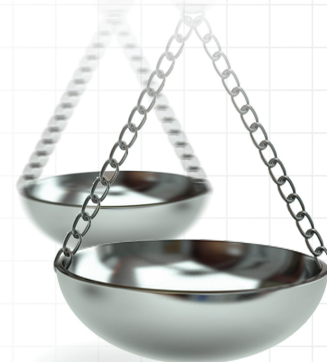




Beyond involvement: multiple methods and purposes of shared decision making

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“Focusing SDM on the real-world problems for which patients and clinicians are making decisions, and on the different methods for how best to reach a ‘good’ decision together may further the adoption of SDM and make it more pertinent in clinical care.”

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Shared decision making (SDM) has been promoted as a way of supporting patient–clinician decision making, yet SDM is not widely adopted in practice. Current models of SDM mostly focus on involving patients in weighing pros, cons and their preferences regarding particular options. However, there are many situations in which patients and clinicians need to, and are, making decisions together in which weighing pros and cons is not the appropriate method for reaching a decision. For example, many chronic care decisions require a problem solving rather than a weighing approach to decision making. Low SDM adoption may be a sign that SDM interventions and trainings do not respond to the problems that clinicians and patient face or provide methods for resolving them.

Millions of healthcare decisions are made daily. Many of these decisions, such as which kind of suture to use in surgery, are technical and do not generally require patients to contribute to decision making. Other decisions, such as how to manage declining kidney function or whether a prostate biopsy can wait until after a long-planned vacation, require patients and clinicians to make decisions together as these decisions have practical implications for how patients live and organize their lives. Decisions like these happen regularly in practice. They are common, are clearly instances in which patients and clinicians are making decisions together and yet they are often unaddressed in efforts to promote SDM.

SDM is mostly described as a process of involving and supporting patients in decision making, discussing the pros and cons of options and eliciting patient preferences [1]. SDM arose in response to paternalistic decision-making practices, a call expressed in phrases such as ‘nothing about me without me’ [2]. It was also seen as a way of lessening unwarranted practice variation and poor evidence use [3]. Today, SDM is increasingly a requirement of reimbursement and promoted in medical education and practice and comparative effectiveness research contributes evidence for use in SDM interventions [4,5]. However, SDM has not been widely adopted.

In a systematic review [6], the second most prevalent facilitator of SDM adoption identified was clinician perceived positive impact on clinical processes, while the second and third most prevalent perceived barriers were lack of applicability due to patient characteristics or clinical situation respectively. These barriers are generally cast as a matter of clinician attitude. However, it is worth considering that it may not be a matter of attitude but rather that the tools and techniques of SDM that clinicians have been provided with do not match the situations that require shared decisions to be made. Focusing SDM on the real-world problems for which patients and clinicians are making decisions, and on the different methods for how best to reach a ‘good’ decision together may further the adoption of SDM and make it more pertinent in clinical care.

Beyond involvement

From the beginning, SDM has justifiably expressed an imperative for patient involvement in decision making and this imperative has largely driven the development of the field and its practice. Without discounting the importance of patient involvement, we also need to pay attention to the problems that are the reason why patients and clinicians

are involved in decision making in the first place. Patients and clinicians make decisions in order to act well in response to the patient's situation. How best to make these decisions will vary with the problem that the patient and clinician are facing [7].

For example, consider two care situations. In the first case a patient, Helen, and her clinician are choosing a new depression medication when the first medicine that they tried did not relieve Helen's symptoms. Making use of a decision aid that lists different antidepressants and their pros and cons, Helen and her clinician weigh the options against the patient's preferences and select a new medication.

In the second situation, Phil, a patient with previously well-controlled Type 2 diabetes, visits with his primary care clinician. Over the last 3 months, the patient's glycated hemoglobin (HbA1c) has risen from 6.9 to 8.3%. In conversation, the two discover a number of factors that may have contributed to this increase. Phil has begun to eat more carbohydrate rich foods due to anxiety about the forthcoming near doubling of the rent of his two-story home as the neighborhood in which he has lived for 40 years is gentrifying. He fears that all he will be able to afford now will be a one-bedroom apartment but he is the caregiver to his daughter who has moved back home after her legs were paralyzed in a car accident 8 months prior. As a result of the accident, she developed a moderate but slowly improving cognitive impairment. As Phil and his doctor talk, they consider adding an anxiolytic but Phil does not feel ready to do that yet and so they decide to reevaluate in 6 weeks. The doctor wonders if any financial support might be available to Phil as a caregiver or if alternative housing might be available for his daughter. Phil's demeanor brightens at these possibilities and the doctor sets up a consultation with a social worker to explore further. They also decide not to worry about Phil's HbA1c or diet for now until other things in his life settle down.

In both instances, patient and clinician are making decisions together. However, the reason why they are making decisions is very different, as is the method used to make the decision. In Helen's case, the situation is fairly clear – she continues to experience depressive symptoms. In Phil's case, the problem at the beginning of their conversation was relatively unclear – it appeared to be high blood sugar, but as they talked, a different problem was uncovered. In Helen's case, potential treatment options were established up front and presented in the decision aid, while for Phil, hypotheses about what might be done emerged alongside a fuller understanding of the situation. In both cases, patient and clinician engaged in shared decision making. Helen's case made use of a method of weighing pros against cons, while Phil and his doctor together used a problem-solving method to come to a decision.

Weighing options and problem solving are not the only methods by which shared decisions are made. For instance, in the case of a woman who comes from a culture where birth is overwhelmingly via cesarean and who is considering vaginal delivery in her new country. Here the decision does not rest on the pros and cons of the different methods of delivery but on what she wants and who she sees herself as being. Her clinician could help her come to a decision by using negotiation methods to reconcile her conflicting inner desires. Another method is appropriate in situations such as end-of-life decision making. For some families, it may be cruel to make a decision about continuing life support based on the pros and cons of options. Instead, a more appropriate method may involve the family and clinicians talking together to discover what really matters in the situation and how the loved ones' life should come to a close.

As the last example demonstrates, using the wrong method of coming to a decision may be ineffective and distressing. Another instance would be asking the woman to make a birthing decision based on pros and cons. This may leave her inner conflict unaddressed and lead to anxiety as birth approaches.

Many clinicians have developed a feel for the situationally appropriate method of making decisions with patients and vary the method according to who the person is and what the problem is that they are addressing. It is quite possible that part of the difficulty of SDM adoption is that current SDM tools and trainings focus on methods of decision making, such as weighing pros and cons, that are not appropriate for the kinds of situations that clinicians and their patients face. Low adoption does not necessarily mean that clinicians are ill-disposed toward SDM; it may well be that SDM intervention design, research and promotion has not produced useful supports for the challenging conversations that clinicians routinely have with their patients. The very real challenges of care warrant turning the attention of SDM funders, policy makers and intervention developers toward supporting patients in making decisions wherever they may arise.

Frameworks exist for what is generally required to involve patients in decision making [8,9]. These could usefully be extended to account for the different methods of deliberation required in different situations. There is also a need to adapt the measures used to evaluate SDM interventions. Current measures largely focus on patient involvement, knowledge and satisfaction. It is quite possible to increase involvement, knowledge and satisfaction yet still have an intervention that is not useful in helping patients and clinicians respond to the problems that they face [10]. In

order to increase and focus SDM implementation, it would be helpful to know not only if an intervention ‘works’ but also if it is useful. It would also be helpful to know if an intervention helps to produce a ‘good’ decision at the time that the decision was made. I continue to be perplexed by the question, “*how would I recognize a good shared decision when I saw one?*”. If the purpose of SDM extends beyond patient involvement to figuring out how to respond to the patients’ situation, then the question of the quality of the response decided on must be confronted.

Every day, patients and clinicians make decisions together in many ways, for many reasons, in response to many problems. SDM should be applauded for strengthening patients’ ability to participate in decision making. Future development oriented to the diverse methods required to address patients’ problems will only further realize SDM’s contribution to care.

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