Debate & Analysis

We need more guidance on shared decision making

The role of the GP has changed. Gone are the days of paternalistic health care. GPs are now leading the way in shared decision making (SDM). To become a member of the Royal College of General Practitioners, a trainee now sits an exam that awards marks for involvement of patients in decision making. Two of the six core competencies of the Royal College of General Practitioners are person-centred care and holistic care, the latter defined as, 'caring for the whole person in the context of the person's values'.¹ However, SDM is not yet the norm within the NHS and a substantial proportion of patients still report that they were not involved as much as they would like, and this is not showing improvement.²

Although surgeons are compelled to seek informed consent, there is no equivalent requirement when a drug is prescribed. Yet drugs cause serious adverse events and can reduce quality of life, often in the context of marginal or unknown risk-benefit ratios. As we lower thresholds for recommending preventive therapies, numbers needed to treat get larger and we medicate more patients at high risk of side effects, particularly older patients. Most therapeutic interventions are pharmacological and most of these are initiated in primary care. Modern health consumerism, and a culture that questions professional authority, can be seen not as challenges but as opportunities for involving patients in a real way in decisions about treatment.

Perhaps shortfalls in SDM relate to variations in doctors' lack of clarity about what it really means.³ Is it absolute autonomy, presenting bare facts and figures? And expecting the patient to understand them and make a yes or no choice? Or, on the other hand, is it the clinician's duty to influence patients to choose the technically gold-standard, evidence-based treatment for their own good?

A THIRD WAY

There is a third way. Emerging thinking proposes an approach to SDM that rejects the polarities of paternalism and autonomy, and their awkward contradictions.^{4,5} Skilful SDM is about a clinician effectively helping a patient explore their values and how these fit best with available treatment or diagnostic options. This model does not set autonomy

Box 1. Sources of guidance and training

E-learning

- e_Learning for Healthcare (www.e-lfh.org.uk/programmes/shared-decision-making).
- BMJ Learning (http://learning.bmj.com/learning/module-intro/decision-making.html?moduleId=10032738&searchTerm=%20shared%20decision%20making&page=1&locale=en_GB).

Work programmes

- MAGIC (www.health.org.uk/areas-of-work/programmes/shared-decision-making).
- NHS Right Care (<http://sdm.rightcare.nhs.uk>).

Courses

- The Medical Protection Society runs a course on 'Mastering Shared Decision Making', which is free for members.

against beneficence, and does not depend on the patient's preconceptions about hierarchy and roles within the consultation. It is particularly, but not exclusively, suited to the preference-sensitive decisions where there is no clear 'best' answer. Choice in SDM is based on a synthesis of patient desires, values, and preferences with available clinical knowledge. Many of the drug treatments that we use in general practice fall into this category, such as primary and secondary prophylaxis for cardiovascular disease, anticoagulation in atrial fibrillation with borderline risk, or drug versus talking treatments for mental health.

Good SDM enhances communication and understanding, signals respect, and improves the doctor-patient relationship.⁶ There is evidence that it has a positive impact on clinical outcomes in a range of conditions seen commonly in primary care, and that it does not prolong consultations.^{7,8} SDM has been shown to reduce uptake of health care, at least for invasive procedures such as joint replacement and hysterectomy. Research is needed on the potential impact of shared decisions on resource use in primary care, particularly in terms of drug spending.^{9,10} Choice based on discussion of the risks, for example, falls and fractures due to cardiac medications, may reduce iatrogenic personal, societal, and overall health economic costs.

Doing SDM effectively requires competencies that are not always developed during medical training. Facilitating a shared decision is part of the art of medicine; there is no one-size-fits-all method. We need to know which questions we should ask a patient, and their relatives and carers, to help them explore their values in regard to each medical decision they make. Individual patients put different weight on benefits and risks, and on long-term versus short-term gains, and clinicians are not good at gauging these preferences.⁴ The practitioner needs to initiate and guide the patient to reflect on their values and make them explicit, an exercise that may be unfamiliar for the patient and clinician alike. The clinician has to communicate probabilities of risk and benefit, and the strength of the evidence, and do so with sensitivity to the individual patient's background and health literacy. This in turn depends on having access to the relevant data, often only available directly from source literature. Accessing this requires skills in searching for, appraising, and interpreting technical evidence. Finally, the practitioner needs to help the patient weigh the various options. Many clinicians have strengths in some of these areas, but fewer will be proficient in all.

Guidance and training are available from a number of sources (Box 1), and practical aids exist for SDM, such as validated

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visual illustrations that replace numerical arguments. These aids provide balanced, individualised information presented in a way understandable to patients, and which translate 'professional' concepts such as relative risk into something with real-world meaning.¹¹ Option grids help patients and clinicians understand, explore, and compare the available choices and their potential risks and benefits. These are freely available online for several common conditions. There are also filmed materials that help patients achieve a clearer understanding of their options. There is evidence (albeit based on clinicians' rather than patients' views) that aids improve patient knowledge and enable individuals to gain an accurate expectation of the impact of treatment and clarity over what matters to them.⁶ Despite this evidence, these aids are not routinely being used.¹²

ROOM FOR IMPROVEMENT

These resources are clearly necessary but will still not be enough, and there remains room for improvement in delivery of SDM. Barriers to SDM include: doctors' perceptions about patients' desire to share decisions; doctors' ability to facilitate shared decision making; concerns regarding time pressures; apprehension about what patients will demand; and a false perception by clinicians that they are already doing SDM effectively.² Pragmatic measures to increase SDM might include:

the collection of more detailed feedback on SDM for individual and practice-level appraisal; more vigorous promotion of training in SDM; the use of aids during undergraduate and postgraduate curricula; and efforts to change patients' expectations for SDM. There is a need for champions to launch a concerted campaign to move universal SDM from an aspiration to a reality. This will not be achieved through guidance alone, and it will not be achieved quickly.

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REFERENCES

1. Royal College of General Practitioners. *Being a general practitioner* (core curriculum statement). London: RCGP, 2015. <http://www.rcgp.org.uk/training-exams/-/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-1-Being-a-GP.ashx> (accessed 21 Oct 2015).
2. Coulter A, Collins A. *Making shared decision-making a reality: no decision about me, without me*. London: King's Fund, 2011. http://www.kingsfund.org.uk/sites/files/kt/Making-shared-decision-making-a-reality-paper-Angela-Coulter-Alf-Collins-July-2011_0.pdf (accessed 21 Oct 2015).
3. Denford S, Frost J, Dieppe P, Britten N. Doctors' understanding of individualisation of drug treatments: a qualitative interview study. *BMJ Open* 2013; **3**(5): pii: e002706.
4. Mulley A, Trimble C, Elwyn G. *Patients' preferences matter: stop the silent misdiagnosis*. London: King's Fund, 2012. http://www.kingsfund.org.uk/sites/files/kt/field/field_publication_file/patients-preferences-matter-may-2012.pdf (accessed 21 Oct 2015).
5. Stevenson FA, Barry CA, Britten N, *et al*. Doctor-patient communication about drugs: the evidence for shared decision making. *Soc Sci Med* 2000; **50**(6): 829-840.
6. Elwyn G, Lloyd A, Joseph-Williams N, *et al*. Option grids: shared decision making made easier. *Patient Educ Couns* 2013; **90**(2): 207-212.
7. Edwards A, Elwyn G, Hood K, *et al*. Patient-based outcome results from a cluster randomized trial of shared decision making skill development and use of risk communication aids in general practice. *Fam Pract* 2004; **21**(4): 347-354.
8. Légaré F, Ratté S, Stacey D, *et al*. Interventions for improving the adoption of shared decision making by healthcare professionals. *Cochrane Database Syst Rev* 2010; **(5)**: CD006732.
9. Walsh T, Barr PJ, Thompson R, *et al*. Undetermined impact of patient decision support interventions on healthcare costs and savings: systematic review. *BMJ* 2014; **348**: g188.
10. O'Connor AM, Bennett CL, Stacey D, *et al*. Decision aids for people facing health treatment or screening decisions. *Cochrane Database Syst Rev* 2009; **(3)**: CD001431.
11. O'Connor AM, Wennberg JE. Toward the 'tipping point': decision aids and informed patient choice. *Health Aff (Millwood)* 2007; **26**(3): 716-725.
12. Couët N, Desroches S, Robitaille H, *et al*. Assessments of the extent to which health-care providers involve patients in decision making: a systematic review of studies using the OPTION instrument. *Health Expect* 2015; DOI: 10.1111/hex.12054.