

Shared decision-making tools: do they really involve patients?

A 70-year-old man has lower urinary tract symptoms. He sees his GP and is then referred to his local urology clinic. The specialist explains the various options for treatment and then gives the man a patient decision aid. The man works through the tool and ends up at the node that suggests that he has a transurethral resection of the prostate. In this typical scenario, the doctor may feel satisfied that he is delivering patient-centred care and doubly satisfied that he can do so in the time constraints of a busy clinic. However, is this good shared decision making for the patient? This editorial considers some of the important issues in this scenario.

Evidence-based care

The use of a decision aid is intended to provide 'evidence-based' information that is required to inform the essential judgment of competing options in decision making (O'Connor et al, 1999). This 'evidence' can create a false sense of certainty of the information that is to be used in making the decision, and this can apply equally to both the doctor and the patient. The creation of evidence is based on research performed on a specific population of patients and this may not be applicable to a different population, health-care system or an individual patient (Feinstein and Horwitz, 1997).

The applicability, transferability and scalability of research findings are increasingly of concern in using evidence-based medicine to inform the health care of populations that are different to the population in which the research was originally performed (Wang et al, 2006). In addition, the results of most

meta-analyses, and their component clinical trials, usually have heterogeneous outcomes, suggesting that some patients may benefit and some may not benefit from treatment (Thompson, 1994). These results can occur because of a variety of confounding factors, such as the ethnicity mix of the sample population, the extent of comorbidities, variability in operator expertise and differences in postoperative supportive care. Many research studies also do not include details about complications or side effects, although this information is essential for making a decision when there are competing options (Zorzela et al, 2016).

Limitations of evidence

Both the doctor and patient have to appreciate the limitations of evidence in shared decision making, using the available information in the decision aid as only one component of a patient-centred consultation. Other essential components of a patient-centred consultation that appear to be often neglected in decision making are the essential perspective of the patient, and the professional expertise of the doctor (Ioannidis, 2016; Peterson et al, 2016).

The specialist could have had an open-ended conversation with the patient about the various treatment options so that he/she obtains the perspective of the patient (Pendleton et al, 2003). The issues raised in this conversation would have included the medical ones that are covered in the decision aid. However, this conversation would also embrace a range of other issues, such as the patient's worry about how his wife with dementia will manage on her own while he is in hospital; the fact that his father died at the age of 70 years in the hospital where his operation would be done (even though his father died of colon cancer); his fear of needles; and his cigarette smoking – which he says that he cannot give up for even a few days.

An understanding of the patient's perspective provides an essential aspect of shared decision making. Respecting and discussing how these issues influence the

choice of potential options offers a unique insight into the concerns that are influencing the patient's judgment of options, but also it provides an important opportunity to challenge misconceptions and discuss how some of these issues can be effectively addressed and overcome (Pendleton et al, 2003).

Who is responsible for the decision?

It is easy for the doctor to devolve all responsibility to the patient in patient decision making, but in the authors' opinion this is not in the best interests of the patient. There is increasing interest in the development of professional expertise through reflective practice and an essential aspect of this approach is to consider the wide range of factors, from personal to technical and organizational, that influence professional practice (Neve and Morris, 2017).

The professional should be aware of potential influences that might impact on the expected outcomes of any treatment being offered, such as local hospital intraoperative and postoperative complication rates. There are some principles of good shared decision making, which focus on the word 'shared' (Charles et al, 1997). Sharing requires a two-way exchange of information between individuals and a supportive discussion of the meaning of the various options for the patient and his/her family. A decision aid can provide a useful tool to initiate this discussion but merely selecting a particular option is not shared decision making. This option needs a collaborative discussion of the identified concerns of the patient, the limitations of the evidence supporting the decision aid and the professional expertise of the specialist. This integrative approach to shared decision making undoubtedly takes time but in the long term it is likely to produce fewer complaints, greater satisfaction and improved treatment compliance (Joosten et al, 2008; Clayman et al, 2016). **BJHM**

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KEY POINTS

- An understanding of the patient's perspective of his/her condition is an essential aspect of shared decision making.
- Both the doctor and the patient have to appreciate the limitations of evidence in shared decision making, using the available information in the decision aid as only one component of a patient-centred consultation.
- Other essential components of a patient-centred consultation that appear to be often neglected in decision making are the essential perspective of the patient, and the professional expertise of the doctor.

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