The Crux of Shared Decision-Making: Who Is Actually Deciding?

written by Theresa Hush | December 21, 2017



Shared Decision-Making is an emotionally charged topic for both

physicians and patients. Physicians believe they have their patients' best interests at heart by guiding them into better health through therapies to improve their conditions. Physicians may believe, in fact, that by explaining health status and treatment alternatives (followed by asking the patient to decide), they are already using a Shared Decision-Making process. Patients, in turn, are facing a higher share of costs, yet an ever-worsening health status that requires improvement to avoid financial disaster.

Imagine a typical physician-patient discussion about an important medical decision or the path for improving outcomes for serious, chronic co-morbidities. Sitting together in the exam room, the physician carefully describes the patient's clinical issues, provides treatment alternatives she believes are appropriate, and asks the patient to make a choice among therapies. Is that not a Shared Decision-Making process?

No, and here is why. First, the physician never questions the patient on his goals or tolerance limits, support system or preferences. Therefore, any decision is totally based on the physician's estimation of the patient's situation.

The physician also assumes that the patient can be persuaded by her guidance and experience. The physician, in fact, has structured the patient decision process to suggest therapies she believes to be most efficacious and has not provided data for the patient to weigh benefit and harm (including cost). Unless the process includes the data necessary for the patient to make an informed purchasing and/or lifestyle decision about the potential value and harm of treatments, the patient is not making the decision. The choice is being made by the physician.

Every medical decision involves biases, previous knowledge, and sets of beliefs for both physician and the patient. The Shared Decision-Making challenge is for physician and patient to collaboratively review actual facts, share preferences, and then for the patient to reach a decision.

Six Shared Decision-Making Essentials

Shared Decision-Making is not simply a conversation about alternatives. Rather, SDM is characterized by a more formal process of reviewing data, information, and the patient's own circumstances. The discussion is characterized by detail, research, full explanations, and taking the necessary time to ensure that the patient has all criteria needed to make an informed decision. Here are six elements to include in that review:

1. Quantified patient status and risk. The patient needs, first of all, to understand his or her health status or risk, as expressed in data such as life expectancy or morbidity, likelihood of disease progression, or other possible outcomes relevant to the decision (e.g. fracture risk, heart attack or stroke risk, progression of diabetes). The consequences of doing nothing as well as alternatives should be addressed. Understandably, the ability to provide patients accurate data is limited both by availability as well as the complexity of the patient's conditions. However, an effort must be made to quantify the decisions for the patient and to explain the risks in factual and not emotional language.

2. Decision alternatives grounded in pertinent research data. "Bigger risk" is not a meaningful term for patients to make decisions. Nor are studies that may not be relevant to the

patient’s age, condition or gender. Information and data must be as unbiased as possible; the patient needs to know the limitations of medical science or the state of knowledge.

3. All alternatives, including those not within the physician’s repertoire. Surgeons who do not present other surgical approaches versus their own techniques do not provide full information to the patient, nor do physicians who present a more limited array of familiar or preferred medicines. The patient should be encouraged to explore information on his or her own.

4. Numerical benefits and harms associated with treatment options. Clear understanding of the benefits and harms associated with any treatment plan is essential for the patient to make an informed choice. This is an area, however, where advances in knowledge may change the actual analysis of benefit and harm; the data must be provided with this understanding.

5. Patient barriers and obstacles. A plan that is patient-centric must take into account the patient’s personal limitations, such as availability of home support for the treatment, ability to take medications as directed, time and affordability.

6. Opportunity to investigate options and make a decision—not necessarily now. Unless circumstances are time-critical, the physician should offer an avenue for further communications with the patient and a mutually agreed-upon time-line for his or her decision. As part of this process, the patient should have access to full medical records, including images and testing results, for review with other providers.

Physicians may respond to this list with a combination of horror and exhaustion. This reaction is justified. They know that they lack the infrastructure, time, information and technique to implement SDM. They will fear another layering of documentation and activities without resources.

The purpose of itemizing these essentials is to underscore the details required to revolutionize medical decision-making so that the patient takes charge. It doesn't mean that the physician has to do it alone. Accomplishing SDM goes way beyond physicians. It requires health systems and physician organizations to train, compile data, and remove obstacles that impede physicians from budgeting the time they need to work with patients, and to provide the tools for physicians to deliver information.

Why go to all that trouble and expense? Because this is the avenue to patient loyalty and to managing cost and quality under financial risk, which looms on the horizon.

Medical Science Is Imperfect

The goal of SDM is to rebuild the process and information involved in medical decision-making so that alternatives can be examined without physician bias.

Patients will often say "I'm not clinical" when they feel uncomfortable challenging a physician's treatment recommendations. I am suggesting that a benefit of rebalancing the roles of physician and patient in decision-making is acknowledging that there is not always a truth or a cure to disease, and that medical science is always in a state of growth. Decisions made by a physician are not "better" than

decisions made by a patient.

Medical science is changing. Headlines about new studies reverse the basic "knowledge" that patients—and physicians—held to be true about disease causes and associated factors in progression. Some research findings are false or premature while others reflect careful study and further science. Unfortunately, even physicians aren't always able to determine which is which, because they don't read the research—or may be too busy to put it into practice.

Savvy patients recognize that much discounted medical information still occupies a prominent position in physicians' advice. They don't know whether to trust the doctor or what they read. Those patients who want the real data do not have access to it independently because medical journal access is restricted to those who pay.

Helping the Patient be the Decision-Maker is Crucial—And Difficult

Physicians are trained to make decisions. Patients are not, overtly. Actually, however, patients often make decisions by avoiding recommendations that they don't believe or will not follow. Physician's decisions inevitably reflect their personalities, mindsets, assumptions and personal beliefs about what patients should do; patients are quick to sniff this out and react in ways that play out their own personal biases.

If the objective of SDM is to have the patient commit to a plan, the physician must be prepared to play the role of coach and facilitate the patient's decision. This will not be easy for either party, as each occupies a somewhat reversed,

unfamiliar role. The physician's primary role is to provide information in an understandable way to the patient, and the patient's role—not the physician's—is to make the final decision.

Emotionally and professionally taxing, SDM requires that physicians set aside some of their past training to take charge. They may not feel confident of the patient's willingness or ability to take over the lead. Patients, used to being told what to do, may feel insecure and afraid. Projects in Shared Decision-Making should be implemented in a way that will help physicians as well as patients achieve success. Defining the clinical areas that can benefit the most, and selecting patients who will be good candidates, are important considerations.

Physicians must also have the support to provide research-based data and decision-making tools to their patients. We cannot expect patients to make major, permanent medical decisions on the basis of verbal advice, without talking to their personal support team—or without seeking other opinions. The health system should establish tools for making that support available to both physicians and patients.

Shared Decision-Making alters the entire relationship and flow of factual information used in medical decision-making. Undertaking such an endeavor exceeds the bandwidth of almost all practices, and requires the development of tools for practices to deploy, as well as the development of motivational expertise for physicians. Without these capabilities, both the patient and physician will be thwarted.

SDM is a Process of Change, Not a One-Time Fix

Shared Decision-Making is not a one-time fix for health care outcomes. It assumes a learning process to work through various conditions, physician groups and patients. Creating the tools and gathering needed information will be iterative and imperfect.

How to determine if SDM is working? Ask both patients and physicians. Since they are collaborating in constructing a path toward the patient's better health, the patient should have a voice in evaluating how the process is working. The physician should be looking at individual and aggregate outcome data to determine the effect (or not), for process adjustment.

Like any partnership, SDM necessitates work by both parties to improve the patient's health. Examination of outcomes as well as patient attitudes over time are both critical measurements for physicians and health systems. The need for providers to engineer communication and information cannot be overstated; if SDM fails, it will likely fail because physicians are not properly supported through access to necessary information, productivity plans have not been adjusted to take pressure off physician time in SDM, or physicians have not received training to undertake complex educational roles.

Shared Decision-Making will not fail because patients make decisions.

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