Shared Clinical Decision Making

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Most patients want to play an active role in their own health care. There is now a movement from medical paternalism to patient-centered care in the consultation process that is based on the therapeutic alliance and negotiation between the doctor and patient, aptly named "shared decision-making" (SDM). It is a process where doctors work together with patients, including their families and caregivers, to select tests, treatments, management, or support packages, based on clinical evidence and personal informed preferences, health beliefs, and values. Successful implementation of SDM is associated with improved quality of consultations, favorable patient-reported health outcomes, and increased patient and doctor satisfaction. Patients are empowered to make proactive health decisions resulting in decreased anxiety, faster recovery, increased treatment compliance, and reduced unnecessary health care expenditure. There are multiple existing models in facilitating SDM. Two simple and easy-to-follow models are the "three-talk model" and "S.H.A.R.E. approach." The three-talk model endorsed by the NICE divides the SDM consultation into three steps, namely: team talk (explaining the need to consider treatment options as a team), option talk (describing the alternatives in more detail, and making use of patient decision aids [PDA] whenever appropriate), and decision talk (helping patients explore and form their personal preferences). On the other hand, the S.H.A.R.E. approach promoted by the Agency for Healthcare Research and Quality (AHRQ) is a five-step SDM consultation process that includes exploring and comparing the benefits, harms, and risks of each treatment option through meaningful dialogue about what matters most to patients.

Key words: Evidence-based family practice, Shared decision making

From Paternalism to Patient-Centered Care

Doctors, being the "knowledgeable experts," were historically entrusted by patients to make health care decisions on their behalf and with their best interests in mind.[1] However, contemporary evidence suggests that there are substantial differences between what patients want and what doctors think patients want, otherwise known as "preference misdiagnoses."[2] Most patients want to play an active role in their own health care. One study reported that half of patients in the primary care setting believed that patients and doctors should discuss, negotiate, and deliberate on health care decisions together.[3] Over several decades, this movement from medical paternalism to patient-centered care called for a consultation process that is based on the therapeutic alliance and negotiation between the doctor and patient, aptly named "shared decision-making" (SDM).

Elements of SDM

The UK National Institute for Health and Care Excellence (NICE), defined SDM as a process where doctors work together with patients, including their families and caregivers, to select tests, treatments, management, or support packages, based on clinical evidence and personal informed preferences, health beliefs, and values. It involves the provision of evidence-based information about options, outcomes, and uncertainties as well as making sure that the patient has a good understanding of the risks, benefits, and possible consequences of different options through information sharing, collaborative discussion, and decision support counseling.[2,4]

Shared decision making recognizes that both the doctor and the patient bring two different but complementary forms of expertise into the decision-making process (Figure 1). Doctors are the experts in medical diagnosis, disease etiology, prognosis, treatment options, and outcome probabilities. On the other hand, patients are the experts in their illness experiences, social circumstances, attitudes towards risk, values, and preferences.2 While doctors may know what's best for their patients based on available evidence, ultimately the patients know what is important and acceptable to them. Both parties have equal decision-making power that is maintained by good rapport and a trusting professional relationship.[5]

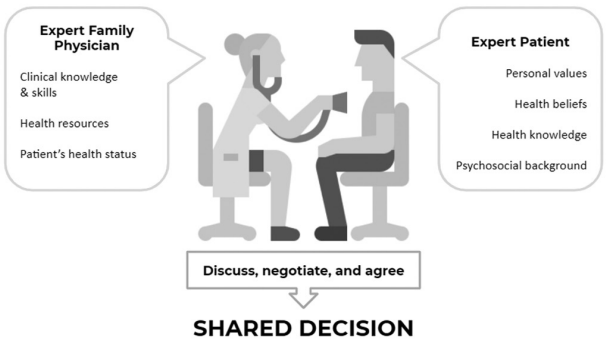

Figure 1. Shared decision-making model: family physicians and patients as experts[5]

Evidence-Based Medicine and Patient-Centered Communication in SDM

Shared decision making is grounded on the combination of evidence-based medicine (EBM) and patient-centered communication (PCC) skills (Figure 2). EBM involves searching for and appraising up-to-date research evidence relevant to addressing the patient's clinical dilemma, applying this evidence, and evaluating its effects. Meanwhile, PCC employs communication skills and counseling techniques to explicitly bring the best available evidence into the consultation; discuss management options with patients in consideration of their values, preferences, and circumstances; and facilitate informed decision-making. Without EBM, patient preferences may result in uninformed and unsafe decisions. Likewise, without PCC, EBM can turn into evidence tyranny. In SDM, patients need both to attain the optimal level of care.[6,7]

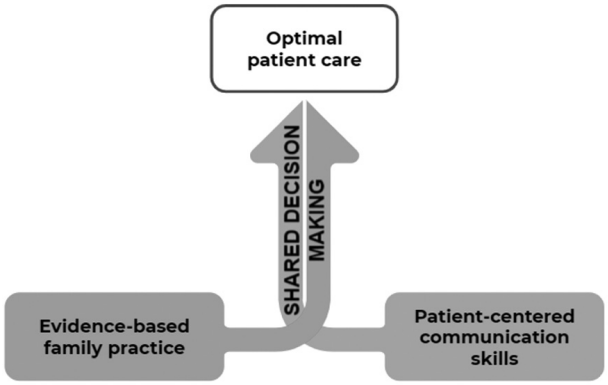

Figure 2. Shared decision-making model: evidence-based medicine and patient-centered communication[6]

Benefits of SDM

Successful implementation of SDM is associated with improved quality of consultations, favorable patient-reported health outcomes, and increased patient and doctor satisfaction. Patients are empowered to make proactive health decisions resulting in decreased anxiety, faster recovery, increased treatment compliance, and reduced unnecessary health care expenditure.[8,9] Overall, routine patient-doctor collaboration and deliberation of well-informed preference-based health care decisions lead to safer and more cost-effective health care, which in turn results in improved health outcomes, reduced utilization rates, and a positive feedback loop (Figure 3).[10]

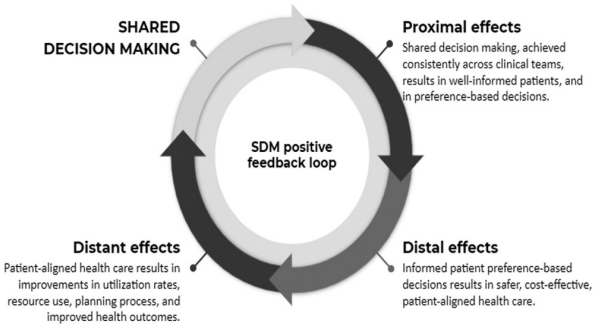

Figure 3. Effects of shared decision-making[10]

The benefits of SDM extend beyond individual patients and their families to higher-level systems. At a group practice level, new norms are established where collaboration and deliberation become expected behaviors. Changes in utilization patterns brought about by SDM spurs changes in delivery structure and capacity at an organizational level, potentially leading to fewer legal challenges. At the level of a healthcare delivery system, SDM can lead to better policies leading to more cost-effective care, and investment in population health and its determinants.[10]

When to Use SDM

Considering the benefits enumerated above, family and community medicine physicians are encouraged to employ SDM in their own practice, for most of their patients. SDM is most applicable in the following scenarios:

1. When recommendations are in conflict with each other
2. When insufficient evidence exists to recommend for or against an intervention
3. When multiple possible interventions have approximately equal effectiveness
4. When the benefits and risks of an intervention vary for different patients
5. When patients weigh the benefits and risks of an intervention differently, based on their personal values, preferences, and circumstances.

However, it is important to note that SDM cannot be applied in the following:

1. When the intervention is clearly harmful

2. When the best choice of intervention is clearly evident based on quality and cost-effectiveness
3. When the patient explicitly communicates that he/she does not want to be involved in the SDM process.

Moreover, keep in mind that declining to share the decision-making is a patient decision in itself but it does not absolve the doctor of the responsibility in explaining the treatment options to the patient.[2,4]

The S.H.A.R.E. Approach to SDM

There are multiple existing models in facilitating SDM. The models may vary in the number and label of steps, but the objectives are the same: to guide the patient through a step-wise process in order to arrive at an informed decision, having taken into consideration patient values, preferences, and circumstances. Two simple and easy-to-follow models are the "three-talk model" and "S.H.A.R.E. approach." The three-talk model endorsed by the NICE divides the SDM consultation into three steps, namely: team talk (explaining the need to consider treatment options as a team), option talk (describing the alternatives in more detail, and making use of patient decision aids [PDA] whenever appropriate), and decision talk (helping patients explore and form their personal preferences).[11]

We also recommend using the S.H.A.R.E. approach promoted by the Agency for Healthcare Research and Quality (AHRQ). It is a five-step SDM consultation process that includes exploring and comparing the benefits, harms, and risks of each treatment option through meaningful dialogue about what matters most to patients (Figure 4).[8]

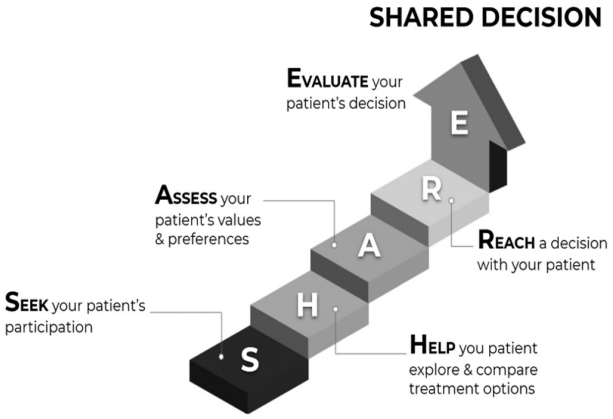

Figure 4. S.H.A.R.E. approach[8]

The first 3 steps in S.H.A.R.E. are congruent with the elements of communicating evidence to patients in the article Communicating Health Information to Patients. Active listening skills and primary counseling techniques such as the Catharsis-Education-Action (CEA) method, SPIKES model, and motivational counseling may be useful throughout the process to assist patients in clarifying what is important to them and in arriving at a deliberate and informed decision.[12] This article focuses on steps 4 and 5 of S.H.A.R.E.

In reaching a decision with your patient, a decision is made together and a follow-up appointment is arranged. The AHRQ recommends the following:

- Ask the patient if he or she is ready to make a decision
- Ask if he or she needs more information tools. Condition-specific PDA can be helpful at this time. PDA are multimedia resources (online, print, video) that aim to inform patients of available evidence-based options, encourage active patient engagement in the SDM process, and help patients think through what is important to them so that they can make health care choices that reflect their values, preferences, and circumstances.[13] See Table 1 for a list of recommended condition-specific PDA. Figure 5 is an example of a decision aid on choice for additional testing among patients with chest pain, based on their risk score.
- Check if the patient needs more time or to discuss with others
- Confirm the patient's decision
- Schedule follow-up

The final step is to evaluate the decision. Monitor the extent of implementation, assist in managing barriers and revisit the decision in order to determine if other decisions need to be made.[8,16]

Table 1. Recommended condition-specific decision aides[14]

Mayo Clinic Shared Decision-Making National Resource Center	https://carethatfits.org/tools
Patient Info Decision Aids	https://patient.info/doctor/decision-aids
Ottawa Hospital Research Institute A to Z Inventory of Decision Aids	https://decisionaid.ohri.ca/AZinvent.php
NHS Patient Decision Aids	https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making

Implementing SDM in Family Practice

Despite the identified benefits of SDM, it is not widely practiced in routine care due to a variety of organizational, provider, patient, and contextual factors. Barriers to SDM adoption include indifference and unpreparedness of patients and health care team, time constraint, high workload and burnout, insufficient provider training, inadequate clinical information systems, lack of organizational support and financial incentives, and seeming paucity of observable clinical outcomes.[17] In the primary care setting, doctors' social participation, patients' employment status, decisional conflict, and duration of consultations were identified to be significantly associated with SDM behaviors. Doctors who are more actively engaged in their social system beyond routine clinical practice and those who spend more time with their

patients (i.e., more than 20 minutes consultation time) were more likely to practice SDM. Additionally, patients faced with distressing decisional conflicts verbalize their uncertainties more, thus presenting doctors with more opportunities to engage patients in SDM. Conversely, patient unemployment was associated with reduced SDM practice similar to patients from lower socioeconomic status who choose to assume a more passive role in decision-making during consultations.[18]

Strategies to work around these identified barriers include the use of decision aids, embedding SDM in doctor training and culture, engaging allied health care personnel, fostering motivation and perceptions that highlight the positive effects of SDM on patient-reported health outcomes, supportive leadership and clinical processes, automated clinical decision support, and constant evaluation and iterative improvement. There is a need for concerted and multilevel efforts to improve SDM implementation in primary care.[17,19]

Implementing SDM is a complex intervention and differs for every health care practice setting. On a system level, National Health Service (NHS) England organized their implementation strategies into four domains, namely: prepared public, supportive systems and processes, trained teams, and commissioned services (Figure 5).[20] This is a good framework that family and community medicine physicians can contextualize in Philippine family and community practice.

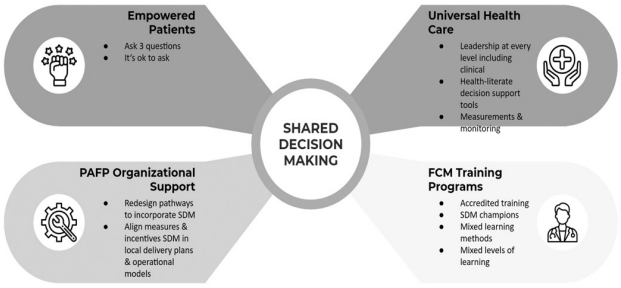

Figure 5. SDM implementation framework[20]

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