



Shared Decision-Making

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Abstract

Shared decision-making has been called the crux of patient-centred care and identified as a key part of change for improved quality and safety in healthcare. However, it rarely happens, is hard to do and is not taught – for many reasons. Talking with patients about options is not embedded in the attitudes or communication skills training of most healthcare professionals. Information tools such as patient decision aids, personal health records and the Internet will help to shift this state, as will policy that drives patient and public involvement in healthcare delivery and training.

“meeting of experts” – the physician as an expert in medicine and the patient as expert in his or her own life, values and circumstances (Tuckett et al. 1985). The doc prescribes but the patient takes the pills (or doesn't). Trends in healthcare policy emphasize involvement of community and service users in many aspects of their care. Indeed, the popular enthusiasm of governments for self-care initiatives cannot be imagined without such involvement. However, authentic involvement surely requires participation in decision-making.

SDM and Patient Safety

The relevance of SDM to patient safety has been highlighted by at least three important concepts. First, major reports and publications about patient safety, such as the Bristol Inquiry (Bristol Royal Infirmary Inquiry 2001) and *To Err Is Human* (Institute of Medicine 2000), have produced important and relevant responses (Department of Health 2002; Institute of Medicine 2003). These responses have insisted on patient involvement in decision-making and training of health professionals for “new rules” for 21st-century healthcare that make the patient the “source of control.” Put simply, a key component of patient-centred care is shared and informed decision making. Second, prescribing errors and (lack of) adherence to medicines

Shared decision-making (SDM) between physician and patient is an idea founded in ethics and the law and in some evidence of superior health outcomes. SDM is the practical reconciliation of respect for persons (autonomy) and the monopoly and power of physicians: a middle ground between “nanny-knows-best” paternalism and rampant consumerism. SDM includes the notion of a medical encounter as a

have raised economic and health concerns. It is believed that some errors and adverse events in healthcare can be avoided through patient involvement. Patients' poor compliance and their inappropriate use of medicines arise from poor communications, a lack of understanding by the patient of how the drug is expected to work and what its side effects might be and a failure to find common ground or concordance between the patient and physician (Dowell et al. 2007; Royal Pharmaceutical Society of Great Britain and Merck Sharp & Dohme 1997).

Third, evidence-based medicine and the revelation of great variations in healthcare in even small, geographically limited areas are further evidence of the need for SDM. The large variation in rates of discretionary surgery, for example, for joint replacement or benign prostatic hypertrophy, can be reduced by SDM. This phenomenon has been advanced as providing the opportunity (in the United States) to reduce unnecessary care (and consequent possibility of harm) as well as provide financial savings (Wennberg et al. 2007).

What Are Characteristics of SDM?

Previously, I have argued that a key characteristic of SDM on the physician's part is the conscientious and judicious search for, and offering of, choices; without choice, there is no decision (Godolphin 2003). This is one element of the set of competencies that my colleague, Angela Towle, and I, and others, have identified. A physician (or other healthcare professional) should have to inform patients and engage them in SDM (Makoul and Clayman 2006; Towle and Godolphin 1999). Physicians ought to be able to do the following:

1. Develop a partnership with a patient
2. Establish or review the patient's preferences for information (e.g., amount or format)
3. Establish or review the patient's preferences for his or her role in decision-making (e.g., risk taking and degree of involvement of self and others) and the existence and nature of any uncertainty about the course of action to take (decisional conflict)
4. Ascertain and respond to the patient's ideas, concerns and expectations (e.g., about disease management options)
5. Identify choices (including ideas and information the patient may have) and evaluate the research evidence in relation to the individual patient
6. Present (or direct the patient to) evidence, taking into account points 2 and 3, above, framing effects (how presentation of the information may influence decision-making) etc.; help the patient to reflect upon and assess the impact of alternative decisions with regard to his or her values and lifestyles
7. Make or negotiate a decision in partnership and resolve conflict

8. Agree upon an action plan and complete arrangements for follow up

SDM may also involve a team of health professionals, involve significant others (partners, family) and differ across cultural, social and age groups. In addition, SDM is not the only option. There are several related terms and "movements" with similar, congruent or complementary intents, such as concordance and evidence-based patient choice (Edwards and Elwyn 2001).

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Does SDM Happen?

A decade of attempts to measure and teach the (mostly communication) skills needed for SDM reveals a great gap between theory and practice. A good level of SDM occurs about 10% of the time. When Braddock et al. (1999) reviewed consultations with surgeons and primary care physicians, only 9% met the full criteria for SDM. Observations of videotaped consultations submitted for qualifying examination showed that the concepts of "checking of understanding, and the involving of patients in decision making ... are rarely demonstrated" (Campion et al. 2002: 692). Distinguishing elements of SDM occurred in 0–11% of audiotaped patient interviews with general practitioners (Elwyn et al. 2003). In another study, six family doctors, well-regarded for their patient-centred practice, attended a training workshop. Of the 196 audiotaped office encounters, 70% did not meet even the minimal criteria of options being mentioned (Towle et al. 2006). Of 287 audio-recorded interactions by 152 primary care physicians, the average score for OPTION (observing patient involvement; a validated observational instrument to assess SDM) was 11 out of a possible 48; none of the interactions scored over the mid-point (Young et al. 2008).

The primary role of the clinician should be to relieve suffering and enhance autonomy. That is, the patient should leave the doctor (or healthcare system) more independent, self-reliant and able than when he or she arrived, not more dependent and disempowered. SDM is a means to this end. However, the effort to achieve this has to come more from the doctor than from the patient because the doctor has the legal monopoly and the power of knowledge – the doctor has to take the initiative.

Why Is SDM Rare?

Physicians have no natural place for SDM in their usual medical interview script. Their learned sequence of the short office inter-

view is to listen to the patient's story, take a history and carry out a physical examination, make a diagnosis and prescribe a management or treatment. The proper place to engage patients in SDM, and hence to exercise many of the competencies listed above, is after the problem has been defined and before the management plan has been decided upon. This is the "neglected second half of the consultation" (Elwyn et al. 1999).

Patients do not expect SDM; nor do they overtly object to its absence, at least not usually to the physician. Patients are generally disempowered in their encounters with physicians. They feel intimidated and unable to make a difference in the relationship, are reluctant to bother the doctor – especially in the current climate of belief that the healthcare system is "a wreck" – and do not understand the language or know the script. Patients prize a good rapport with health professionals, which they equate with increasing their likelihood of getting good care, and they avoid assertiveness, which may jeopardize the rapport (Towle et al. 2003). This disempowerment of patients, when they confront the healthcare system, leads to misunderstandings and "wimpish" behaviours that can have important adverse outcomes (Britten et al. 2000; Berland 2007).

Audit is currently not possible. These are not the sorts of things that are entered into the written (paper-based) medical record, though the fixed format of the electronic medical record could be adjusted to remind or force entries about which options were considered or discussed. Indeed, this concept was recommended over a decade ago in the Krever Report (with respect to blood transfusion): "That the treating physician document in the patient's medical chart that he or she has discussed the risks, benefits, and alternatives" (Krever 1997: 1134).

The communication skills associated with SDM are difficult to learn and practise. Any complex communication involves attitude, effort and time to acquire or change. In this way, SDM is no different from and actually resembles learning a new language. One has only to try, in one's normal daily life, to consistently engage significant others in SDM, to discover how challenging it can be! Many barriers have been identified (Légaré et al. 2008; Towle et al. 2006). Time constraints have been the most frequently anticipated or perceived barrier, a reason given by physicians for why they do not practise SDM. In fact, SDM probably does increase the time required since its inclusion would represent a new component of the consultation, but studies have not consistently shown superior communication achieved with longer time spent. Skill must surely be a major factor, but, to date, there are no reported studies of a cohort of physicians skilled in the art, thus leaving this question unanswered.

The skills and habits of SDM are not currently learned in undergraduate or postgraduate medical training – the very time when physicians acquire their medical identity (O'Flynn and Britten 2006) and develop their interviewing and consulta-

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tion scripts. Although in the past decade, formal communications training has become part of most medical undergraduate training, the focus has remained mainly on skills such as getting information from the patient and delivering bad news. Furthermore, most of the communication skills of healthcare professionals are learned from their role models during the clinical apprenticeship – and judging from the evidence of studies quoted above, good role models for SDM are rare. The underlying essence of SDM is choice, but the training that medical students experience is largely about having the single best answer. When interrogated by their preceptors or responding to multiple choice examination questions, learners rarely have the opportunity or are challenged to include the effect of variability in patient preferences, values, ideas, concerns or expectations.

Another perceived barrier is that of practice guidelines and protocols, though the proponents of evidence-based medicine consistently emphasize the importance of patient preference in clinical decision-making (Haynes et al. 2002). However, there is an intrinsic potential for conflict between autonomy (patient choice) and beneficence (the physician's need to do good). What if the patient, made aware of the choice between drug A (the doctor's preference, based on the evidence of population studies or the opinion of a colleague) and drug B (less effective but easier to swallow), chooses the latter? To many physicians, it might seem much easier simply not to mention the choice and to thus perpetuate passivity.

What Will Make a Difference?

Society

The doctor-patient relationship is changing. We are living in a more consumerist society, with better-informed patients (e.g., from their use of the Internet), a greater public involvement in healthcare institutions and a gradual movement away from paternalism and closer to the ethical imperative of autonomy (Coulter 2002).

Regulatory Pressures

Laws and professional guidelines have increasingly adopted the language of SDM in rules about consent. Recent guidelines from health professional bodies in Canada, the United States, the United Kingdom and Australia (Australian Council for Safety and Quality in Health Care 2005) now prescribe SDM as part of training programs and good practice. For example, in the United Kingdom, the General Medical Council states:

Whatever the context in which medical decisions are made, you must work in partnership with your patients to ensure good care. In so doing, you must:

- (a) listen to patients and respect their views about their health
- (b) discuss with patients what their diagnosis, prognosis, treatment and care involve
- (c) share with patients the information they want or need in order to make decisions
- (d) maximise patients' opportunities, and their ability, to make decisions for themselves
- (e) respect patients' decisions.' (2008: 6)

These remarkable words mirror the elements of SDM, and the GMC declares this statement to be an "overriding duty or principle." In addition, the admonition is added that "serious or persistent failure to follow this guidance will put your registration at risk" (General Medical Council 2008: 5). These are strong directives – but they seem to assume that one simply must want to do these things and the skill will be there.

Trends in Medical Education

Medical schools have increasingly expanded communication skills training beyond history taking and delivering bad news. There is a busy-ness with change in medical education today, a century after the last major re-creation following the Flexner report (Flexner 1910). The important (often negative) influence of the learning environment – the hidden curriculum (Hafferty 1998) – on physicians in training and on curriculum reform is recognized and being addressed by accreditation standards. Examples of the hidden curriculum of relevance to SDM are the lack of respected role models who practise SDM and the rewarding of confidence, control and the "right answer." The American Medical Association (AMA) notes that, among problems, "physicians are trained to believe it is important to have 'the answer'" and "are socialized to be 'in charge' and desire to act as autonomous decision-makers in the care of their patients" (2007: 14). AMA recommends changes to the student evaluation system – applying the educator's credo that assessment drives learning – to permit the acknowledgement of uncertainty.

The movement toward inter-professional education for collaborative patient-centred care may also force physicians to modify their assumption of autonomy and shift the culture toward SDM. However, there is also the danger of increasing decision-making among the myriad of health professionals who might be caring for one patient and diminishing the patient's voice. The use of simulation and virtual patients as an approach to the teaching of and learning about SDM is underdeveloped, although it has been used increasingly in other areas of communication training. Movements toward the active involvement

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of patients as educators of health professionals also have the potential to change attitudes and health professional culture (Farrell et al. 2006).

New Formats of Healthcare Records

Another stimulus for change will come from the electronic medical record, to which patients have access, and from the patient-held medical record. The latter especially, although still technologically immature and fraught with cultural and social issues, will not only shift the power balance but will be a strong stimulus for patients to ask questions and may be a spur to greater clarity and accountability on the physician's part.

Decision Support Tools

Proponents of SDM have developed the tool of decision aids and the idea of decision support for patients. This very active pursuit has yielded a range of information about options and outcomes and a guide to help patients consider their own values. Decision aids are often designed to be used as a complement to the medical consultation and have been shown to be effective in prompting greater involvement by patients. Currently, decision aids have been developed and made available for several dozen, mostly chronic, conditions (Ottawa Hospital Research Institute 2009).

Conclusion

The "informed" patient, consumer power and a demand for accountability by the public may ultimately be more powerful drivers than the ethical imperative of autonomy and the modest evidence of improved health outcomes. The rhetoric of the patient safety movement seems well salted with the term patient-centred care. Perhaps SDM, which has been referred to as the crux of *patient-centred care* (Weston 2001), deserves to have a higher profile in the deliberations and interest of quality healthcare and, ultimately, that of patient safety. Greater SDM is certainly possible, given the motivation, role models, time and training to acquire the skills (competencies). What is wanted are the external "carrots and sticks" that will motivate continual effort to improve. Without those, the development of our understanding of the best ways to learn and apply these unfamiliar communication skills will continue to be slow; the fundamental ideas and benefits were articulated 25 or more years ago. **HQ**

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