when implementing shared decision making. The increased consultation and argumentation because of shared decision making has been taken into account by planning longer consults between the urologist and the patients. In that way, the urologist has sufficient time to make a decision with the patient and this gives the urologist a feeling of peace. Also, certain parts of the care process, for example the preparation, have been outsourced to the nursing specialist. These conditions ensured a low workload for the urologist. This can be seen as fewer job demands which led to higher doctor satisfaction. Furthermore, because of the adjusted allocation of tasks, the nursing specialist has his own consults with patients, he is in control of his own planning and he can manage the care process of the different patients. Therefore, he feels that the degree of work control and autonomy in his work is quite high. With these higher degrees of work control and autonomy, he has more job resources and this leads to higher doctor satisfaction. In addition, because of shared decision making and the changed work design with the adjusted allocation of tasks and the longer consults, the content of work is good and work is pleasant. These working conditions can be seen as job resources and also lead to higher doctor satisfaction. Thus, by changing the work design of the doctors when implementing shared decision making, they enabled higher doctor satisfaction.

Several conditions appeared to be important for the positive relationship and together they can contribute to theory development. The conditions explain why shared decision making does not lead to the expected high workload and less work control and autonomy, but instead to a low workload and high work control and autonomy and therefore to high doctor satisfaction. By providing insight in the conditions that are needed for shared decision making to have a positive influence on doctor satisfaction, this research adds value to the existing knowledge gap about the exact influence of shared decision making on doctor satisfaction.

These insights are also relevant for future research. The mentioned conditions seem quite essential for a positive influence of shared decision making on doctor satisfaction. Future research could investigate the relationship between shared decision making, with the use of option grids, and doctor satisfaction in other situations where they implemented shared decision making in other ways. In that way, there can be found out if shared decision making

also has a positive influence on doctor satisfaction when departments do not adjust the work design or when departments adjust the work design in a different way. So, since it is likely that the relationship between shared decision making and doctor satisfaction depends on certain conditions, future research should not only investigate if departments use shared decision making but also how they implement it. The idea that the way of implementation is an important determinant of the effects, for example satisfaction, is in line with findings of existing literature about high performance work systems (Boxall & Macky, 2014; Tregaskis, Daniels, Glover, Butler, & Meyer, 2013).

5.2.2 Limitations

This research has some limitations, which offer possibilities for future research. First of all, the scope of the research is quite small. The data has been collected in only one department of the Canisius-Wilhelmina hospital in Nijmegen and therefore it is difficult to generalize the results. The way in which shared decision making, with the use of option grids, influences the satisfaction of both patients and doctors may be different for other departments with other contextual circumstances. For this reason, the external validity of this research is quite low. However, the results may be applied to departments with comparable contexts, for instance departments where patients have a comparable number of options to choose from and departments in which the work design is adjusted in the same way. To find out the effects of shared decision making on patient and doctor satisfaction in other contexts, future research can focus on other departments of the Canisius-Wilhelmina hospital in Nijmegen or departments of other hospitals. It would be particularly interesting to investigate other departments where patients are diagnosed with other diseases to find out in what situations shared decision making is appropriate and leads to higher satisfaction. With other diseases, patients may have less possible treatment options to choose and they may get the feeling that there is no choice for them to make. Therefore, this may lead to higher or lower levels of satisfaction. Also, this research focused on only 10 patients, 1 nursing specialist and 1 urologist. Future research should take into account much more respondents to improve the external validity.

Another limitation of this research is the fact that both the nursing specialist and the urologist are only used to work with shared decision making and they do not know a working situation without. Therefore, they are not able to compare the current situation of shared decision making with a situation without. As a consequence, they could only tell about their

satisfaction with shared decision making and they could not know for sure how their satisfaction changed because of shared decision making. For future research, it is therefore recommended to interview doctors with more knowledge about a previous situation without shared decision making.

5.2.3 Practical recommendations

For a positive effect on patient and doctor satisfaction several conditions are important when implementing shared decision making. First of all, it is essential that shared decision making is implemented in a situation in which the patient really has a choice to make. Otherwise the patient gets the feeling that there is nothing to decide about and this can negatively influence their satisfaction. Furthermore, when implementing shared decision making, it may be advisable to focus on the extensiveness, completeness and clarity of the given information and option grid because this can lead to high levels of patient satisfaction. The provision of extensive, complete and clear information will also ensure well informed patients and this may satisfy doctors. In addition, guaranteeing the work control and autonomy of doctors when implementing shared decision making may help to positively influence doctor satisfaction. This can be achieved by assigning planning tasks to doctors and by giving them the opportunity to solve problems. In order to prevent an increase in doctors' workload after implementing shared decision making, the entire care process needs to be adjusted to the new situation. An informative option grid of high quality is necessary to facilitate the shared decision making process and to ensure that less work remains for the doctor. Furthermore, to lower the workload of the urologist, it is recommended to adjust the work design of doctors. This can be done by outsourcing certain parts of the care process, for example the preparation, to other care professionals like a nursing specialist. Moreover, it is important to adjust the durations of the consults and plan more time for every patient when introducing shared decision making. In this way, the workload of the doctor will not increase. The sufficient time may give the urologist a feeling of peace, may improve the quality of the consults, may improve the content of work and may ensure more pleasant work. In this way it can lead to higher doctor satisfaction.

As the results of this research indicate, it may be wise for hospitals to implement shared decision making since it can, under the mentioned conditions, lead to higher patient and doctor satisfaction. Patient satisfaction positively influences the profitability of the hospital (Ruyter, Wetzels, & Bloemer, 1998) and doctor satisfaction has a positive influence on the quality of care (Firth-Cozens, 2015). Thus, by implementing shared decision making,

with the use of option grids, satisfaction of both patients and doctors can be increased and in that way it can lead to better organizational performance.

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Appendix

1. Permission form patients

Beste heer…,

Het CWZ vindt het belangrijk om aan te sluiten bij de wensen en behoeften van de patiënt. Daarom wordt er op de afdeling urologie een onderzoek gedaan naar “samen beslissen”. Dit is een proces waarbij de arts en de patiënt samenwerken bij het maken van beslissingen in de zorg, bijvoorbeeld bij de keuze voor een bepaalde behandeling. Het is hierbij de bedoeling dat de patiënt beter geïnformeerd wordt over de aandoening en de mogelijke behandelopties en er bij het uiteindelijke besluit voor een behandeling rekening gehouden wordt met de voorkeuren van de patiënt. Om het “samen beslissen” te ondersteunen worden keuzehulpen gebruikt, met informatie over de aandoening en mogelijke behandelopties en vragen over de voorkeuren van de patiënt. Het uiteindelijke doel van dit onderzoek is om inzicht te krijgen in de manier waarop “samen beslissen”, met het gebruik van keuzehulpen, van invloed is op de tevredenheid van zowel patiënten als artsen. Het onderzoek wordt uitgevoerd door een student van de Radboud Universiteit Nijmegen en dient als input voor een masterscriptie.

U komt in aanmerking voor dit onderzoek omdat er tijdens de consulten die de arts met u heeft gehad “samen beslissen” is toegepast en u toegang heeft gekregen tot de keuzehulp voor prostaatkanker. Momenteel worden er patiënten gezocht die benaderd mogen worden om mee te doen aan een interview, voor in de periode september/oktober/november. Tijdens het interview zal gevraagd worden naar uw mening over het “samen beslissen” en de keuzehulp en de invloed hiervan op uw tevredenheid. De vragen zullen gaan over het gebruik van de keuzehulp, uw mening over de keuzehulp, uw ervaringen met samen beslissen, uw tevredenheid en de relaties hiertussen. Het interview zal circa een half uur tot één uur duren en zal plaatsvinden in het CWZ. De afname van het interview kan plaatsvinden op een voor u geschikt moment, bijvoorbeeld direct na het consult met de arts. Om de resultaten zo zorgvuldig mogelijk te kunnen verwerken, zal er een geluidsopname gemaakt worden. Deze geluidsopname zal worden vernietigd na het transcriberen van het interview. De resultaten van het interview blijven anoniem en worden alleen gebruikt voor dit onderzoek en het CWZ. De deelname aan dit onderzoek is vrijwillig en er staat geen vergoeding tegenover.

Met behulp van uw mening kan het CWZ de zorgverlening verbeteren. **Als u deel wilt nemen aan het onderzoek kunt u hieronder uw gegevens invullen. U geeft hiermee toestemming voor het opnemen van contact door de student van de Radboud Universiteit Nijmegen, de uiteindelijke afname van het interview en de geluidsopname van het interview.**

Naam:

E-mail adres:

Telefoonnummer:

Datum:

Handtekening:

Bij voorbaat dank voor uw medewerking,

Met vriendelijke groet,

Afdeling urologie CWZ & Radboud Universiteit Nijmegen

2. Letter of approval

Dr. Somford, Uroloog
B28

LTC/TT/023-2018 024-3657759 2 mei 2018

Betreft: Msc:MBA:SHRL, CWZ-nr.023-2018

Geachte dr.Somford,

Hierbij laat ik u weten dat het RSO van het Canisius-Wilhelmina Ziekenhuis kennis heeft genomen van het onderzoek getiteld: *Master of Science: Master Business Administration: Strategic Human Resource Leadership'* (Msc:MBA:SHRL, CWZ-nr.023-2018).

Deze studie is voorgelegd aan de voorzitter van de Lokale Toetsingscommissie (LTC). Het betreft een niet WMO-plichtig onderzoek waarbij er vanuit de LTC geen bezwaar is tegen de uitvoering van deze studie. Voor de tot standkoming van dit besluit verwijs ik u graag naar de documenten zoals opgenomen in bijgevoegd overzicht.

Het RSO heeft per e-mail vernomen dat mw.Noor Snijder, manager bedrijfsvoering Urologie, akkoord is met de uitvoering van deze studie binnen haar zorgeenheid in het CWZ.

Er is door de LTC ontheffing van de beoordelingskosten verleend.

Ik verzoek u het RSO periodiek over het verloop en te zijner tijd over de afsluiting van het onderzoek te informeren. Het RSO zal hiervoor jaarlijks reviewgegevens bij u opvragen.

Met vriendelijke groet,
Namens de LTC,

Dr. J.M.W. van den Ouweland
Voorzitter

3. Interview guide patients

Welkom. Allereerst bedankt voor het deelnemen aan dit interview. Het onderzoek waarvoor dit interview wordt afgenomen, gaat over “samen beslissen”. Dit is een proces waarbij de arts en de patiënt samenwerken bij het maken van beslissingen in de zorg, bijvoorbeeld bij de keuze voor een bepaalde behandeling. Het is hierbij de bedoeling dat de patiënt beter geïnformeerd wordt over de aandoening en de mogelijke behandelopties en er bij het uiteindelijke besluit voor een behandeling rekening gehouden wordt met de voorkeuren van de patiënt. Om het “samen beslissen” te ondersteunen worden keuzehulpen gebruikt, met informatie over de aandoening, informatie over de mogelijke behandelopties en vragen over de voorkeuren van patiënt. Het uiteindelijke doel van dit onderzoek is om inzicht te krijgen in de manier waarop “samen beslissen”, met het gebruik van keuzehulpen, van invloed is op de tevredenheid van zowel patiënten als artsen.

Tijdens de consulten die de arts met u heeft gehad is er “samen beslissen” toegepast en u heeft toegang gekregen tot de keuzehulp voor prostaatkanker. Ik wil tijdens dit interview graag uw mening hierover weten en wat de invloed hiervan is geweest op uw tevredenheid. De vragen zullen gaan over het gebruik van de keuzehulp, uw mening over de keuzehulp, uw ervaringen met samen beslissen, uw tevredenheid en de relaties hiertussen.

Ik wil u vragen om de vragen zo zorgvuldig en eerlijk mogelijk te beantwoorden. Wanneer er nog aanvullende zaken zijn, waar niet letterlijk naar wordt gevraagd tijdens het interview, maar die wel gerelateerd zijn aan het onderwerp en waarvan u denkt dat ze wellicht relevant zijn voor het onderzoek, begin hier dan gerust over. Als er tijdens het interview vragen of onduidelijkheden zijn dan hoor ik dat graag. De resultaten van dit interview blijven anoniem en worden alleen voor gebruikt voor dit onderzoek en het CWZ. U heeft via het toestemmingsformulier al toestemming gegeven voor het opnemen van het interview, klopt dit? Heeft u nu vooraf aan het interview nog vragen?

Option grid	<u>Used steps</u>	1. Heeft u toegang gekregen tot de keuzehulp? 2. Is het doel van de keuzehulp door de arts toegelicht? 3. Heeft u de keuzehulp gelezen? 4. Heeft u de vragen in de keuzehulp beantwoord?

		. Heeft de arts de keuzehulp en de bijbehorende vragen naderhand met u besproken?
	Opinion	6. Wat vindt u van de keuzehulp? 7. Zou u de keuzehulp aanraden aan andere patiënten? 8. Waarom zou u de keuzehulp wel/niet aanraden aan andere patiënten?
	Tool	Maakte het gebruik van de keuzehulp samen beslissen makkelijker en waarom?
Shared decision making	Experienced?	10. Heeft u samen beslissen ervaren tijdens de consulten?
	SDM-Q-9	11. Mijn arts heeft mij duidelijk gemaakt dat er een beslissing genomen moet worden. 2. Mijn arts heeft mij precies gevraagd hoe ik betrokken zou willen worden bij het nemen van de beslissing. 13. Mijn arts heeft mij precies verteld dat er voor mijn klachten verschillende behandelmogelijkheden zijn. 14. Mijn arts heeft mij de voor- en nadelen van de behandelingsmogelijkheden precies uitgelegd. 15. Mijn arts heeft mij geholpen alle informatie te begrijpen. 16. Mijn arts heeft mij gevraagd welke behandelingsmogelijkheid mijn voorkeur heeft. 17. Mijn arts heeft met mij de verschillende behandelingsmogelijkheden grondig afgewogen. 18. Mijn arts en ik hebben samen een behandelingsmogelijkheid uitgekozen. 19. Mijn arts en ik hebben een afspraak gemaakt over het verdere vervolg.
	How experienced?	20. Hoe heeft u samen beslissen ervaren?

	Opinion	21. Wat vindt u van samen beslissen? 22. Welk cijfer zou u de behandeling tot nu toe geven?
	Consequences	23. Welk effect heeft samen beslissen op u? 24. Wat zijn volgens u de gevolgen van samen beslissen? . Denkt u dat het traject anders was gegaan zonder samen beslissen?
Satisfaction		26. Hoe tevreden bent u? 27. Waarom bent u wel/niet tevreden? 8. Is samen beslissen van invloed op uw tevredenheid en waarom?
Factors	Preferences patient	. Is het voor uw tevredenheid belangrijk dat er bij de keuze voor de behandeling rekening werd gehouden met uw voorkeuren en waarom?
	Choice patient	30. Is het voor uw tevredenheid belangrijk dat uiteindelijk de behandelingsoptie is gekozen die u wilde en waarom?
	Costs care	. Spelen kosten van de zorg een rol in uw tevredenheid en waarom?
	Confidence patient	32. Is de mate waarin u zeker/overtuigd bent van de gemaakte beslissing van invloed op uw tevredenheid en waarom?
	Efficiency care	33. Speelt efficiency van de zorg een rol in uw tevredenheid en waarom?
	Outcomes patient	. Zijn eventuele positieve uitkomsten van de behandeling voor u en uw gezondheid van invloed op uw tevredenheid en waarom?
	Relationship doctor-patient	5. Speelt de relatie tussen u en de arts een rol in uw tevredenheid en waarom?
	Information & knowledge	36. Is de hoeveelheid informatie die u heeft gekregen over de aandoening en de behandelingsopties belangrijk voor uw mate van tevredenheid en waarom? 37. Is de hoeveelheid kennis die u momenteel heeft over de aandoening en de behandelingsopties belangrijk voor uw mate van tevredenheid en waarom?

	Socio-demographic characteristics patient	38. Hoe oud bent u? 39. Wat is uw afkomst? 40. Wat is uw burgerlijke staat? 41. Wat is uw hoogst afgeronde opleiding? 42. Hoe is uw gezondheid?

Dan hebben we nu alles besproken. Bedankt voor u deelname aan het interview. Heeft u nog vragen of aanvullende opmerkingen?

4. Interview guide nursing specialist and urologist

Welkom. Allereerst bedankt voor het deelnemen aan dit interview. Het onderzoek waarvoor dit interview wordt afgenomen, gaat over “samen beslissen” en keuzehulpen. Het uiteindelijke doel van dit onderzoek is om inzicht te krijgen in de manier waarop “samen beslissen”, met het gebruik van keuzehulpen, van invloed is op de tevredenheid van zowel patiënten als artsen.

Tijdens de consulten die u met verschillende patiënten heeft gehad is er “samen beslissen” toegepast. Verder hebben de patiënten toegang gekregen tot de keuzehulp voor prostaatkanker. Ik wil tijdens dit interview graag uw mening weten over “samen beslissen” en keuzehulpen en wat de invloed hiervan is geweest op uw tevredenheid. De vragen zullen gaan over het gebruik van de keuzehulp, uw mening over de keuzehulp, uw ervaringen met samen beslissen, uw tevredenheid en de relaties hiertussen.

Ik wil u vragen om de vragen zo zorgvuldig en eerlijk mogelijk te beantwoorden. Wanneer er nog aanvullende zaken zijn, waar niet letterlijk naar wordt gevraagd tijdens het interview, maar die wel gerelateerd zijn aan het onderwerp en waarvan u denkt dat ze wellicht relevant zijn voor het onderzoek, begin hier dan gerust over. Als er tijdens het interview vragen of onduidelijkheden zijn dan hoor ik dat graag. De resultaten van dit interview blijven anoniem en worden alleen voor gebruikt voor dit onderzoek en het CWZ. Gaat u akkoord met het opnemen van het interview? Heeft u nu vooraf aan het interview nog vragen?

Option grid	Opinion	1. Wat vindt u van de keuzehulp? 2. Zou u de keuzehulp aanraden aan andere artsen? Waarom zou u de keuzehulp wel/niet aanraden aan andere artsen?
	Tool	Maakt het gebruik van de keuzehulp samen beslissen makkelijker voor u en waarom? Maakt het gebruik van de keuzehulp samen beslissen makkelijker voor de patiënt en waarom? 6. Verschilt het per patiënt of de keuzehulp samen beslissen makkelijker maakt en waarom?

Shared decision making	Extent to which	Wat bepaalt de mate waarin een beslissing samen wordt gemaakt met de patiënt? 8. Hoe beïnvloeden de behandel opties de mate waarin een beslissing samen wordt gemaakt met de patiënt? Hoe beïnvloedt de persoonlijkheid van de patiënt de mate waarin een beslissing samen wordt gemaakt met de patiënt?
	Way in which	0. Wat bepaalt de manier waarop de patiënt wordt betrokken bij het maken van de beslissing? 11. Hoe bepalen kenmerken van de patiënt (culturele achtergrond, gezondheidsvaardigheden, karakter, opleidingsniveau, leeftijd) de manier waarop de patiënt wordt betrokken bij het maken van de beslissing?
	Applied?	12. Heeft u samen beslissen toegepast tijdens de verschillende consulten? (Bespreek vragenlijsten)
	How experienced?	13. Hoe heeft u samen beslissen ervaren tijdens de verschillende consulten? (Bespreek vragenlijsten) 4. Hoe ging het samen beslissen tijdens de verschillende consulten? (Bespreek vragenlijsten) 5. Wat bepaalt of het samen beslissen goed gaat tijdens een consult? (Bespreek vragenlijsten)
	Opinion	16. Wat vindt u van samen beslissen?
	Consequences	17. Welk effect heeft samen beslissen op u? 18. Welk effect heeft samen beslissen op de patiënt, denkt u? 9. Wat zijn de gevolgen van samen beslissen voor u, de patiënt, het ziekenhuis of anderen? 0. Wat zijn de nadelen van samen beslissen? (Kost het meer tijd per consult of vanwege extra consulten?) 21. Wat zijn de voordelen van samen beslissen/wat levert samen beslissen op? (Zorgt het voor minder telefoontjes en een beter geïnformeerde patiënt?)

	Costs care	22. Zorgt samen beslissen voor hogere/lagere zorgkosten?
	Efficiency care	3. Zorgt samen beslissen voor efficiëntere zorg? (Minder electieve chirurgie, minder herhaalconsulten, minder verzoeken voor een second opinion?)
Satisfaction		24. Hoe tevreden bent u? 25. Waarom bent u wel/niet tevreden? 6. Is samen beslissen van invloed op uw tevredenheid en waarom?
Factors	Relationship doctor-patient	. Speelt de relatie tussen u en de patiënt een rol in uw tevredenheid en waarom?
	Outcomes patient	8. Zijn eventuele positieve uitkomsten van de behandeling voor de patiënt en zijn/haar gezondheid van invloed op uw tevredenheid en waarom?
	Patient satisfaction	29. Beïnvloedt de tevredenheid van de patiënt uw tevredenheid en waarom?
	Working conditions: work control & work autonomy	). Is samen beslissen van invloed op de controle en autonomie die u heeft over het werk? 31. Hoe beïnvloedt dit uw tevredenheid?
	Working conditions: interaction patient & doctor	32. Is samen beslissen van invloed op de mate van interactie die u heeft met de patiënt? 33. Hoe beïnvloedt dit uw tevredenheid
	Working conditions: workload	34. Is samen beslissen van invloed op de werkdruk? (meer tijd om consult voor te bereiden omdat meer scenario's moeten worden uitgewerkt, consulten duren langer vanwege toegenomen consultatie en argumentatie, meer consulten, meer moeite doen

		om patiënten te overtuigen, intensivering van het werk door meer interactie met patiënt) 35. Hoe beïnvloedt dit uw tevredenheid?

Dan hebben we nu alles besproken. Bedankt voor u deelname aan het interview. Heeft u nog vragen of aanvullende opmerkingen?

5. Questionnaire nursing specialist and urologist

Naam patient:

Naam verpleegkundig specialist/uroloog:

1. Heeft u samen beslissen toegepast tijdens dit consult? JA/NEE
2. Ik heb mijn patiënt duidelijk gemaakt dat er een beslissing genomen moet worden. JA/NEE
3. Ik wilde precies van de patiënt weten hoe hij/zij betrokken zou willen worden bij het nemen van de beslissing. JA/NEE
4. Ik heb de patiënt verteld dat er voor zijn/haar klachten verschillende behandelmogelijkheden zijn. JA/NEE
5. Ik heb de patiënt de voor- en nadelen van de behandelingsmogelijkheden precies uitgelegd. JA/NEE
6. Ik heb de patiënt geholpen alle informatie te begrijpen. JA/NEE
7. Ik heb de patiënt gevraagd welke behandelingsmogelijkheid zijn/haar voorkeur heeft. JA/NEE
8. De patient en ik hebben de verschillende behandelingsmogelijkheden grondig afgewogen. JA/NEE
9. De patiënt en ik hebben samen een behandelingsmogelijkheid uitgekozen. JA/NEE
10. De patiënt en ik hebben een afspraak gemaakt over het verdere vervolg. JA/NEE
11. Hoe heeft u samen beslissen ervaren tijdens dit consult?
    - Heel positief
    - Positief
    - Gemiddeld
    - Negatief
    - Heel negatief
12. Hoe ging het samen beslissen tijdens dit consult?
    - Heel goed
    - Goed
    - Gemiddeld
    - Slecht
    - Heel slecht
13. Waarom ging het samen beslissen goed/niet goed tijdens dit consult?

    ……..……..……

    ……..……..……

6. Codes

Codes interviews patients		
Deductive	Steps og	**Option grid**
	Opinion og	
	Tool	
	Steps sdm	**Shared decision making**
	Experience	
	Opinion sdm	
	Consequences	
	Satisfaction	**Satisfaction**
	Preferences	**Factors**
	Choice	
	Costs	
	Confidence	
	Efficiency	
	Outcomes	
	Relationship	
	Information	
	Characteristics	
Inductive	Involvement	
	Openness	
	Confirmation	
	Reassurance	
	Clarity	
	Acceptance	

Codes interviews nursing specialist and urologist		
Deductive	Opinin og	**Option grid**
	Tool	
	Steps sdm	**Shared decision making**
	Experience	
	Extent to which	
	Way in which	
	Opinion sdm	
	Consequences	
	Satisfaction	**Satisfaction**
	Relationship	**Factors**
	Outcomes	
	Patient satisfaction	
	Work control	
	Interaction	
	Workload	
	Characteristics	
Inductive	Information	
	Self-determination	
	Content of work	
	Quality of consult	