Professional identity and shared decision making among psychiatry residents: designing a brief teaching module

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Abstract

Purpose – *The purpose of this paper is to increase awareness of shared decision making, the initial aim of the study was to understand how psychiatrists-in-training defined themselves as unique among physicians with an eye on how professional identity might shape approach to care. The second aim was to use those definitions and descriptions related to professional identity and tailor a brief training module to promote awareness of the shared decision making model.*

Design/methodology/approach – *The authors do this by first conducting focus groups to ascertain how psychiatric residents characterize their professional identity and unique disciplinary characteristics. The authors then designed a brief training session that exploits the relationship between how they define themselves as physicians and how they approach clinical decision making with patients.*

Findings – *Three major themes that emerged from the focus group data: the central role of societal and treatment contexts in shaping their professional identity and approaches to care, a professional identity characterized by a great sense of pride, and a strong commitment to systematic decision-making processes in practice. While the assessment of the training module is preliminary and lacks rigor for any generalizability or statements of causality, responses likely affirm the training tailored around professional identity as a possible vehicle for effective exposure to the concept of shared decision making and served as a useful avenue for self-reflection about needed changes to more fully embrace the practice.*

Research limitations/implications – *More inquiry may be needed into the association between trust, relationship longevity and power and paternalism, as a way to bring greater insight into the adoption of shared decision making. Future research will have to investigate whether or not including identity-related content is empirically connected to successful training on shared decision making. Likewise, future research should also look at the reciprocal impact of effectively using shared decision making on the affirmation of professional identity among psychiatrists, and indeed all who embrace patient-centered care.*

Originality/value – *This is the one of the first papers to investigate issues of professional identity among psychiatry residents, and also among the first papers to consider the relationship between professional identity and use of shared decision making.*

Keywords *Shared decision making, Professional identity among psychiatrists, Psychiatric medication management, Training for psychiatry residents*

Paper type *Research paper*

Even in the face of seeming reluctance and slow adoption of shared decision making within psychiatry, scholars and leaders in the profession have called for more widespread adoption as a means of enacting evidence based and ethical care, as well as bolstering patient engagement and autonomy. The ultimate aim of the project described here was to increase awareness of shared decision making models among a group of psychiatry residents (MDs) and promote its use in their daily practice. We do this by first conducting focus groups to ascertain how psychiatry residents characterize their professional identity and unique disciplinary characteristics. We then designed a brief training session that exploits the relationship between how they define themselves as physicians and how they approach to clinical decision making with patients. Finally, we offer some promising preliminary assessment data and considerations for future research.

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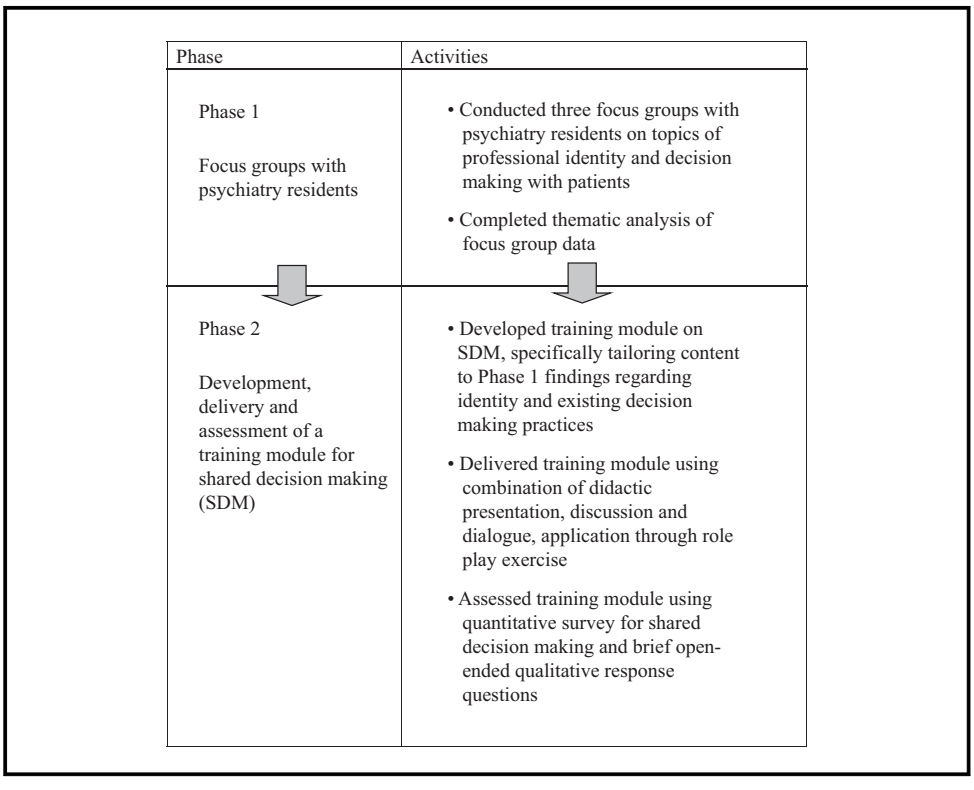
Psychiatrist's conceptualization of their role in the patient encounter and their self-definitions as unique and distinct from other medical and mental health providers surely guides their work and influences how they approach care and decision making. Amidst calls for improved quality, safety, and accountability in health care, shared decision making has emerged as one specific and promising approach to care for the present day psychiatrist (Godolphin, 2009; Hoffman *et al.*, 2014). Shared decision making is an approach which emphasizes intentional information exchange, shared preferences, and close patient-provider collaboration in treatment decision making (Bentley and Walsh, 2014; Barry and Edgman-Levitan, 2012; Charles *et al.*, 1997.) Because it is an approach that acknowledges and respects both the client's expertise with regard to their lived experience of illness and the provider's expertise in treating mental illness (Deegan, 2007), shared decision making is often contrasted with more authoritarian or paternalism approaches. In fact, it is an approach thought to bolster patient engagement and autonomy (Curtis *et al.*, 2010; Adams and Drake, 2006). But, in spite of calls for expanded use of shared decision making and a plethora of training programs touting its use, there has been seeming slow adoption within the discipline of psychiatry. It is reasonable to suspect that subtle resistance to shifting attitudes towards paternalism and other issues related to professional identity among psychiatrists may play a role in understanding that reluctance (Lepping *et al.,* 2016; Read, 2015). Thus, while the ultimate aim of the study was to increase awareness of shared decision making, the initial aim of the study was to understand how psychiatrists-in-training defined themselves as unique among physicians with an eye on how professional identity might shape approach to care. The second aim was to use those definitions and descriptions related to professional identity and tailor a brief training module to promote awareness of the shared decision making model.

The project was organized in two distinct phases around the two aims of the study (see Figure 1). As noted, the first phase involved focus groups with psychiatry residents designed to solicit and uncover important dimensions of their common professional identity and their current philosophical and practical approaches to decision making with patients. Building upon the

Figure 1 Project phases and corresponding activities



results of thematic analysis of the focus groups, the second phase involved designing and implementing a brief training session about shared decision making, which included a simple assessment component. Before detailing the methods and findings of the two phases of the project, we will first describe several basic premises of the article around the connection between professional identity and decision-making approaches, then provide some contextual and theoretical background about shared decision making in psychiatry.

Professional identity and decision making in mental health service provision

Professional identity refers to how one conceptualizes himself or herself in relation to their work. Within medicine specifically, professional identity means "how a doctor thinks of himself or herself as a doctor" (Wilson *et al.*, 2013, p. 369). Many factors are thought to influence professional identity, such as personal values, practice setting, interactions with clients and other providers, and social and cultural expectations related to geographic region or country of origin. Medical education, including residencies, obviously plays a significant role in the process of professional identity development for physicians and heavily influences their approach to treatment provision (Jarvis-Selinger *et al.*, 2012; Monrouxe, 2010; Wilson *et al.*, 2013; Wong and Trollope-Kumar, 2014; Guimón, 1997). Importantly for this study, research suggests that, for many health and mental health care professionals, adherence to a collective authoritarian identity can result in decision-making processes that limit participation of the client (Barry and Edgman-Levitan, 2012; Seale *et al.*, 2006). In a study with primary care patients, participants agreed that physicians with an authoritarian or overly paternalistic approach to care pose significant obstacles to collaborative decision making (Frosch *et al.*, 2012). Unfortunately, little research has been conducted on the professional identity of psychiatrists specifically. The extant literature includes a small smattering of studies of professional identity in the related professions of psychiatric nursing (Gregg and Magilvy, 2001; Bowers, 1997), clinical social work (Baylis, 2004; Gibelman, 1999; Glaser, 2001; Miehls, 2001), and psychology (Hage, 2003; Henriques and Sternberg, 2004; Mrdjenovich and Moore, 2004; Wiggins and Wedding, 2004). However, literature pertaining to professional identity in psychiatry is limited to anecdotal reflections (e.g. Jellinek, 1995; Pumpian-Mindlin, 1967) or the discussion of specific scenarios, such as identity and the pregnant psychiatrist (e.g. Tinsley, 2000).

The practice of shared decision making incorporates contemporary concepts of health literacy, evidence-informed care and person-centered practice. Specifically, those interested in expanding the health literacy of clients are interested in increasing a person's access to, and comprehension of, health care information needed to make decisions and follow-up with treatment recommendations. Those who embrace evidence-informed care as an ethical imperative are interested in increasing the reliance on techniques associated with empirically supported positive outcomes. And those interested in person-centered practice are interested in decreasing the primacy of paternalism, and instead increasing the voice of the patient/consumer/client and more explicitly putting patient goals and preferences at the center of care. Thus the prevailing climate in medicine in general and psychiatry in particular – which endorse the expansion of health literacy and person-centered care (as opposed to more rigid hierarchical authority-based approaches) – clearly affirm shared decision making as an important evidence-informed practice in mental health (Adams and Drake, 2006; Deegan and Drake, 2006; Deegan *et al.*, 2008; Hamann *et al.*, 2006; Hoffman *et al.*, 2014).

However, challenges and obstacles are well documented. In addition to philosophical doubts about the practice, research repeatedly finds that physician concerns over time demands, and their apprehension over the decisional capacity of clients have interfered with the uptake of shared decision making among psychiatrists (e.g. Beitinger *et al.*, 2014; McCabe *et al.*, 2013; Joosten *et al.*, 2008). That is, while psychiatrists readily express positive views and attitudes toward shared decision making and a willingness to embrace it, their actual use does not follow and they very quickly offer up serious concerns around client capacity and readiness to make decisions as reasons for their lack of implementation (Pollard *et al.*, 2015; Ali *et al.*, 2015).

Exposure to education and training related to shared decision making may be an important variable in the reception and application of these practice behaviors in a treatment context. Perhaps the

most ambitious and rigorous examination of training programs that relate to shared decision making to counteract barriers to implementation was conducted by Légaré and colleagues. They comprehensively searched for then examined 54 different training programs across 14 countries that taught anything related to shared decision making, the involvement of patients in treatment decisions, and the use of decision aids (Légaré *et al.*, 2012). Not surprisingly, they found tremendous variability in format and focus. In general, the training programs reviewed seem to target attitudes toward shared decision making and were geared toward already licensed doctors rather than other health care providers or to those earlier in their training (pre-licensed). We saw this gap as a unique and important opportunity. As will be described, our response was to develop a brief training program which intentionally targeted psychiatry residents early in their professional development with content that was tailored to promote awareness of the principles of shared decision making, emphasizing the consistencies and inconsistencies/tensions with various aspects of their professional self-identity, as revealed in the focus groups. In this way, both facilitators and potential barriers to adoption could be identified and addressed in the training.

The project

The focus groups (phase 1)

Method. In order to explore professional identity and approaches to decision making among psychiatry residents, the authors conducted focus groups with psychiatry residents and interns at (Virginia Commonwealth University). The sample for the focus groups was drawn from all residents in the Department of Psychiatry beyond the first year of training. In total, 28 individuals comprised this sampling frame, 11 from the second- and third-year classes and six from the fourth-year class. A co-primary investigator was the Director of Psychiatry Residency Education, and he assisted with the recruitment of subjects via e-mail. Using an approved script, he also made several announcements about the research project during a weekly meeting for psychiatry students. He was not present at any of the focus groups nor did he play any other role in the analysis of data.

The other researchers, all social workers, held three one and a half hour focus groups – one focus group each for second-year, third-year, and fourth-year residents – using a semi-structured facilitation guide to promote discussion around the research questions (see the focus group interview guide list provided below). Several overarching questions guided the first phase: How do psychiatrists-in-training describe their professional identity, treatment philosophy, professional tasks, and the nature of their own doctor-patient relationships? Focus groups also incorporated several case-based questions that explicitly solicited perceptions related to decision making around psychotropic medication, self-determination, use of authority, and philosophies of medication management as it related to provided patient scenarios. No identifiable information was collected, and no incentive was provided to participants other than light refreshments. All three researchers who conducted the focus groups independently kept extensive field notes on participant responses. In terms of data analysis, the group engaged in a collaborative process of thematic analysis, typically used with narrative data (Beaudry and Miller, 2016), whereby we came together to share and compare notes and engage in an iterative process of data reduction, eventually coming to consensus around the organized themes apparent in the data. The findings were then subjected to member checking in the second phase of the project, that is, participants were invited to comment on the perceived accuracy of the researcher's interpretations and findings. Member checking is one accepted technique for establishing credibility to subjective analysis of narrative data. Both phase 1 and 2 of our project were approved as "exempt" by the University's Institutional Review Board/Human Subjects Committee.

Questions about professional identity:

1. What word or phrase would you use to describe a "psychiatrist"?
    - Prompts: explain word choice; most important qualities/attributes
2. What does it mean to be a psychiatrist?
    - Prompts: professional tasks; differences/similarities to other medical specialties and other mental health providers; perceptions of patients and other medical professionals

3. What aspects of "being a psychiatrist" are most important to you?
    - Prompts: role enjoyment, central activities, choice of psychiatry as a specialty
4. How would you describe the doctor-patient relationship in psychiatry?
    - Prompts: what does it depend on? The psychiatrist's role Ideal relationship?

Questions about decision-making practices:

1. In your own practice of psychiatry, how do decisions typically get made about the type and dosage of medication to use for treatment?
    - Prompts: what does it depend on? Initial decisions about type and dosage made the same or different from adjustments or maintenance medications?
2. How do you typically present information on potential therapeutic and side effects of medication with patients?
    - Prompts: levels of information sharing, hesitancy around side effects
3. Are you familiar with the term "shared decision-making"? What does it mean or look like in psychiatry?
4. How does the "shared decision-making" model fit or conflict with the values and philosophy of care in psychiatry?
    - Prompts: does psychiatry have "values," does it fit or conflict with client-centered medicine or your own approach/values/practice philosophy, contrast with "informed choice" or "medical model" (implies passive recipient of care)
5. What concerns do you have about patient involvement in decision making?
    - Prompts: competence to decide, patient level of knowledge, "insight," liability,
6. Are there benefits to patient involvement and using a "shared decision-making" approach?
    - Prompts: enhanced relationship, adherence, goal achievement

Patient scenarios discussed in focus groups:

1. Jeremiah is a 19-year-old, male college student visiting the student health clinic for the first time. He reports that he has been feeling down for about three months. He reports multiple symptoms of major depressive disorder, including depressed mood, irritability, decreased appetite, hypersomnia, and occasional suicidal ideation. He wants to find a treatment option that will help him feel better, but he reports several concerns about taking medication. No one in his family has ever taken anything other than antibiotics, and he grew up believing that illness, especially mental illness, is a sign of weakness. He is also worried about what his friends would think if they found out he is having "emotional problems."
2. Darlene is a 36-year-old female attending a routine medication management appointment at the neighborhood health clinic. Darlene has a diagnosis of paranoid schizophrenia and a history of medication non-adherence. She is currently prescribed 500 mg of Seroquel (quetiapine) and 1 mg of Cogentin (benztropine) daily. Darlene has reported a decrease in delusional content and auditory hallucinations as well as a moderate improvement in daily functioning since switching to these medications from her previous regimen six months ago. During her appointment, Darlene states that she would like to stop taking the Seroquel because she has noticed a substantial weight gain since switching to the medication. Darlene's roommate at the group home suggested that Darlene try Invega, which has worked well for the roommate.
3. Monica is a 52-year-old female visiting the emergency room after experiencing a panic attack. Monica is currently prescribed 100 mg of Zoloft (sertraline) daily by her primary care physician, which she has been taking consistently for over five years for the treatment of Generalized Anxiety Disorder. This is the first time she has experienced a panic attack, and she visiting the emergency room because she believed she was in cardiac arrest. She is presenting as extremely agitated, and she is very anxious about potentially

experiencing another panic attack once she is discharged from the hospital. She requests some form of medication that will help her calm down and avoid future panic attacks.

Questions about patient scenarios:

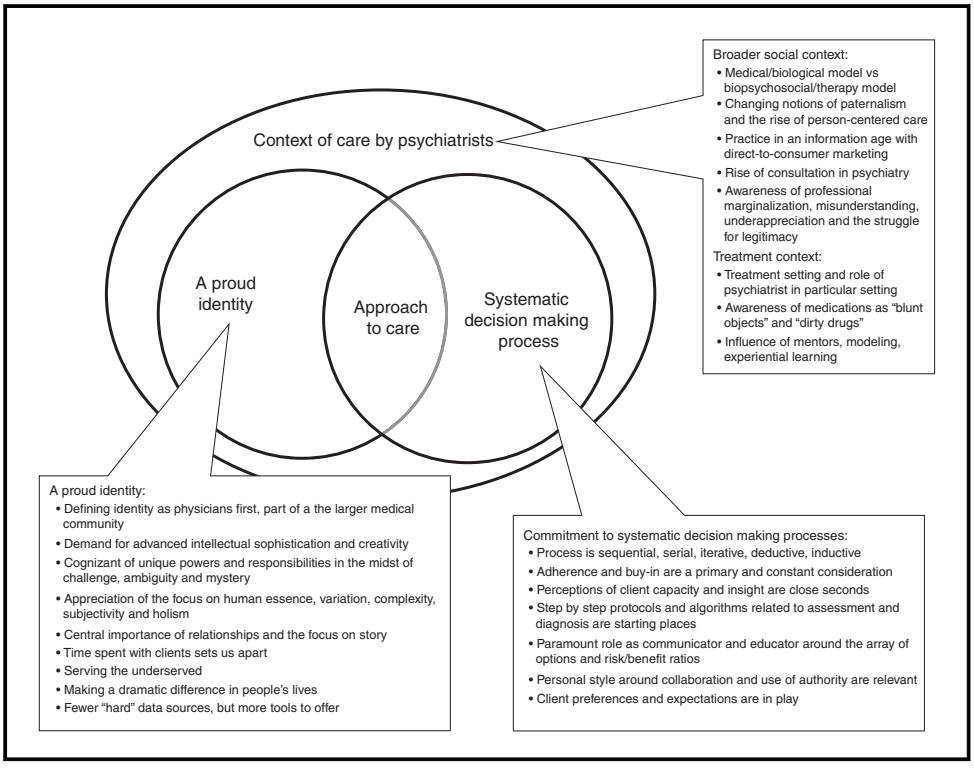
1. How special concerns might you have regarding this client?
   - Prompt: explain, compare/contrast with other clients
2. How would you approach the decision-making process with this client?
   - Prompt: factors influencing process, goals for session
3. What do you think shared decision making would look like with this client?

Findings. A total of 18 of the 28 eligible psychiatry residents participated in one of the three focus groups (64 percent). The most important findings relate to three major themes that emerged from the data that are summarized in Figure 2 and discussed below:

1. the central role of societal and treatment contexts in shaping their professional identity and approaches to care;
2. a professional identity characterized by a great sense of pride; and
3. a strong commitment to systematic decision-making processes in practice.

That is, the focus group data palpably revealed that if one wants to understand the professional identity of psychiatry residents and their approach to care and decision making, one must understand the defining importance of the broader social context of psychiatry as well as how specific treatment contexts influence care. Specifically, the data suggested that psychiatrists really must come to terms with the tension in in their discipline between the medical/biological model of treatment vs the biopsychosocial/therapy model of care, as well as changing notions of paternalism and the rise of person-centered care. According to this group of residents, the fact that psychiatry practice today takes place in an information age with direct-to-consumer

Figure 2 Thematic findings



marketing of psychotropic medications (at least in the USA) has a major effect on care and especially patient-provider communication. Further, they said that to truly appreciate the context of care, psychiatrists have to be aware of their own historic professional marginalization, misunderstanding, and underappreciation relative to their peers in other medical specialties. Said one participant: "Psychiatrists struggle with the question of legitimacy because people don't understand what we do." Another remarked "People can say whatever they want about psychiatrists or look down on us, but I like what I do." At the same time, in terms of their identity, residents in this study were quite aware of the power they wielded as prescribers to affect people's lives including wielding the management of potent psychotropic medications. "There's more power in this specialty than others, like the power to detain." "Our medications are dangerous 'dirty drugs' and blunt objects" so-called for their robust and pervasive therapeutic effects as well as negative side effects. They noted the influential role of mentors, modeling, and experiential learning on both their identity and approach to care. In addition to the larger social context of care, the residents spoke extensively about how their professional identity and roles shift depending on treatment setting. How one sees oneself and approaches care depends at least in part on whether one is operating in an emergency room of an urban hospital, a public community mental health clubhouse program, or in a suburban outpatient private practice.

The second palpable theme that emerged from the focus groups was the unmistakable pride these residents felt in regard to being psychiatrists. They clearly saw themselves foremost as part of the larger medical community. "Before we are psychiatrists, we are physicians" said one participant succinctly. They expressed pride in the fact that their particular specialization demands advanced intellectual sophistication and often calls for creativity in responding to patient needs and demands. They were cognizant of the unique powers and responsibilities of their discipline in the midst of everyday challenges, ambiguities and mysteries. "There's more of an art to psychiatry and a lot of unknowns," remarked one participant. Likewise, they appreciated the focus of psychiatry on human essence, variation, complexity, subjectivity, and holism. They noted that, in their work, relationships were of central importance and the focus of their practice was people's whole lives. "We get to know them on a personal level." They noted that psychiatrists typically spend more time with their patients than other medical specialties and have a special commitment to serve the underserved. "We are more patient with our patients, and have the privilege of time, more time to listen to their story." While they acknowledged they have fewer "hard" data sources compared with other medical specialties (no x-rays or lab tests) they may actually have more tools to offer (a range of medications, different therapies, referrals to a plethora of resources) and often make a dramatic and lasting difference in people's lives.

Finally, as a third major theme, the data revealed a firm commitment to systematic decision-making processes around treatment choices, including the prescription of psychotropic medications. Their training to date had taught the psychiatry residents that decision-making processes are sequential, serial, iterative, and involve both deductive and inductive thinking. They admitted that, to them, adherence and patient "buy-in" are absolutely primary and are literally constant considerations in negotiating with patients about medication. "The more buy-in, the better off we are all going to be." Their own perceptions of client capacity and insight are also highly influential in shaping patient receptivity during treatment planning. In making decisions with patients around medication, they begin with step-by-step protocols and algorithms related to assessment and diagnosis and proceed from there. They acknowledge that personal style around collaboration and use of authority are clearly relevant, as suggested by the literature cited earlier. They define as paramount their roles as communicator and educator around the array of options and the risk/benefit ratios associated with them. Client preferences and expectations are in play in decision making, according to the residents, but they did not emerge as a predominant consideration. "I try to give patients choice, if they have the capacity […]."

A pilot training module on shared decision making (phase 2)

Method. After phase 1, the researchers took the above thematic findings into account in designing a brief teaching module, described in detail below. Specifically, content for the training was planned so that it directly and extensively addressed the themes that emerged from the focus groups, especially

how shared decision making compares and contrasts with how the residents defined and described themselves – their professional identity – and how they already think about decision making. Specifically, we framed the training around how the use of shared decision making echoes and affirms aspects of their professional identity, as well as raises some tensions for their current approach to care, as they described it. For example, in terms of "tensions," we noted that truly embracing shared decision making might suggest rethinking the rigidity of the current provider-patient hierarchy and increasing their use of person-first language. We noted that shared decision making calls for even more solicitation of client experiences and preferences and that "buy in" may look and feel different in that it would be more mutually achieved. The shared decision making approach demands that the residents explicitly encourage client inquiry and their search for existing information about their treatment and medications.

On the other hand, the training also highlighted how shared decision making data affirms the part of their professional identity that wants and needs to respond to human diversity and human complexity. It calls for greater awareness of the use of power and authority, and allows for creativity, free thinking, and management of shades of gray, all disciplinary characteristics that the residents were proud of. Likewise it clearly affirms pursuing client "buy-in," validates their professional roles as communicators and educators, and affirms that decisions should be the result of an intentional processes. Shared decision making validates the importance of story and increases the likelihood of a strong therapeutic relationship, again all characteristics that the focus groups revealed are important to the identity of these soon-to-be psychiatrists. Finally, shared decision making loudly affirms that treatment setting, the social milieu, and context matter deeply, the first major theme of the focus groups.

The researchers implemented the training three times in individual 1.5 hour sessions on shared decision making in psychiatry to three different waves of the psychiatry residents. Each session was open to all four classes of residents, 39 people in all (our sampling frame from phase 1, plus the first-year class). In all, 22 participated in the training (56 percent). As outlined in the list given below, the training involved didactic presentation that defined shared decision making and put it in its general scholarly and scientific context, reviewed needed competencies for mastery, then presented an overview of the literature on shared decision making and decision aids in psychiatry. An extensive bibliography on shared decision making was provided and briefly reviewed (available from the authors upon request).

Outline of brief training on shared decision making:

1. Definition of shared decision making in health care
    - The context
        - Decision science, health literacy and evidence-based practice
        - Emerging emphasis on lived experiences of patients and patient-centered care in contrast to paternalism and hierarchy
    - Building specific competencies in shared decision making
        - Creation of an appropriate communication milieu
        - Enacting systematic process/steps in shared decision making
        - Using decision aids effectively
2. Psychiatry and shared decision making
    - An ethical and empirical imperative?
    - Critical overview of psychiatric literature on shared decision making
    - Implications for professional identity
        - Where are the affirmations/validation?
        - Where are the tensions/needed shifts?
3. Identity, professional roles, and "shared decision-making" in four psychiatric contexts (ER, inpatient, outpatient, consultation)

The training ended with a role play exercise, which also served as an assessment activity. Specifically, after each of two six minute role play activities where participants took turns playing the role of psychiatrist and patient, each completed either the "physician" version or "patient" version of an adapted shared decision making questionnaire (Kriston *et al.*, 2010), which had respondents rate 13 items on a six point Likert scale. Items included such statements as "My patient's (My) preferences are directly reflected in this treatment decision" and "My doctor (I) asked me (my patient) which treatment option I (he/she) prefers."

Findings. Given the methodological limits of our assessment, its main purpose was to get a sense of participants' responses to the module and a vehicle for post-training reflections on the experience. Results of the assessment were overwhelmingly positive with respondents strongly agreeing or completely agreeing with all of the statements that affirmed the use of shared decision making practices. The statements with the strongest endorsement were "My doctor wanted to know exactly how I wanted to be involved in making the decision" and "My doctor created space where I felt open to asking questions, voicing opinions and generally sharing their input towards the decision" ($N = 20$). "Psychiatrists" were harder critics of themselves than their "patients," however. The two statements incurring the most disagreement following the role plays was "I explained to my patient why their input is important to this decision" ($N = 6$) and "I precisely explained the advantages and disadvantages of the treatment options to my patient" ($N = 7$).

The researchers also administered a brief questionnaire with two items asking about what participants learned about shared decision making practices and how their approach to care provision might change as a result of participation in a one and a half hour training provided by the researchers. All 22 respondents affirmed they learned the importance and logistics of shared decision making. When asked what, if anything, they might do differently in their practice as a result of participating in the session, respondents were quick to commit to increasing their use of the model and doing "more" to embrace its major tenets of listening and inclusion: "I will ask patients specifically how exactly they want to be included in the treatment and how they want to be helped," "I will be mindful of the patient and their opinion," and "I will more actively solicit patients input and wait for patients to speak up," and "I like (the idea of using) decision aids." Thus, while the assessment lacks rigor for any generalizability or statements of causality, responses likely affirm the training tailored around professional identity as a possible vehicle for effective exposure to the concept of shared decision making and served as a useful avenue for self-reflection about needed changes to more fully embrace the practice.

Discussion

In phase 1, we started with the ideas that professional identity and approach to decision making in psychiatry were connected in some way and that understanding more about those connections might help inform training around the developing practice of shared decision making. What emerged is that approach to care takes place in an evolving social and treatment context, and is likely influenced by both a proud professional identity and a commitment to systematic processes of decision making. While recent research that investigated psychiatrists' approach to diagnostic and treatment decision making found that intuition, reasoning, evidence, training and collegial conversations were all influences on their approach to decision (Bhugra *et al.*, 2011), we speculate that imbedded in those things may very well be important notions of professional identity. Interestingly, this same research also showed that more experienced psychiatrists tend to rely more on "intuition" rather than systematic guidelines or algorithms. Thus, more inquiry may be needed to tease out the complex meanings of "intuition" and how professional identity might enacted in such approach to care as psychiatry residents' transition to board certified practicing clinicians.

Another key finding is that the context of care, both the larger social context as well as the smaller treatment context, such as type of setting, might be very important to psychiatrists' approaches to care and their nuanced level of paternalism and use of authority. These interrelationships call for future inquiry. For example, treatment setting may have been important distinction to our resident participants because nature of patient-provider relationships is vastly different in different

settings. This would echo the findings of Matthias *et al.* (2013) who found that the context of the patient-provider relationship, especially in terms of trust and longevity, shapes the degree to which shared decision making is embraced. Since we noted earlier in the paper that authoritarian or overly paternalistic attitudes are thought to serve as barriers to shared decision making, more inquiry may be needed into the association between trust, relationship longevity and power and paternalism, as a way to bring greater insight into the adoption of shared decision making (Joseph-Williams *et al.*, 2014).

In terms of phase 2 and training for shared decision making, we speculated that explicitly infusing content on how professional identity is affirmed or potentially challenged when using shared decision making may be an effective strategy for the future. Admittedly, future research will have to investigate whether or not including such content is empirically connected to successful training on shared decision making. Likewise, future research should also look at the reciprocal impact of effectively using shared decision making on the affirmation of professional identity among psychiatrists, and indeed all who embrace patient-centered care.

Conclusion

Légaré and colleagues recently pointed out that "(a)lthough obstacles continue to slow the scaling up of shared decision making across the health care continuum, shared decision making is making progress" (Légaré and Witteman, 2013, p. 282). In light, the current lack of routine inclusion of curriculum content related to shared decision making in medical education, large scale training workshops with both medical and psychiatry residents have shown promise in teaching skills in shared decision making (e.g. Simmons *et al.*, 2016; Morrow *et al.*, 2011). It may also be true, however, that shorter and smaller scale shared decision making training projects like ours that use fewer resources may also offer potential for that expansion. We also hope, however, that our project inspires more explicit attention to the relationship between decision making and issues of professional identity, authority and paternalism, especially how instilling both disciplinary pride in psychiatry and truly embracing contemporary models of patient-centered care, may advance the acceptance and use of shared decision making in psychiatry.

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