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Review Article

Shared Decision Making: Pinnacle for Patient-Clinician Relationships

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Definition

Shared decision making (SDM) is an interactive, collaborative process where clinicians focus on the available best scientific evidence and patients' goals, preferences, and values to make healthcare decisions.[1,2] Clinicians assist patients to analyze potential risks, benefits, and outcomes to reach evidence-based and value-congruent medical decisions. SDM is concurrent with patient-centered care, a core value of our health system.

Traditional Paternalistic Approach Versus Shared Decision Making

Many clinical situations entail multiple reasonable options to choose from and are not always straightforward. Appropriate medical and surgical decision making to maximize treatment outcomes can be complex even for a clinician. The traditional paternalistic approach is unidirectional; the clinician decides the best course of action and then presents it to the patient.[1] Even if the patients are well-informed, their involvement could be within the boundaries of giving or not giving consent, and not adhering to the recommendations. SDM has been recommended to optimize patient involvement in healthcare decisions since the early 1980s. The U.S. Preventive Services Task Force (USPSTF) & the Institute of Medicine encourage clinicians to use SDM for preventive health and treatment recommendations to improve the quality of healthcare in the U.S. The shared decision making notion was inspired by "nothing about me, without me," in 1998 during a seminar Through the Patient's Eyes.[1]

Patients have the right to be informed and actively participate in their care decisions with a clear understanding of potential risks, benefits, and alternatives. A recent systematic review found that most patients prefer to be actively involved in their medical decision-making and perceived that physicians make the decisions more often than their preferences.[2] In this digital era inaccurate medical information which could be far from evidence-based is easily accessible. Clinicians must actively interact with patients to understand their knowledge and expectations and facilitate their comprehension of the probable outcomes before making medical decisions.

SDM is a bi-directional approach that offers a structured pathway where clinicians collaborate with patients by providing relevant evidence to patients to decide whether to accept any services or treatment depending on their preferences, circumstances, and core values.[1,2,3] For example, many screening recommendations have the potential for both benefits and harms. Individual patients might pursue different screening tests depending on their preferences and perspectives toward possible risks. SDM is crucial for patients to decide whether the benefits are worthwhile to pursue. Another commonly encountered clinical situation is the decision of anticoagulation in a patient with atrial fibrillation of high CHA_2DS_2-VASc score and significantly high bleeding risk. SDM elicits the understanding of patient and surrogate preference on a weighting between bleeding and thromboembolic stroke.

Shared Decision Making with Elderly Patients

The elderly patient population is a wide spectrum consisting of highly independent patients to patients with multimorbidity requiring significant assistance on daily activities from others. Shared decision making is critical for older adults with multiple chronic conditions as the best treatment for each

disease may not be the best treatment for the elderly patient as a whole. The conversation between elderly patients with multimorbidity, their caregivers, and the medical team should focus on preferred health outcomes to guide the discussion and treatment options rather than the treatment of each medical condition.

Undiagnosed cognitive impairment in elderly patients is a huge obstacle for SDM during clinical encounters. Disabling hearing impairment is prevalent among 50% of patients who are more than 75 years old.[1] Occasionally, hearing loss could be misinterpreted as cognitive impairment. Mini-Cog can assess the likelihood of cognitive impairment in less than 3 minutes. Advanced age is the perceived notion of not being willing to participate in and understand SDM. This belief can result in an unintentional paternalistic approach by healthcare professionals resulting in a barrier to SDM in geriatric medicine. Older patients with multiple comorbidities suffer from anxiety, which may lead them to rely entirely on their clinicians for any crucial healthcare decision. Low health literacy is highly prevalent among older adults, ranging from 30-68% which can cause suboptimal shared decision making discussions.[3] Geriatric patients have been excluded from clinical trials deliberately based on age cutoffs. Very few clinical trials enrolled adults over 80 years, making it challenging for healthcare professionals to tailor the best available evidence to an elderly individual with multiple coexisting chronic conditions. Older patients may have multiple generations of young family members, and caregivers highly involved in their care. They may provide important collaterals to promote SDM consistent with patients' values. In contrast, sometimes they may have their own agendas and perspectives that may not be aligned with patients. One study found that discussion with older adults about their healthcare priorities and goals leads to a better professional relationship with physicians.[4]

Positive Impacts of Shared Decision Making

A study published in JAMA found that SDM has been associated with higher patient satisfaction.[5] Patient satisfaction relates to increased treatment adherence.[5] Patients involved in shared decision making were 80% less likely to contact a lawyer for lawsuits than those not involved in shared decision making. The study participants rated their physicians higher and were less likely to fault their physicians for the adverse outcomes compared to no shared decision making.[6] SDM empowers clinicians to know patients as persons which is the cornerstone of safe and exceptional patient-centered care. Clinical prediction scores like Pulmonary Embolism Severity Index (PESI) can predict patient outcomes and classify risk categories. These clinical tools do not replace clinical judgment and shared decision making. For instance, patients with new diagnoses of pulmonary embolism with low risk for complications can be discharged home on a direct oral anticoagulation (DOAC) per the American Society of Hematology 2020 guidelines for the management of venous thromboembolism. SDM is of utmost essential to actively engage patients and caregivers to communicate the risks vs benefits of anticoagulation, their willingness, and comfort level to be discharged on the same day. Facilitation of SDM has been associated with improved quality of life and patient outcomes.[7] This meta-analysis of 4419 patients showed that SDM has a significant impact to reduce decisional conflict and increase patient knowledge.[8]

There is often no picture-perfect treatment choice. Nearly all treatment options involve some uncertainty and meaningful tradeoffs. Informed clinical decisions require the judicial application of diagnostic testing, overcoming biases, and customizing population-based evidence to an individual patient.

Barriers to Shared Decision Making

Time constraints are the most frequently identified barrier to SDM in clinical practice.[9] The reality is a 15 to 20 minutes encounter at a physician's office is not always sufficient to listen to patients, address all their needs, emotional concerns, and assist them to make informed decisions that are consistent with their core values & preferences. A recent study looked at the mean time required for a primary care physician (PCP) to provide guideline-recommended care. PCPs were estimated to require 26.7 h/day;14.1 h/day for preventive care, 7.2 h/day for chronic disease care, 2.2 h/day for acute care, and 3.2 h/day for documentation and inbox management.[10] On the other hand, patients may prioritize other parts of their physicians' visits viewing SDM requires more time, not wanting to feel rushed and not feeling comfortable asking

many questions. A study revealed that only 36% of clinical encounters addressed patients' purpose for physician visits.[11] As addressing goals is an integral part of SDM, only 36% of clinical visits achieved SDM.[11] To increase the quality of patient-clinician visit time, clinicians can streamline each patient encounter by directly asking about the main reason for the visit. In addition, clinicians should sit at the patient's level and avoid sitting behind a computer screen to enhance quality and set a positive tone during encounters. The quality and quantity of time are critical to cultivating strong patient-clinician relationships, patient-centered interviewing, and patient satisfaction. Due to the growing demands of clinical productivity, clinicians should focus on how to navigate clinical encounters that will bring value to patients and clinicians alike.

In Conclusion

Shared decision making (SDM) is the clinical interaction that is responsive and respectful to each patient's preferences, needs, values, and goals and incorporates them meticulously into their treatment plan. The evermore important goal is to ensure engagement with patients, caregivers, or authorized representatives. SDM empowers patients to make informed healthcare decisions rather than their clinicians solely deciding treatment options. Due to SDM's robust benefits on patient satisfaction, improve quality of life, and patient outcomes, it is worthwhile for clinicians to practice it deliberately. SDM is embedded in collaborative patient-and family-centered care which a clinician would expect from another clinician during their own medical care.

Conflict of Interest

The author had no conflicts of interest to disclose.

Keywords

Shared decision making, clinical decision making, patient-centered care, informed decision making, geriatric care

References

1. Backman, WD, Levine, SA, Wenger, NK, Harold, JG. Shared decision-making for older adults with cardiovascular disease. Clin Cardiol. 2020; 43: 196–204. https://doi.org/10.1002/clc.23267

2. Ellen M. Driever, Anne M. Stiggelbout, Paul L.P. Brand, Patients' preferred and perceived decision-making roles, and observed patient involvement in videotaped encounters with medical specialists, Patient Education and Counseling, Volume 105, 2022, https://doi.org/10.1016/j.pec.2022.03.025.

3. MacLeod S, Musich S, Gulyas S, et al. The impact of inadequate health literacy on patient satisfaction, healthcare utilization, and expenditures among older adults. Geriatr Nurs. 2017; 38 (4):334-341. https://doi:10.1016/j.gerinurse.2016.12.003

4. Feder SL, Kiwak E, Costello D, et al. Perspectives of Patients in Identifying Their Values-Based Health Priorities. J Am Geriatr Soc. 2019; 67(7):1379-1385. https://doi:10.1111/jgs.15850

5. Thibau IJ, Loiselle AR, Latour E, Foster E, Smith Begolka W. Past, Present, and Future Shared Decision-making Behavior Among Patients With Eczema and Caregivers. JAMA Dermatol. 2022; 158 (8):912–918. https://doi:10.1001/jamadermatol.2022.2441

6. Schoenfeld, E. M., Mader, S., Houghton, C., Wenger, R., Probst, M. A., Schoenfeld, D. A., Lindenauer, P. K., & Mazor, K. M. (2019). The Effect of Shared Decision making on Patients' Likelihood of Filing a Complaint or Lawsuit: A Simulation Study. Annals of Emergency Medicine, 74(1), 126-136. https://doi.org/10.1016/j.annemergmed.2018.11.017

7. Hibbard JH, Greene J. What the evidence shows about patient activation: better health outcomes and care experiences; fewer data on costs. Health Aff (Millwood). 2013; 32(2):207-214. https://doi:10.1377/hlthaff.2012.1061

8. Mitropoulou P, Grüner-Hegge N, Reinhold J, et al Shared decision making in cardiology: a systematic review and meta-analysis Heart 2023; 109:34-39. http://dx.doi.org/10.1136/heartjnl-2022-321050

9. Yahanda, A., Mozersky, J., AMA J Ethics 2020; 22(5): E416-422. https://doi.org/10.1001/amajethics.2020.416

10. Porter, J., Boyd, C., Skandari, M.R. et al. Revisiting the Time Needed to Provide Adult Primary Care. J GEN INTERN MED (2022). https://doi.org/10.1007/s11606-022-07707-x

11. Singh Ospina N, Phillips KA, Rodriguez-Gutierrez R, et al. Eliciting the patient's agenda—secondary analysis of recorded clinical encounters. J Gen Intern Med. 2019; 34(1):36-40 https://doi:10.1007/s11606-018-4540-5

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Dr. Hoque received an MD through a 6-year program at Dhaka University, Bangladesh. She completed her residency in Internal Medicine at St. Luke's Hospital. Dr. Hoque received the Caring Physician Award, the Attending Physician of the Quarter Award, Excellence in Professionalism Award from SSM Health St. Louis University Hospital. Dr. Hoque was featured twice as "Movers and Shakers" by the Society of Hospital Medicine, The Hospitalist Newsmagazine in 2022. She was also awarded the Clinical Award: Physician of the Year as the only physician from all SSM Health hospitals in St. Louis, Missouri.

Dr. Hoque is the President of the Society of Hospital Medicine St. Louis Chapter. She has been invited as a speaker at multiple regional, national, and international conferences. The American College of Physicians has selected Dr. Hoque to receive the Young Achiever Award for three consecutive years.