If Shared Decision Making Is So Good, Why Don't We Do It?

by Guylène Thériault MD CCFP

Shared decision making (SDM) has been defined as "an approach where clinicians and patients share the best available evidence when faced with the task of making decisions, and where patients are supported to consider options, to achieve informed preferences."[1]

Many clinicians would say that is how they practice. But ask yourself: Do you really practice with the idea that self-determination is a desirable goal?

When it comes to making many decisions in health care, individual judgements about what matters (values), informed by balanced information is of central importance. This translates 'evidence' - information on risks and benefits - into an understanding of what is personally meaningful. Research studies consistently show that patients whose decisions are made this way are less likely to regret their decisions, more likely to judge later that they were good decisions and be more satisfied with the care they received[2].

That does not apply to my practice

Is SDM at the heart of family practice? Isn't it the real idea behind patient-centered care? It has been estimated that at least 25% of decisions in health care are preference-sensitive and thus, should be approached by a shared decision[3]. Even so, studies tell us that clinicians tend to talk more about benefits than harms and often don't ask for patients' input[4], demonstrating that SDM is not yet part of many practices. Maybe that is why we think it does not apply in real life. Even if the expectations to make this part of our practice seem like a burden, out of touch with the reality of day-to-day practice, SDM is central to each and every practice.

It takes time that we don't have

SDM takes time, and time is the scarcest commodity in primary care practice. There is an abundance of literature showing that SDM does not take more than a few minutes for most topics[5]. Lack of skills probably makes it look worse than it is, but there are ways to help.

A hospital in Hanover, New Hampshire has a shared decision center where physicians can refer patients. For example, an orthopedic surgeon sees a patient and advise this patient that knee replacement is an option. He sends this patient to the SDM center where he is guided through a library of decision aids to help him make his decision[6]. Why not replicate this on a smaller scale in your setting? You could have a nurse guide patient through healthcare decisions like the next diabetes medication, to take or not to take a statin or even through screening decisions.

Alternatively, you could give information materials to your patients before you see them (either by email or at the last visit you had with them). This approach could facilitate efficient and meaningful discussions with your patients. You could also practice with colleagues how to efficiently present some of the common discussions (e.g. screening decisions). Build your knowledge and confidence gradually, similar to most other skills you have acquired. The CFP series on this topic can be of help.

Beware, you won't escape

More and more guidelines are recommending an SDM approach. The recent Canadian Task Force guidelines on breast cancer screening made SDM central to their recommendations. Consequently, none of us are expected to simply follow a recommendation for or against, but rather engage in SDM.

Annette O'Connor, a central figure for her work on SDM in Canada and abroad has led one of the most substantial research efforts in the world to develop practical tools to support patients and practitioners. She was at the forefront of the science of SDM and generated evidence on how this approach can make a difference[2]. Even if research is still needed to find how to best implement SDM so that it can have the most impact on patients' outcomes[7,8], making SDM a part of our everyday practice should matter to those of us who espouse the ideals of patient-centred family practice.

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References

1. Elwyn G, Coulter A, Laitner S, Walker E, Watson P, Thomson R. Implementing shared decision making in the NHS. *BMJ* 2010;341:c5146. doi: 10.1136/bmj.c5146

2. Stacey D. et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database of Systematic Reviews 2017, Issue 4. Art. No.: CD001431

3. Wennberg, John E. The Darmouth Atlas. Estimates based on Medicare claims done for the Institute of medicine. 2010

4. Fagerlin, Angela and al. Patients' Knowledge about 9 Common Health Conditions: The DECISIONS Survey. Med Decis Making 2010;30:35S-52S

5. Legaré F., Thompson-Leduc P. Twelve myths about shared decision making. Patient education and counselling 96 (2014) 281-286.

6. https://www.dartmouth-hitchcock.org/patients-visitors/decision-making-help

7. Aubree Shay L., Elston Lafata J. Where is the evidence? a systematic review of shared decision making and patient outcomes. Med Decis Making. 2015 Jan; 35(1): 114-131.

8. Legare F. and al. Interventions for increasing the use of shared decision making by healthcare professionals. Cochrane systematic review database. July 2018.